March 2010 ORDERS

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-763-411

ISSUES

The sole issue determined herein is claimant's request for a change of authorized treating physician ("ATP").

FINDINGS OF FACT

1. On May 25, 2008, claimant suffered an admitted work injury.

2. On June 17, 2008, claimant had left inguinal hernia repair surgery.

3. After surgery, claimant improved, but then suffered back pain, neck pain, and groin pain.

4. On July 11, 2008, Dr. Manart determined that claimant was at maximum medical improvement ("MMI").

5. Claimant received chiropractic treatment after MMI. On August 18, 2008, she also sought treatment from her personal physician, Dr. Katherine Fitting, who diagnosed pneumonia.

6. Claimant lives in F, Colorado, where Dr. Fitting has her medical practice.

7. On November 11, 2008, Dr. Schakaraschwili performed an independent medical examination ("IME") for respondents. He agreed that claimant was at MMI for the left inguinal hernia and for upper back pain that he attributed to the work injury. He concluded that claimant's continuing low back pain and abdominal pain was not due to the work injury.

8. On December 12, 2008, respondents filed a final admission of liability, denying liability for any permanent disability benefits, but admitting liability for post-MMI medical benefits.

9. Dr. Fitting continued to follow claimant's care. On February 25, 2009, Dr. Fitting diagnosed chronic abdominal pain and muscle spasm secondary to complications from the left inguinal hernia repair.

10. On April 8, 2009, Dr. Healey performed an IME. He concluded that claimant was not at MMI for the work injury. He recommended injection for ilioinguinal neuropathy, surgical

evaluation, trigger point injections, and treatment for myofascial pain related to thoracolumbar pain.

11. On April 30, 2009, Dr. Campbell performed a Division IME ("DIME"). Dr. Campbell determined that claimant was not at MMI for the work injury. She made several recommendations for additional treatment, including ultrasound, magnetic resonance image ("MRI"), additional surgical evaluation of the hernia, evaluation of injection treatment for ilioinguinal neuralgia, physiatry consultation, physical therapy for the abdomen, and thoracolumbar and sacroiliac joint treatment.

12. On June 23, 2009, the insurer filed a general admission of liability, reinstating TTD benefits and admitting for medical benefits.

13. On June 23, 2009, -A-, the claims adjuster, sent an email to claimant's attorney, inquiring about claimant's address in order to locate a physician to facilitate the care recommended by the DIME. Claimant's counsel responded that claimant lived in the middle of nowhere near F, Colorado. Claimant suggested that care be undertaken in Colorado Springs, over 80 miles from F. Claimant also argued that respondents were not allowed to select a physician.

14. On June 30, -A- responded to claimant, designating Breckinridge Medical Center ("BMC") as the ATP. -A- indicated that the care as outlined by the DIME could be performed at BMC. Claimant did not respond to this email and on July 7 and July 14, 2009 -A- inquired for claimant's response on this matter.

15. On July 16, 2009, claimant's attorney responded via email that claimant would not agree to go to BMC because it was not convenient or safe, citing travel over Hoosier Pass and 40 mile distance from claimant's residence. Claimant requested a change of physician to her primary physician, Dr. Fitting.

16. On July 20, 2009, -A- e-mailed claimant's attorney to deny claimant's request for a change of physician to Dr. Fitting. Respondents agreed to provide transportation for claimant to BMC.

17. On July 20, 2009, claimant's attorney replied by e-mail, again citing the difficulties of travel between F and B. -A- replied, denying claimant's request to be treated by her own personal care physician. Claimant did not send any additional communication to the insurer.

18. On July 28, 2009, -A- sent another e-mail to claimant's attorney, again noting that respondents would provide transportation to BMC.

19. On August 4, 2009, -A- sent another e-mail to claimant's attorney, offering three different physicians for Claimant, as well as BMC. -A- offered Dr. David Karli or Dr. Scott Raub

in Vail, Colorado, or Dr. Kenneth Finn in Colorado Springs, Colorado.
20. On August 6, 2009, claimant, through counsel, agreed to Dr. Karli in Vail. Travel from F to Vail would involve the same travel over Hoosier Pass to B and then additional travel over Vail Pass, or would require traveling considerably out of the way to Buena Vista and then to Leadville to go over either Tennessee Pass or over Fremont Pass and Vail Pass.

21. On August 21, -A- informed claimant that Dr. Karli would not accept claimant as a patient. -A- reiterated the previously offered physicians. -A- sent additional e-mails to claimant's attorney on August 27 and September 3, to solicit claimant's choice of the designated ATP. Claimant did not respond to -A-.

22. On September 17, 2009, -A- wrote to claimant's attorney, insisting that claimant respondent by September 28 or an appointment would be set for claimant at BMC.

23. On September 25, 2009, claimant, through counsel, responded by again requesting authorization of Dr. Fitting in F, or one of four other facilities in Salida or Buena Vista: First Street Family Health in Salida, Salida Family Medicine, Buena Vista Family Practice Clinic, and Mountain Medical Center in Buena Vista.

24. On September 25, 2009, claimant also applied for hearing on the issue of change of physician.

25. -A- contacted Mountain Medical Center to determine if they would accept claimant as a patient. The facility would not accept claimant as a patient. -A- also contacted at least two other medical providers, who did not respond if they would accept claimant as patient.

26. On November 16, 2009, counsel for claimant wrote to respondents, again requesting authorization of Dr. Fitting. On November 30, respondents, through counsel, replied, again denying this request and reiterating that BMC was the designated provider.

27. Claimant has not made a proper showing for a change of ATP to her own personal physician, Dr. Fitting. The insurer properly designated BMC as the ATP after the DIME. The insurer timely denied claimant's request for a change of ATP to Dr. Fitting. Claimant's primary reason for the requested change is the approximate 40-mile trip over Hoosier Pass from her residence in F to BMC, which was designated by the respondents to be the ATP for the additional treatment recommended by the DIME. Respondents, however, have offered to provide transportation for claimant to all medical appointments. Additionally, when provided a choice of providers, claimant chose Dr. Karli in Vail, apparently indicating that the trip over Hoosier Pass is not a deterrent to all medical care. Unfortunately, Dr. Karli declined to accept claimant as a patient. Similarly, the Mountain Medical Center in Buena Vista declined to accept claimant as a patient. Claimant has refused to agree to any appointments at BMC. Consequently, the record evidence does not establish whether BMC will accept claimant as a patient and whether those providers can provide the medical treatment recommended by the

DIME.

CONCLUSIONS OF LAW

1. 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). Nevertheless, respondents have the right to select the initial authorized treating physician. Section 8-43-404(5), C.R.S. Respondents are liable only for treatment from authorized providers. Section 8-43-404(5), C.R.S. requires that the respondents designate a physician who is willing and able to provide treatment. *See Ruybal v. University Health Sciences Center*, 768 P.2d 1259 (Colo. App. 1988); *Tellez v. Teledyne Waterpik*, W.C. No. 3-990-062, (Industrial Claim Appeals Office, March 24, 1992). If the designated treating physician refuses to treat the claimant for non-medical reasons, the respondents' duty to select a replacement physician arises immediately upon knowledge that the designated physician has refused to treat. *Tellez v. Wal-Mart Stores Inc.,* W.C. No. 4-413-780 (ICAO July 20, 2000)*; Wesley v. King Soopers,* W.C. No. 3-883-959 (ICAO November 22, 1999); *Clemons v. Harrison School District #2*, W.C. No. 4-357-814 (ICAO, November 30, 2001). 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). As found, claimant has not made a proper showing for a change of ATP to her own personal physician.

ORDER

It is therefore ordered that:

1. Claimant's request for a change of authorized treating physician to Dr. Katherine Fitting is denied.

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

DATED: March 1, 2010 Martin D. Stuber

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-797-025

ISSUES

The issues for determination are compensability and medical benefits.

FINDINGS OF FACT

1. Claimant was employed by Employer. She spent all day working on a computer keyboard. Her chair could not be adjusted properly and she did not have a footrest at her workstation.

2. In June 2009, Claimant complained of increasing pain in her back, neck, and arms.

3. On June 17, 2009, Claimant complained to Dr. Bruce Morgenstern, M.D., that her work was extremely stressful and that her supervisor was harassing her. Dr. Morgenstern attributed Claimant's multiple neurologic and somatic symptoms to depression with somatization.

4. On June 18, 2009, Claimant told A. Christine Linares, M.D., that she was concerned about the ergonomics of her workstation. Dr. Linares assessment was cervicalgia, lumbago, and generalized anxiety disorder. She recommended an ergonomic evaluation. She did not give an opinion as to whether Claimant's condition was related to her employment.

5. On July 7, 2009, Claimant complained to Perry L. Haney, M.D., of severe neck pain, burning sensation in her right arm, and lower back pain. Dr. Haney's assessment was of probable cervical and lumbar three-joint complex disorder with cervical radiculopathy. In a July 15, 2009, form, Dr. Haney stated that Claimant's diagnosis and treatment was related to her employment.

6. An ergonomic assessment was completed on August 10, 2009. It was recommended that Claimant have a new chair and a footrest.

7. Claimant was evaluated by Pamela Knight, M.D., on August 19, 2009. Dr. Knight opined that, although an ergonomic evaluation was appropriate, Claimant's condition was not related to her employment.

8. The opinions of Dr. Morgenstern and Dr. Knight are credible and persuasive. Claimant was not injured as a result of a compensable accident or occupational disease.

CONCLUSIONS OF LAW

1. Section 8-40-201(14), C.R.S., defines an occupational disease as follows:

> `Occupational disease' means a disease which results directly from the employment or conditions under which the 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 the employment.

2. The question of whether a claimant proved the conditions of employment caused or contributed to a disease is a question of fact for determination by the ALJ. *Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999). If an industrial injury aggravates or accelerates a preexisting condition so as to cause a need for treatment, the treatment is compensable. *Joslins Dry Goods Co. v. Industrial Claim Appeals Office*, 21 P.3d 866 (Colo. App. 2001); *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *Seifried v. Industrial Comm'n*, 736 P.2d 1262 (Colo. App. 1986). Under Section 8-40-201(14), C.R.S., a claimant is not required to prove the conditions of the employment were the sole cause of the disease. Rather, it is sufficient if a claimant proves the hazards of employment caused, intensified, or aggravated to some reasonable degree the disability for which compensation is sought. *Anderson v. Brinkhoff,* 859 P.2d 819, 824 (Colo. 1993).

3. The opinions of Dr. Morgenstern and Dr. Knight are credible and persuasive. The conditions of Claimant's employment did not cause or contribute to her condition. Claimant has failed to establish by a preponderance of the evidence that she sustained occupational disease. The claim is not compensable.

ORDER

It is therefore ordered that the claim is denied and dismissed.

DATED: *March 1, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-803-073

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUE

The sole issue to be determined by this decision concerns whether the Claimant committed a willful violation of an Employer's safety rule which would result in a 50% reduction in compensation under § 8-42-112(1)(b), C.R.S. (2009).

FINDINGS OF FACT

1. Claimant has worked for Employer for thirty-three years. Throughout the majority of her employment, Claimant has worked in a distribution center warehouse as a janitor. Her job consists of driving a pallet jack ("mule") up and down aisles to clean up trash and spills.

2. On September 1, 2009, the Claimant was involved in a collision with a forklift while driving a mule. -B- was driving the forklift that collided with Claimant's mule. Claimant received a compensable injury to her left hip as a result of the collision.

3. The Respondent filed a General Admission of Liability, dated September 14, 2009, admitting for an average weekly wage (AWW) of $841.62, 2/3rds of which $561.08 per week. Respondent, however, took it upon itself to exact a 50% reduction for a then alleged safety rule violation, this, admitting for $280.54 per week in temporary total disability benefits from September 2, 2009.

4. Before the collision, according to the Claimant, she slowed down and looked in a mirror to check for other vehicles as she approached the intersection in which the collision took place. Claimant did not stop and did not honk her horn. -B- also testified that he did not honk his horn as he approached the intersection.

4. The Employer's training materials indicate that equipment operators should slow down and honk their horn "at all cross aisles or other locations where [the operator's] visibility is obstructed or reduced." Both Claimant and -C- stated that the proper procedure requires equipment operators to slow down and honk.

5. According to the Claimant, she did not recall receiving any training since she began her employment regarding the operation of a mule. The ALJ finds Claimant's testimony in this regard unpersuasive and not credible. Regardless, Claimant stated that she knew of the rule requiring equipment operators to honk when approaching an intersection with reduced visibility.

6. Claimant initially stated that her visibility was not obstructed or reduced as she approached the intersection where the collision took place. The photographs of the intersection, however, show a large wall near the intersection. Additionally, Claimant testified that she looked to make sure that no vehicles were coming before she entered the intersection, but she did not see the forklift driven by -C-. Insofar as the Claimant implies that she dealt with the intersection in a safe manner, the ALJ finds her testimony in this regard unpersuasive and not credible.

7. Claimant also testified that she slowed down but did not stop. At least some portions of

the training materials suggest that stopping is not required, rather slowing down is sufficient. The ALJ finds, however, that this fact does not excuse a willful failure to honk in violation of the safety rule.

8. According to the Claimant, she did not honk because employees in the warehouse did not follow the honking procedure. -C- testified that he also did not honk as he approached the intersection due to a “lapse in judgment”, but he disagreed with the Claimant’s statement that employees typically did not abide by the honking rule. -C- indicated that he often heard honking in the warehouse. The ALJ finds Claimant’s testimony that employees did not honk when approaching visibility-obstructed intersections unpersuasive and not credible. On the other hand, -C- has no interest in the outcome of this claim, and he presented credibly and persuasively. Therefore, the ALJ finds the testimony of -C- on this point both persuasive and credible.

9. Following the collision, the Employer issued safety citations to both Claimant and -C- for failing to stop and honk when approaching the intersection where the accident took place, further buttressing the fact that -C- had “no dog in this fight.”

10. Claimant’s testimony established that she knew of the safety rule but nevertheless failed to honk before crossing the intersection. Additionally, visibility at the intersection was greatly reduced by a large obstruction. The photographs in Exhibit F show a wall running the length of the warehouse that easily could prevent an employee operating a piece of equipment from seeing other vehicles about to cross into the intersection. Moreover, Claimant testified that she slowed down and looked in a mirror as she approached the intersection. Despite looking, Claimant stated that she did not see any other vehicles. This testimony, in addition to the fact that -C- apparently did not see Claimant, supports the notion that Claimant could not see the forklift driven by -C- because the wall obstructed her view. Thus, because Claimant knew of the rule and failed to observe it, Claimant willfully violated Employer’s reasonable safety rule, and the violation of that safety rule proximately caused the collision that injured the Claimant.

11. Respondents have proven, by a preponderance of the evidence that Claimant willfully violated a known Employer safety rule, and this willful violation proximately caused the Claimant’s injury.

CONCLUSIONS OF LAW

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

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is

empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). The medical opinions on reasonable necessity are essentially un-contradicted. As found, the ALJ resolved credibility determinations in favor of -B- and against the Claimant with regard to the existence of the safety rule and with respect to observance thereof as opposed to widespread disregard thereof. -C-' testimony that he had a "lapse in judgment" causes the ALJ to infer that the rule was observed, contrary to Claimant's testimony.

Burden of Proof

b. Ordinarily, the injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. (2009). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). Nevertheless, 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. X-ray,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Respondent sustained its burden of proving a willful violation of a safety rule by the Claimant.

Safety Rule Violation

c. Compensation provided to an injured employee "shall be reduced by 50%" where the employee's injury comes about as a result of "the employee's willful failure to obey any reasonable rule adopted by the employer for the safety of the employee." § 8-42-112(1)(b), C. R.S. (2009). The burden of establishing a willful violation rests with the employer. *Lori's Family Dining, Inc. v. Indus. Claim Appeals Office of State of Colo.*, 907 P.2d 715, 719 (Colo. App. 1995) [citing *City of Las Animas v. Maupin*, 804 P.2d 285, 286 (Colo. App. 1990)]. To show

that a violation was willful, an employer must demonstrate that the employee knew of the rule yet "intentionally performed the forbidden act." *Stockdale v. Indus. Com'n of Colo.*, 232 P. 669, 670 (Colo. 1925). As found, the Employer's rule required employees to slow down and honk before entering an intersection with obstructed or reduced visibility. Claimant knew of this rule but nevertheless failed to honk before crossing the intersection. Additionally, visibility at the intersection was greatly reduced by a large obstruction. As found, the photographs in Exhibit F show a wall running the length of the warehouse that easily could prevent an employee operating a piece of equipment from seeing other vehicles about to cross into the intersection. Moreover, Claimant slowed down and looked in a mirror as she approached the intersection. Despite looking, Claimant stated that she did not see any other vehicles. This testimony, in addition to the fact that -B- did not see Claimant, supports the notion that Claimant could not see the forklift driven by -C- because the wall obstructed her view. Thus, because Claimant knew of the rule and failed to observe it, she willfully violated the Employer's reasonable safety rule.

d. Courts will not reduce compensation if an employer fails to enforce its rule "with knowledge of and acquiescence in its violation." *Lori's Family Dining*, 907 P.2d at 719 [citing *Pac. Employers Ins. Co. v. Kirkpatrick*, 143 P.2d 267, 270 (Colo. 1943)]. Here, however, the Claimant failed to offer any persuasive evidence that employees failed to follow the honking rule other than her own testimony. As found, -C-' testimony contradicted the testimony of Claimant on this point, as he indicated that he often heard honking in the warehouse. Regardless, Claimant introduced no persuasive evidence that the Employer was aware of the violation and acquiesced in it. To the contrary, the Employer issued safety citations to both Claimant and -C- following their collision. Even assuming that employees regularly violated the honking rule and that Employer knew of these frequent violations, the evidence suggests that Employer did not acquiesce but rather actively sought to discourage violations by issuing safety citations.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents may exact a penalty of 50% of Claimant's indemnity benefits.

B. All matters not determined herein are reserved for future decision.

DATED this_____day of March 2010.

_____
EDWIN L. FELTER, JR.

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-797-652

ISSUE

The issue presented for consideration at hearing is whether Claimant suffered a compensable injury in the course and scope of his employment for Respondent.

FINDINGS OF FACT

Having considered the evidence presented at hearing, the following Findings of Facts are entered.

1. Claimant was an assistant store manager for Respondent. The Respondent employer operates a convenience store. Claimant's job required that he remain on his feet 95% of the time. Claimant's duties included that he schedule employees, cashier, stock shelves, and order merchandise.

2. Claimant testified that, on or about June 2008, he started experiencing foot pain. He speculated that the pain might be associated with the standing that he had to do at the Respondent. Claimant did not recall any specific injury.

3. Sometime after June 2008, Claimant developed pain in his right hip, buttock, and back area. Claimant testified that in August or September 2008, he reported to his supervisor, -D-, store manager, that he was starting to experience pain into his hip and knee.

4. -D- noticed Claimant limping and, in August 2008, Claimant complained to her about his pain. -D- asked Claimant about his physical condition, including specific questions about whether his problems were work-related. -D- credibly testified that Claimant indicated that he had no memory of any work-related activity, such as twisting, climbing, bending or lifting associated with the onset of foot and hip pain.

5. Claimant was seen by Panorama Orthopedics. Records dated October 20, 2008, and January 23, 2009, reflect that Claimant also referenced low back and buttock pain becoming symptomatic on August 25, 2008, with no known injury.

6. Physical therapy notes on October 24, 2008, indicate that the mechanism of injury was "gradual onset" during the previous two-month period with no known injury.

7. On December 19, 2008, Claimant applied for and received extended illness leave from the Respondent. Extended illness leave is a benefit provided by the Respondent, which is similar to short-term disability. Claimant received extended medical leave with wage replacement benefits for a period of six (6) months. It was not until after the six (6) months of extended illness leave expired in June 2009 that Claimant filed a workers' compensation claim, referencing as the date of injury Claimant's last day of work, December 19, 2008.

8. On January 27, 2009, Claimant had a MRI of his lumbar, hip and pelvic area, which showed degenerative changes, but was essentially normal.

9. A medical report of February 9, 2009, from Associated Spine Specialists, LLC, Kelly J. Culhane, D.C., indicates that Claimant was having back pain, right hip pain, neck and intrascapular pain, as well as paresthesia of his left forearm and fingers. No injury or specific cause of the problem was noted in February 2009.

10. Respondent's incident report generated on July 17, 2009, indicates that the Claimant's attorney gave notice of a claim for workers' compensation to the Respondent. The report contained an allegation of a right hip injury or strain of unknown mechanism.

11. Claimant consulted with Dr. Robert E. Brown, a pain management specialist in August 2009. Dr. Brown's, August 6, 2009, narrative report indicates that there was nothing about Claimant's physical examination that supported his degree of complaint, including his low back, buttock and hip. The report references that Claimant had a right SI joint block in July 2009 that caused him to have significant chronic pain when walking. The doctor indicated in his narrative report, "I really have no explanation why he is having pain and discomfort."

12. Claimant testified at hearing that he did not have a complete final diagnosis from his physicians on the cause of his current condition. At hearing, Claimant was in a wheelchair. He testified that his deterioration and confinement to a wheelchair occurred when he received the injection, noted in Dr. Brown's progress report of August 6, 2009. At that time, Claimant had moderate discomfort and was using a cane. According to Dr. Brown, Claimant associated his significant deterioration with a right SI joint block performed on July 27, 2009.

13. On August 20, 2009, Respondent requested that orthopedic specialist, Robert Messenbaugh, examine Claimant. The doctor prepared a report dated August 24, 2009. Dr. Messenbaugh examined Claimant and reviewed medical records. At that time, Claimant gave a history of foot problems starting in August 2008 that developed into hip and back pain on or about September 2008. Dr. Messenbaugh noted that Claimant had an essentially normal MRI. There was no consensus from treating physicians as to the anatomic issues involved. Dr. Messenbaugh could not indicate that Claimant's symptomatology was "work-related."

14. Claimant went to see Dr. Douglas J. Radosh, a neurologist, on October 12, 2009. At that time, according to Dr. Radosh, Claimant gave a history of a work-injury wherein he fell and passed out in the back of his convenience store. This history is inconsistent with the history given to other physicians concerning the gradual onset of low back pain.

15. After Claimant mentioned a history of a fall, Respondent requested further review by Dr. Messenbaugh. Dr. Messenbaugh, in his December 23, 2009, narrative report indicated that the history given to Dr. Radosh was inconsistent with the history given to him by Claimant and his mother when he interviewed Claimant in August 2009.

16. Claimant's supervisor, -D-, testified that, although she noted that Claimant had difficulties and limping while working for Respondent, she never received a history of a work-related condition, aggravation or incident from the time she first started noticing problems until Claimant discontinued his work in December 2008. This was despite a specific conversation inquiring whether Claimant had any problem that was work-related.

17. -D- also credibly testified that Claimant, as an assistant manager, was aware of the procedures for reporting a workers' compensation injury or condition and that he would have been authorized to receive reports of injury or work-related conditions of other employees in Ms. Yarling's absence. In fact, she noted that Claimant received forms for reporting workers' compensation claims from Respondent's corporate offices on prior occasions.

18. Based on the totality of the evidence, it is concluded that Claimant failed to establish by a preponderance of the credible and persuasive evidence that he suffered an injury in the course and scope of his employment. The medical record contains conflicting information about the etiology and diagnosis of Claimant's condition. Claimant's reports to medical professionals were contradictory and there was an absence of objective credible and persuasive evidence to support the conclusion that Claimant suffered a work injury.

CONCLUSIONS OF LAW

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

1. The claimant has the burden to establish that his injuries arose out of and within the course and scope of his employment. Section 8-41-301(1)(b), C.R.S. There is no presumption that injuries, which occur in the course of employment necessarily, arise out of employment. *See, Finn v. Industrial Comm'n***,** 165 Colo. 106, 437 P.2d 542 (1968). The burden is on the claimant to prove a causal relationship between his employment and his injury or condition. *See, Industrial Comm'n v. London & Lancashire Indem. Co.,* 135 Colo. 372, 311 P.2d 705 (1957).

2. An injury or condition arises out of employment if "there is a causal connection between the duties of employment and the injuries suffered." *Deterts v.Times Pub. Co***.,** 38 Colo. App. 48, 552 P.2d 1033 (1976).

3. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 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 Respondents, 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 8-42-101, 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. X-ray*, 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.

4. When determining credibility, the ALJ considers, 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, C.R.S.

5. 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).

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

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

8. The determination of whether there is a sufficient "nexus" or causal relationship between the claimant's employment and the injury or occupational disease is one of fact that the ALJ must determine based on a totality of the circumstances. *Moorhead Machinery & Boiler Co. v. DelValle,* 934 P.2d 861 (Colo. App. 1996). Temporal proximity or correlation is not causation. *Scully v. Hooters of Colorado Springs,* W.C. No. 4-745-712 (October 27, 2008).

9. The ALJ concludes that Claimant has not met his burden of proof that he had an injury or condition arising out of his employment. First, Claimant did not report an alleged injury or occupational disease at or near the time he began to experience symptoms. It is significant in the context of this claim that Claimant was an assistant manager and was knowledgeable about how to make workers' compensation claims and he assisted other employees with such claims. Further, when Claimant's supervisor, -D-, inquired about his condition and discussed

the activities required by his employment, Claimant failed to even suggest that the symptoms were in any manner related to his work.

10. The ALJ also concludes that Claimant's history, given to his treating physicians, is not credible and reliable. At first, Claimant gave a history of a gradual onset of foot, hip and low back pain that was not related to any specific incident or condition. He also gave the same history to the independent medical examiner, Dr. Messenbaugh. Thereafter, he gave a history of a blackout and fall in the back of the convenience store. This latter explanation given to Dr. Radosh in October 2009 is not deemed credible as an explanation for Claimant's condition. Further, this report was not made at the time of the alleged work injury, aggravation or condition. It was reported to Dr. Radosh over a year after the alleged precipitating events. To the extent that Claimant's medical record is premised on Claimant's report of symptoms, those reports are not credible or persuasive.

11. Based on the totality of the evidence, the ALJ finds and concludes that the Claimant has failed to establish by preponderance of the evidence that he suffered an injury, aggravation or an occupational disease arising out of the course and scope of his employment.

ORDER

It is therefore ordered that:

Claimant has not suffered a compensable injury, aggravation or occupational disease arising out of the course and scope of his employment for the Respondent. Therefore, his claim under the Act is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: February 26, 2010

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-765-159

ISSUES

1 Whether Claimant has proven by a preponderance of the evidence that his Average Weekly Wage ("AWW") should be increased to include Claimant's alleged concurrent employment?

FINDINGS OF FACT

1. Claimant suffered an admitted injury while employed with employer on July 4, 2008. Respondents have admitted liability for the claim and admitted wages in the amount of $443.13 per week for his employment with employer. Respondents amended the general admission of liability to increase Claimant's AWW to $531.38 per week effective November 30, 2008 based on Claimant's receipt of COBRA medical benefits. Respondents have admitted for temporary total disability ("TTD") benefits for July 7, 2008 through ongoing.

2. In addition to his employment with employer, Claimant was also employed as a bouncer for a bar named -E- in Aspen, Colorado. Claimant testified his last day of work for -E- was July 2, 2008. The wage records entered into evidence demonstrate that Claimant was not paid for work with -E- after June 30, 2008.

3. Claimant testified that on July 2, 2008, he left -E- because they had no more work for him. Claimant testified that he the proceeded to -F-, another bar in Aspen, and was hired to do security. Claimant did not sign any paperwork with -F- regarding his employment.

4. Claimant testified he was scheduled to begin work with -F- Thursday through Saturday and was to begin work on July 12, 2008. Claimant testified he was hired at -F- by "Roy", but could not recall Roy's last name. Claimant testified that he was paid $15 per hour for his work at -E-. Claimant testified he was hired at -F- at a rate of pay of $20 per hour.

5. Claimant testified that he routinely held a job working bar security before his industrial injury since he was twenty-one (21) years old.

6. Respondents obtained testimony from -G-, the former general manager with -E- in Aspen. -G- testified Claimant worked security for -E- beginning in the end of March or early April and worked until June, 2008. -G- testified he was unaware of why Claimant no longer worked for -E-, but thought they had just quit using him.

7. According to the wage records from -E-, Claimant earned $1,050.00 in the 14 weeks between March 24, 2008 and June 30, 2008 for an average of $75 per week. Claimant testified he only worked 11 of those weeks, as the bar was closed for several weeks in the April/May timeframe due to slow business.

8. The ALJ finds that Claimant did not have concurrent employment at the time of his industrial injury. While Claimant testified that he had obtained a job with -F- after being let go by -E-, Claimant was not scheduled to start his employment until July 12, 2008, and Claimant had not filled out any paperwork for his new employer as of yet. The ALJ finds that as of Claimant's date of injury, his employment with -E- had ended, and Claimant had the prospects of employment with -F-, but had not yet filled out the paperwork to begin the potential new employment.

9. Based on the fact that Claimant's employment with -F- had not yet begun, and Claimant's employment with -E- had ended, the ALJ rejects Claimant's assertion that his AWW should be

increased to include his other employment when Claimant did not maintain that employment at the time of the injury.

CONCLUSIONS OF LAW

1. The Claimant's average weekly wage is based upon the Claimant's wages at the time of the injury. Section 8-40-201(19)(a), C.R.S. 2008; *Campbell v. IBM Corporation*, 867 P.2d 77 (Colo. App. 1993). However, the overall purpose of the statutory scheme is to "arrive at a fair approximation of the claimant's wage loss and diminished earning capacity." *Campbell, supra.* Therefore, Section 8-42-102(3), C.R.S. 2008 affords the fact finder discretionary authority to use an alternative method to calculated the AWW where manifest injustice would result by calculating the Claimant's AWW under Section 8-42-102(2), C.R.S. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). This includes the discretion to include concurrent wages in the AWW. *See Broadmoor Hotel v. Industrial Claim Appeals Office*, 939 P.2d 460 (Colo. App. 1996).

2. In the present case, the ALJ finds Claimant has failed to prove that inclusion of wages from a job he did not hold on the date of his injury is necessary for a fair calculation of his AWW. Therefore, Claimant's request to increase his AWW beyond the admitted rate is denied and dismissed.

ORDER

It is therefore ordered that:

1. Claimant's appropriate AWW shall continue to be $531.38.

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

DATED: March 3, 2010

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-798-136

ISSUES

1 Whether Claimant proved by a preponderance of the evidence that he suffered a worsening of his condition after August 2, 2009 entitling Claimant to Temporary Total Disability ("TTD") benefits?

2 Whether Respondents proved by a preponderance of the evidence that Claimant's non-medical benefits are subject to a 50% penalty for violation of a safety rule pursuant to Section 8-42-112(1)(b).

3 The parties stipulated prior to the hearing to an Average Weekly Wage ("AWW") of $685.00.

4 The parties stipulated prior to the hearing that Claimant was responsible for his termination of employment on June 15, 2009.

5 The parties stipulated prior to the hearing Respondents have authorized Dr. Knutson to treat Claimant for the effects of his May 27, 2009 work injury.

FINDINGS OF FACT

1. Claimant was hired by employer on January 7, 2009. Employer performs work trimming trees and brush around electrical lines. Claimant was employed as a crew supervisor at the time of his industrial injury.

2. On May 27, 2009, at approximately 10:30 a.m., Claimant injured his left wrist when he was trimming a tree away from power lines while in a bucket and his chainsaw came in contact with his wrist causing a laceration. Claimant was treated at the Memorial Hospital Emergency Room ("ER") on the date of his injury and received sutures. X-rays performed at the ER did not reveal any evidence of fractures.

3. Claimant testified at hearing that he does not remember what happened when he injured his wrist on May 27, 2009. Claimant acknowledged that he had on occasion used a chainsaw with one hand but denied performing his work with one hand on May 27, 2009, as he did not know of a circumstance in his work on May 27, 2009 where it would be of benefit to use one hand on the chainsaw. Claimant surmised that while using the chainsaw, the chainsaw kicked causing his hand to come off the chainsaw and resulting in his injury, but admitted he did not know if this was actually how the injury occurred.

4. Claimant was examined by Dr. Knutson after his injury on June 3, 2009. Claimant reported that he inadvertently slipped and a chainsaw lightly lacerated the volar aspect of his left writs. Dr. Knutson noted that Claimant had lacerations at the volar writs that are superficial appearing and his sutures were intact. Dr. Knutson instructed Claimant on wound care and provided medications for pain. Dr. Knutson requested Claimant return in one week for suture removal and noted that Claimant would likely be back to work without restrictions in roughly two weeks. Claimant returned to Dr. Knutson on June 8, 2009 for suture removal and noted he was improving steadily. Dr. Knutson instructed Claimant to return in one month for what would likely be his final appointment.

5. Claimant returned to work for employer in a modified duty capacity, but was terminated from employer on June 15, 2009 when his May 27, 2009 drug test was positive for marijuana. Claimant does not contest that he was responsible for his termination from employment.

6. Claimant was examined by Dr. Knutson on July 6, 2009. Dr. Knutson noted Claimant had not attended physical therapy, but had been trying to do some range of motion and strengthening on his own. Claimant reported intermittent symptoms of sharp, intense pain and occasional tenderness over the dorsoradial aspect of his hand. Dr. Knutson noted mottling of Claimant's palm skin along with significant sensitivity in the scar area with very light pressure. Dr. Knutson diagnosed Claimant with early reflex sympathetic dystrophy ("RSD").

7. Claimant reported to physical therapy on July 20, 2009 and reported an injury occurring on May 27, 2009 when he was trimming some trees. Claimant reported to Dr. Knutson that he was not exactly sure what happened, but woke with the chain saw down on the ground while he was in the basket in the air. Claimant continued with physical therapy as recommended by Dr. Knutson. The physical therapy records document Claimant complaining of increased pain with therapy on July 27, 2009 and August 3, 2009.

8. Claimant returned to Dr. Knutson on August 3, 2009. Dr. Knutson noted Claimant had an increase in discomfort and had not been able to participate effectively in physical therapy. Dr. Knutson again noted mottling of his skin in the palm with flexor function intact in the fingers and thumb. Dr. Knutson again diagnosed RSD and referred Claimant to a pain specialist and psychologist. Dr. Knutson provided Claimant with a release from all work for at least the next month.

9. Claimant returned to Dr. Knutson on August 27, 2009. Dr. Knutson noted that Claimant had still not been seen in the pain clinic secondary to his insurance company "failing to return our phone calls." Dr. Knutson noted no improvement with Claimant's complaints and indicated Claimant was not making any headway with physical therapy and would not allow Dr. Knutson to touch his hand on examination. Dr. Knutson again recommended a referral to a pain clinic and provided Claimant with a prescription for pain medication.

10. Respondents referred Claimant to Dr. Fall for an Independent Medical Examination ("IME") on October 22, 2009. Dr. Fall noted that Claimant complained of pain greater than 10/10 and reports of Claimant's hand turning purple. Dr. Fall opined that Claimant likely had chronic regional pain syndrome ("CRPS") as a result of his May 27, 2009 work injury. Dr. Fall opined Claimant was in need of treatment from a pain management specialist, preferably a physiatrist and was not at MMI. Dr. Fall agreed with Dr. Knutson that Claimant should be referred to a pain clinic and for psychological counseling.

11. Dr. Fall testified at hearing in this matter and indicated that she disagreed with Dr. Knutson that Claimant was incapable of performing any work. Dr. Fall testified that she would recommend promoting activity for the left upper extremity and that Claimant could perform work with no use of the left upper extremity. Dr. Fall recommended further medical treatment in the form of sympathetic blocks followed by physical therapy. Dr. Fall also recommended medication and psychological counseling. Dr. Fall noted that Claimant reported he continued to use the treadmill and step machine and this activity is not consistent with someone who needs

bed rest.

12. On cross-examination, Dr. Fall agreed that Claimant was likely dealing with depression that was aggravated by his injury, but opined that the depression was not so severe that he could not work.

13. Respondents presented the testimony of -H-, a General Foreman from employer with regard to the employer's safety policy and appropriate use of a chain saw. -H- testified he had extensive experience in tree felling, safe saw training, and certification as a Class II tree-felling instructor. -H- testified employer had a strict policy regarding no one-handed use of chainsaws. -H- testified he was Claimant's direct supervisor from January through June 2009 and personally conducted safety meetings with numerous crews, including Claimant's crew, on a weekly basis. -H- testified that he personally reviewed the proper use of chainsaws with the crews and noted that employer issued a bulletin on February 21, 2009 that specifically addressed proper use of a chainsaw, including the admonishment, "Never 1-Hand' the saw!" Respondents presented the employer's Line Clearance Quality Standard handbook signed by Claimant that included the following instruction with regard to the use of Chainsaws "Do not let go of handles!" and "Never use the saw one-handed". Claimant initialed the instructions regarding proper use of the chainsaw, including the instruction to "NEVER ONE-HAND AN OPERATING CHAINSAW!" on January 14, 2009. -H- also testified that the Line Clearance Quality Standard handbook was an ongoing training process that employees would review with their supervisors and managers and that he would attend job sites to observe employees to ensure that they were complying with employer's safety policy.

14. -H- testified that after Claimant's accident on May 27, 2009, he went to the worksite ad tested Claimant's chainsaw and found the chainsaw to be functioning normally. -H- testified he tried to reconstruct how Claimant could have been injured on the underside of the left wrist by the chainsaw and determined that Claimant could not have been injured in this area if he was properly operating the chainsaw with two hands.

15. -H- testified that after investigating the accident, he told Claimant that he believed Claimant "had to be one-hading the chainsaw." India testified that Claimant responded by saying, "I guess I can see how it looks that way."

16. Respondents presented the testimony of -G-, a Safety Supervisor for employer who was qualified as an expert in the area of proper use and handling of a chainsaw and tree felling. -G- testified employer had a strict safety policy for the proper use and hading of chainsaws, including the requirement that an employee should not use a chainsaw with only one hand. -G- testified that to properly handle the chainsaw, both hands should be placed on the chainsaw with the left hand on the handlebar. -G- testified that in using the chainsaw this way, in the event of a violent kickback, the operator's left hand would be forced into the lever, thereby shutting down the chainsaw immediately.

17. Both -G- and -J- testified light duty was available from employer, including positions as crew

supervisor, flagger, or permitter (the position Claimant was working after he was injured).

18. The ALJ credits the reports from Dr. Knutson and Dr. Fall and finds that Claimant has shown that it is more likely true than not the his work injury resulted in the development of RSD (also now referred to as CRPS). The ALJ finds that the RSD developed after June 15, 2009 and was not diagnosed until July 6, 2009 when Claimant's subjective complaints became worse. The ALJ finds that Claimant has proven a worsening of his condition after June 15, 2009 that resulted in new work restrictions from Dr. Knutson on August 3, 2009, that included no work at all for at least one month.

19. Respondents argue in this case that the work restrictions set forth by Dr. Knutson are not reasonable in this case, and therefore, should not be followed. The ALJ is not persuaded. Claimant was referred by employer for medical treatment with Dr. Knutson following his work injury. Respondents apparently had no issue with Dr. Knutson's work restrictions when it appeared he would be released without restrictions in mid-June, but take issue with the increased restrictions later in the course of Dr. Knutson's treatment.

20. Respondents also argue that because Dr. Knutson does not specialize in RSD treatment, his work restrictions should be ignored. Again, the ALJ is not persuaded. Dr. Knutson noted on August 3, 2009 that Claimant should be referred to a pain specialist and a psychiatrist for additional treatment. Dr. Knutson noted on August 27, 2009 that he had made at least six attempts to contact the insurance carrier regarding this referral, but was unable to obtain a return phone call. If Respondents were significantly concerned with regard to the work restrictions set forth by the treating physician, they had the opportunity to comply with the referral of Dr. Knutson to have Claimant treated by a pain specialist and psychiatrist. Instead, Respondents chose to have Claimant examined by an IME physician before honoring the referral from Dr. Knutson. Regardless, the ALJ credits the opinion of Dr. Knutson that as of August 3, 2009 Claimant was unable to work in any capacity and rejects any medical opinions to the contrary.

21. The ALJ notes Claimant's testimony at hearing regarding his recollection of events as they occurred on May 27, 2009 is consistent with the history he provided to the physical therapist on July 20, 2009. The ALJ finds Claimant's testimony regarding his recollection of events on May 27, 2009 credible. The ALJ finds that while Claimant may have violated a safety rule in performing his job duties on May 27, 2009, Respondents have failed to prove Claimant willfully violated a safety rule.

22. The ALJ notes that Claimant's recitation to the physical therapist regarding the accident history on July 20, 2009 was prior to any claim for temporary disability benefits by the Claimant, and prior to any affirmative defense of a fifty percent reduction in benefits by employer. The ALJ finds Claimant would not have reason to fabricate his recitation of the accident history to the physical therapist on July 20, 2009 and finds that this history is likely Claimant's recollection of the event as it occurred.

23. The ALJ further notes that the Claimant did not have a history of documented violations of safety rules prior to his May 27, 2009 accident that could establish that Claimant was aware of the safety rules and was consciously choosing to ignore the safety rule at the time of the injury. While Claimant testified that he had operated a chain saw with one hand on previous occasions, Claimant was not previously cited for a violation of the safety rule. The ALJ determines that if Claimant was operating the chain saw in a violation of the safety rules on May 27, 2009, it was likely due to negligence and not a willful violation.

CONCLUSIONS OF LAW

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

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

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

restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

4. The “termination statues,” Section 8-42-103(1)(g), C.R.S. 2008 and Section 8-42-105(4), C. R.S. 2008 contain identical language stating that “[i]n cases where it is determined that a temporarily disabled employee is responsible for termination from employment, the resulting wage loss shall not be attributable to the on-th-job injury.” Here, the parties stipulated that Claimant was responsible for his termination of employment as of June 15, 2009. Therefore, the issue in this case involves the application of *Anderson v. Longmont Toyota, Inc.*, 102 P.3d 323 (Colo. 2004) in determining whether the Claimant’s right to TTD was reestablished. In *Anderson*, the court held that the termination statutes did not constitute a permanent bar to the receipt of TTD following a discharge from employment for cause. Rather, although a claim for TTD was barred when the termination caused the wage loss, a claim was not barred “when the worsening of a prior work-related injury incurred during [the] employment causes the wage loss.” *Anderson*, 102 P.3d at 326.

5. While Respondents maintain that modified employment was available for the Claimant in the positions of a crew supervisor, flagger or permitter, Claimant would not have been able to perform these jobs when he was taken off of work completely by the treating physician. Therefore, the ALJ determines that Claimant has established that he is entitled to TTD benefits beginning August 3, 2009 when he was taken off of work completely, and continuing until terminated by law.

6. Respondents also argue that Claimant’s injury resulted from a willful violation of a safety rule. Section 8-42-112(1)(b), C.R.S. permits imposition of a fifty percent reduction in compensation in cases of claimant’s "willful failure to obey any reasonable rule" adopted by the employer for the claimant's safety. The term "willful" connotes deliberate intent, and mere carelessness, negligence, forgetfulness, remissness or oversight does not satisfy the statutory standard. *Bennett Properties Co. v. Industrial Commission*, 165 Colo. 135, 437 P.2d 548 (1968). The respondents bear the burden of proof to establish that the claimant's conduct was willful. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995). The question of whether the respondent carried the burden of proof was one of fact for determination by the ALJ. *City of Las Animas v. Maupin*, 804 P.2d 285 (Colo. App. 1990).

7. The claimant's conduct is "willful" if he intentionally does the forbidden act, and it is not necessary for the respondent to prove that the claimant had the rule "in mind" and determined to break it. *Bennett Properties Co. v. Industrial Commission, supra; see also, Sayers v. American Janitorial Service, Inc.,* 162 Colo. 292, 425 P.2d 693 (1967) (willful misconduct may be established by showing a conscious indifference to the perpetration of a wrong, or a reckless disregard of the employee's duty to his employer). Moreover, there is no requirement that the respondent produce direct evidence of the claimant's state of mind. To the contrary, willful conduct may be inferred from circumstantial evidence including the frequency of warnings, the obviousness of the danger, and the extent to which it may be said that the claimant's actions were the result of deliberate conduct rather than carelessness or casual

negligence. *Bennett Properties Co. v. Industrial Commission, supra; Industrial Commission v. Golden Cycle Corp.,* 126 Colo. 68, 246 P.2d 902 (1952). Indeed, it is a rare case where the claimant admits that his conduct was the product of a willful violation of the employer's rule.

8. The ALJ finds that Respondents had a reasonable adopted by the employer for the safety of the employee. However, the ALJ finds that Claimant's violation of this safety rule was not "willful." Therefore, Respondents request for penalties for a willful violation of a safety rule is denied and dismissed.

ORDER

It is therefore ordered that:

1. Respondents shall pay Claimant TTD benefits beginning August 3, 2009 and continuing until terminated by law based on an AWW of $685.00.

2. Respondents claim for a 50% penalty for a willful violation of a safety rule pursuant to Section 8-42-112(1)(b) is denied and dismissed.

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

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

5. DATED: March 2, 2010

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-724-217

ISSUES

1 Whether Claimant's cervical complaints are related to the admitted workers' compensation claim?

2 Whether treatment recommended by Dr. Bohachevsky, is reasonable, necessary and related to Claimant's admitted workers' compensation claim?

FINDINGS OF FACT

1. Claimant is a 54 year old female who was employed with employer as a reading teacher. Claimant retired from employer in August 2009. Claimant suffered an admitted injury to her

right knee, hip and upper extremity on December 13, 2006 when she tripped over a rug and fell to the ground. Claimant was evaluated at the emergency room ("ER") on the date of her injury and reported immediate pain to her right upper extremity, right hip, trapezius and shoulder. Claimant also reported neck pain. Claimant underwent x-rays of the cervical spine in the emergency room that revealed degenerative changes in the mid and lower cervical spine.

2. Claimant was referred to Dr. Jernigan who became Claimant's authorized treating physician ("ATP"). Dr. Jernigan examined Claimant on December 18, 2006 and noted Claimant complained of neck soreness and stiffness from the accident. Dr. Jernigan diagnosed Claimant with a right rotator cuff strain, prescribed medications and recommended Claimant undergo massage therapy to help with the trapezius muscle and neck soreness. Dr. Jernigan provided Claimant with restrictions and instructed her to follow up in one week. Claimant returned to Dr. Jernigan on December 26, 2006 and reported that the massage therapy that helped out the trapezius and neck issues, but continued to complain of shoulder pain. Based on Claimant's continued complaints of shoulder pain, Dr. Jernigan referred Claimant for an MRI of the right shoulder. Claimant's care at that point began to focus significantly on her right shoulder issues. Claimant eventually underwent surgery on her right shoulder on August 6, 2007 that included a subacromial decompression with debridement.

3. Claimant has a history of prior issues with her cervical spine, including a motor vehicle accident ("MVA") in 1979. Claimant was under treatment with Dr. Pirnat in August 2006, for complaints of left cervical neck ache with pain into the left hand and thumb. Dr. Pirnat noted Claimant had acute neck pain on August 31, 2006 with paresthesias as well as a hot burning poker sensation down into her left thumb. Dr. Pirnat diagnosed Claimant with cervical radiculopathy. Claimant treated these pre-existing complaints with physical therapy. Claimant continued with physical therapy until approximately October 11, 2006, at which time she reported doing OK and was instructed to continue with physical therapy on a weekly basis. Claimant did not receive any further treatment for her cervical spine until after her industrial injury.

4. Claimant returned to Dr. Jernigan on August 28, 2007 after her shoulder injury. Claimant reported to Dr. Jernigan that she noticed a very tight muscle that comes across from her neck into her shoulder that feels like a steel cord. Dr. Jernigan noted Claimant had significant muscle tension in her neck and recommended a trial of Restoril.

5. Claimant suffered another trip and fall injury at work on September 25, 2007. Claimant was evaluated at the ER and provided with x-rays of her right shoulder, right hip and neck. Claimant reported having a lot of discomfort in her neck after this fall. Claimant reported to Dr. Jernigan on September 27, 2007 and Dr. Jernigan assumed her care for the September 25, 2007 incident. Dr. Jernigan noted Claimant's neck was causing her much less discomfort. On December 6, 2007, Dr. Jernigan placed Claimant at MMI for the September 25, 2007 slip and fall and determined this incident to be an exacerbation of previous problems and considered the injury merged into the December 13, 2006 claim. Dr. Jernigan thereafter referred Claimant to Dr. Dvirnak, an orthopedic surgeon.

6. Claimant was examined by Dr. Dvirnak on March 20, 2008 for evaluation of her ongoing shoulder condition. Claimant reported to Dr. Dvirnak that she still experienced neck pain at times and Dr. Dvirnak recommended Claimant be seen by a physiatrist. Claimant returned to Dr. Jernigan on April 1, 2008 with reports of her radiating pain feeling better in the previous 10 days. Dr. Jernigan noted Claimant may need to undergo an EMG to rule out any neurologic component to her radiating symptoms and continued Claimant with her current restrictions. Claimant returned to Dr. Jernigan on May 1, 2008 and noted her symptoms had increased during a period of testing. Dr. Jernigan noted Claimant may benefit from a bit more time in her home exercise program and massage therapy. Dr. Jernigan also noted that Claimant's symptoms may settle down after school let out for the Summer.

7. Claimant underwent an EMG of the right upper extremity with Dr. Isser on June 19, 2008. The EMG results were normal and showed no electrodiagnostic evidence of a right upper extremity mononeuropathy, radiculopathy or brachial plexopathy. Claimant continued treating with Dr. Jernigan and it was noted that she was doing much better in August, 2008 after her physical therapy was directed to her thoracic outlet exercises. When Claimant returned to Dr. Jernigan on December 16, 2008, she reported her neck and shoulder pain have persisted and remained intractable for approximately six (6) weeks. Claimant described her neck pain as "an extremely tight rope of muscle coming out of neck down into her trapezius." Dr. Jernigan recommended an MRI of the cervical spine and referred Claimant to Dr. Bohachevsky. Claimant underwent an MRI of the cervical spine on December 17, 2008 that revealed "combination of soft disk and endplate osteophytes at C4-C5, C5-C6 and C6-C7, most significant at C4-C5 where there is indentation of the ventral cord resulting in moderate canal stenosis. There is also moderate left-sided neural foraminal narrowing at this level."

8. Claimant was examined by Dr. Bohacevsky on January 12, 2009 and noted he was asked to address whether her current neck symptoms were related to her injury or from some other cause. Dr. Bohacevsky noted Claimant had reduced cervical range of motion and complained of pain at the top of her deltoid and trapezius with movement. Dr. Bohachevsky reviewed the MRI scan and noted the MRI revealed a right-sided disk extruded fragment at the C4-5 level on the right side that he opined was related to Claimant's injury. Dr. Bohachevsky noted that Claimant's complaints of neck pain were not new as there was evidence of neck pain after the initial injury. This bolstered Dr. Bohachevsky's opinion with regard to relatedness. The ALJ finds Dr. Bohachevsky credible.

9. Claimant was referred by Respondents to Dr. Douglas Scott for an Independent Medical Examination ("IME") on January 27, 2009. Dr. Scott reviewed Claimant's medical records and noted Claimant complained of a tight band running up into the right side of her neck that would increase during the day. Dr. Scott noted Claimant did not tell him she jerked her neck when she fell on December 13, 2006 and noted no description of having her head jerk in the medical records. Dr. Scott opined that Claimant did not injury or aggravate her cervical spine as a result of the December 13, 2006 industrial injury.

10. Claimant returned to Dr. Bohachevsky on April 13, 2009 with complaints of right-sided neck

pain and trapezius pain. Claimant described the pain as a burning sensation into her mid neck that radiates into her trapezius and even her right deltoid. Dr. Bohachevsky noted that Claimant's physical therapy and massage were only providing temporary relief and recommended discontinuing this course of treatment. Dr. Bohachevsky noted Claimant's MRI from December 2008 showed a large C4-5 disc herniation with mostly left-sided components but also a moderate right-sided extruded fragment causing lateral recess narrowing, that could potentially impinge the right C5 nerve. Dr. Bohachevsky recommended an epidural steroid injection ("ESI") at this level and referred Claimant to Dr. Cotgageorge, a pain psychologist.

11. Claimant returned to Dr. Jernigan on March 5, 2009 and noted Claimant continued to complain of significant pain in her right shoulder girdle muscles up into her neck that is aggravated by significant amounts of writing and testing. Dr. Jernigan noted he had the opportunity to review Dr. Scott's IME report and noted that Dr. Scott and Dr. Bohachevsky had differing opinions regarding the relatedness of Claimant's neck symptoms. Dr. Jernigan noted he could not currently offer an opinion as to the relatedness of Claimant's neck symptoms as he did not have records from Dr. Pirnat and the physical therapist. On March 24, 2009, Dr. Jernigan placed Claimant at MMI for her shoulder injury with an MMI date of December 16, 2008, and noted that the insurer was sending him updated medical records to determine his opinion as to whether the neck condition was related to Claimant's compensable work related injury. Dr. Jernigan subsequently noted in his March 19, 2009 report that he believed Claimant's neck injury was related to her compensable workers' compensation claim because of the right-sided aspect of the complaints. The ALJ finds the opinion of Dr. Jernigan and Dr. Bohachevsky credible and persuasive and supported by the medical records.

12. Dr. Scott issued an addendum to his IME report on May 21, 2009 after reviewing additional medical records from Dr. Pirnat, Dr. Jernigan and Dr. Bohachevsky. Dr. Scott noted that Claimant had pre-existing cervical neck multi-level degenerative disk disease with pre-existing history of left cervical neck radiculitis that was unrelated to her work injury. Dr. Scott opined that Claimant's right-sided neck complaints were probably related to tension and tightness in the supporting right-sided posterior shoulder musculature into the neck. Dr. Scott agreed with Dr. Jernigan's report that Claimant's right-sided neck complaints had been present from Claimant's initial examination, but denied that any left-sided complaints were related to Claimant's compensable injury. Dr. Scott further opined that the MRI did not reveal any disc fragment on the right side that would extrude to compress or irritate the cervical nerve root. Dr. Scott noted that Claimant's right sided neck complaints could be secondary to myofascial pain and tightness causing biomechanical traction on the neck in a downward manner.

13. Claimant returned to Dr. Jernigan on June 30, 2009 and continued to follow up with regard to her ongoing shoulder issues. Dr. Jernigan reviewed Dr. Scott's May 21, 2009 report and recommended Claimant return to Dr. Bohachevsky to evaluate and possibly do facet injections in the neck to treat Claimant's myofascial issues.

14. Dr. Scott issued another addendum report on August 1, 2009 noting that he had reviewed the December 17, 2008 MRI with a reading radiologist. Dr. Scott noted the MRI showed a

protrusion of the disc to the right at the C4-C5 level with possible tear of the annulus fibrosis that may contact the right side of the spinal cord or nerve root at that level. Dr. Scott noted, however, that he was not able to determine if the protrusion was related to Claimant's December 13, 2006 injury. Dr. Scott opined that Claimant's symptoms and structural findings do not suggest a facet problem and therefore, he did not believe that facet blocks were indicated or reasonable at this time.

15. Claimant testified at hearing in his matter that following her December 13, 2006 industrial injury, her neck was hurting and she reported to Mercy Regional Medical Center. Claimant testified she was eventually treated by Dr. Jernigan and had a lot of pain in her neck, shoulder and upper back. Claimant testified she underwent a significant amount of treatment for her shoulder, but her neck has bothered her since the date of injury. Claimant also testified that she received treatment for neck pain prior to her injury that consisted of five physical therapy appointments and her symptoms then resolved. Claimant testified her neck pain prior to her industrial injury was 4/10 before physical therapy and 0/10 after physical therapy. The ALJ finds the testimony of Claimant credible and persuasive and supported by the medical records.

16. Dr. Scott testified by deposition in this matter. Dr. Scott reiterated his points set forth in his IME during the deposition and opined that Claimant's cervical spine abnormalities were not caused or aggravated by the December 13, 2006 industrial injury. Dr. Scott noted that Claimant did not complain of cervical spine pain after her initial evaluations at the ER and with Dr. Jernigan for the period of time between December 18, 2006 and August 28, 2007. Dr. Scott reviewed the MRI scan with a radiologist to reach his conclusions and testified that if Claimant had suffered a disc injury to her cervical spine, he would have expected Claimant to complain of sever pain in her neck with a burning type of pain running from her neck to her right shoulder and down her arm. Dr. Scott acknowledged that Claimant complained of radiating right arm pain in the ER on December 14, 2006, but opined that this report of pain emanated from Claimant's right shoulder injury.

17. The ALJ credits the opinions of Drs. Bohachevsky and Dr. Jernigan over the testimony and reports of Dr. Scott. The ALJ notes that Claimant complained of right sided neck complaints on the date of her initial evaluation and finds that Claimant's current complaints of right sided neck pain are related to her December 13, 2006 admitted injury. The ALJ credits the opinions of Dr. Bohachevsky and Dr. Jernigan and finds that the treatment recommended by Dr. Bohachevsky, including but not limited to facet block injections, is reasonable and necessary medical treatment to cure and relieve Claimant from the effects of her December 13, 2006 industrial injury.

18. The ALJ finds that Claimant has shown that it is more probably true than not that her cervical spine complaints are related to her December 13, 2006. The ALJ finds that Claimant has shown that it is more probably true than not that the treatment recommended by Dr. Bohachevsky to Claimant's cervical spine is reasonable and necessary to cure and relieve the effects of her industrial injury.

CONCLUSIONS OF LAW

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

2. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.* Section 8-42-101(1)(a) provides that respondents shall furnish medical care and treatment reasonably necessary to cure and relieve the effects of the industrial injury or to prevent a deterioration of claimant's condition. *See Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Where the reasonableness or necessity of medical treatment is disputed, it is claimant's burden to prove that the disputed treatment is reasonably necessary to cure or relieve the effects of the industrial injury. *Ciesiolka v. Allright Colorado, Inc.*, W.C. No. 4-117-758 (Industrial Claim Appeals Office, April 7, 2003). Even if ongoing benefits have been provided, the insurer retains the right to contest the reasonableness, necessity or relatedness of a particular treatment. *Rizo v. Monfort, Inc.*, W.C. No. 4-310-241 (ICAO, June 16, 1999).

3. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

4. As found, the ALJ determines that the treatment to Claimant's cervical spine recommended by Dr. Bohachevsky is reasonable, necessary and related to Claimant's admitted industrial injury of December 13, 2006.

5. The ALJ finds that the treatment recommended by Dr. Bohachevsky, including the facet block injections, is reasonable, necessary and related to Claimant's December 13, 2006 industrial injury.

ORDER

It is therefore ordered that:

1. Respondents shall pay for all reasonable, necessary and related medical treatment provided by Dr. Bohachevsky to Claimant's cervical spine, including but not limited to facet block injections.

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

All matters not determined herein are reserved for future determination.

DATED: February 11, 201

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-784-091

ISSUES

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

2 If Claimant did prove a compensable injury, whether Claimant proved by a preponderance of the evidence that the medical treatment he received was reasonable, necessary and related to the industrial injury?

3 If Claimant did prove a compensable injury, whether Claimant proved that his treating physicians were authorized?

4 If Claimant did prove a compensable injury, whether Claimant proved by a preponderance of the evidence that he is entitled to temporary total disability ("TTD") benefits commencing January 19, 2009 through March 12, 2009?

FINDINGS OF FACT

1. Claimant is a 45 year old job safety man and line locator for employer. Claimant testified that on January 19, 2009 he injured his right groin and right ankle as the result of two incidents while attempting to locate lines. Claimant testified he was walking in deep snow when he twisted his right ankle and leg on something underneath the snow. The incident occurred around 10:00 a.m. Claimant testified he continued to work after this incident and did not contact his employer to report the incident.

2. Later that same day, around 5:00 p.m., Claimant testified he was walking down a hillside, turned to walk back up, slipped and did the splits before falling to the ground and rolling a couple of times down the hill. Claimant testified he used a thin survey stake to support himself as he climbed back up the hill. Claimant testified there were two other workers at the site with him, but he did not request assistance from the workers. Claimant worked a total of 13.5 hours on January 19, 2009.

3. Claimant went to work the next day and reported the incidents to employer. Claimant reported to his supervisor, Mr. -K-, on January 20, 2009 that his leg was hurting and also reported the incidents to Mr. -L-. Claimant worked 11 hours on January 20, 2009 despite being in pain. Claimant did not ask employer for medical treatment on January 20, 2009.

4. Claimant contacted his employer on January 21, 2009 and reported he was in too much pain to come to work. Claimant asked employer for a referral to a physician. Claimant reported employer advised him to go to a physician and to have the doctor's office call employer about billing arrangements. Claimant was evaluated on January 21, 2009 at Rangely Family Medicine by Dr. Riethmiller. Claimant reported to Dr. Riethmiller that he was injured at work and reported pain in his leg that radiated to his back and down to his toes. Dr. Riethmiller noted that examination of the Claimant's leg was difficult because Claimant was in so much pain. Dr. Riethmiller ordered x-rays of Claimant's right lower extremity and provided Claimant a brace for his ankle and crutches. Claimant testified Dr. Riethmiller instructed him to keep off his feet for approximately a week. The ALJ finds that this instruction by Dr. Riethmiller constitutes work restrictions for the Claimant.

5. Claimant contacted Mr. -L-, his immediate supervisor, after the appointment with Dr. Riethmiller and informed Mr. -L- that the doctor had told him to take it easy for a couple of days. Claimant again spoke with Mr. -L- on January 23, 2009 and Mr. -L- asked Claimant to go out to locate a line. Claimant inquired as to whether the area in which he was to work was even ground, and Mr. -L- told him it was flat ground near a driveway on level terrain. Claimant attempted to return to work, but as he was going to his car, he spoke to his neighbor who informed him that the highway from Claimant's home in Rangely to where the job was to be performed was closed. Claimant testified he called the police to confirm the road was closed and later called Mr. -L- to inform him that the highway was shut down and he would not be able to return to work.

6. Mr. -L- testified in this matter and confirmed that Claimant contacted him in the early

morning of January 21, 2009 and reported to Mr. -L- that he had been up all night with leg pain and said he wanted to go to the doctor. Claimant called Mr. -L- on the evening of January 21, 2009 and informed Mr. -L- that he had a “slight groin pull” and would need to take it easy for a couple of days. Mr. -L- testified that Claimant did not report any issues with his ankle. Mr. -L- testified he did not speak to Claimant again until January 23, 2009 at approximately 6:00 a.m. to 7:00 a.m. Mr. -L- testified that Claimant could not work on January 23, 2009 because of an ice storm and testified that he did not speak to Claimant after January 23, 2009.

7. On cross-examination, Mr. -L- admitted that when he spoke to Claimant on January 21, 2009, he instructed Claimant to have the doctor’s office contact employer regarding payment for the initial visit. Mr. -L- also testified he paid Claimant for eight (8) hours worth of work on January 21, and January 22, 2009 even though Claimant did not work either of those days. Mr. -L- testified he did paid Claimant for time he did not work just to be nice.

8. Nonetheless, even though Mr. -L- had paid Claimant for time he did not work on January 21 and January 22, 2009, and had spoken to Claimant on January 23, 2009, a Friday, regarding the ice storm, when he hadn’t heard from Claimant on January 26, 2009 he decided to terminate Claimant as of January 27, 2009 for violating the no call – no show policy.

9. Mr. -K-, a field supervisor for employer, testified in this matter. Mr. -K- testified that he was Claimant’s supervisor during Claimant’s period of employment with employer. Mr. -K- testified that on January 5, 2009 he warned Claimant that employer does not tolerate absences when Claimant would not call to report he would not be at work. The “work calendar” submitted at hearing showed that Claimant was warned regarding violations of the no call – no show policy on December 29, 2008 and January 5, 2009 when he failed to call in to work. Mr. -K- testified that on January 20, 2009, the day after Claimant slipped in the snow, he saw Claimant working at a pad doing his job safety analysis. Mr. -K- testified he saw Claimant come out of a four (4) foot ditch and told Claimant he had pulled his groin climbing a hill. Mr. -K- testified Claimant was limping when he saw him on January 20, 2009. Mr. -K- testified he asked Claimant if he needed medical treatment and Claimant responded that he didn’t think it was too bad. Claimant left a message for Mr. -K- the next day saying he wouldn’t be in to work, but did not explain why in the message. Mr. -K- testified that the phone message was the last he heard from Claimant. Mr. -K- testified he left messages for Claimant on his company cell phone, but did not hear back from Claimant. Mr. -K- testified that Mr. -L- asked him to terminate Claimant on January 27, 2009.

10. Claimant was examined by Dr. Riethmiller on January 21, 2009 and presented with severe pain in his right leg, upper leg, groin and ankle. Claimant reported to Dr. Riethmiller that he was injured while at work when he fell. Dr. Riethmiller noted Claimant reported pain on the inside of his right leg in groin and right ankle. Dr. Riethmiller obtained x-rays of Claimant’s right hip and ankle that were negative, and recommended Claimant treat with an ace bandage, ice, rest and Ibuprofen.

11. Dr. Reithmiller later provided a synopsis of his treatment on January 21, 2009 dated April 15, 2009 that elaborated on the notes from the initial visit. Dr. Riethmiller noted that to the best of his recollection, Claimant reported that while at work, he slipped while trying to climb a hill and did the "splits" and experienced immediate discomfort in his right groin. In addition, earlier that day, Claimant reported having stepped awkwardly on a now covered tree branch, causing him to twist his right ankle.

12. Claimant subsequently sought treatment on January 31, 2009 with the Ashely Regional Medical Center in Vernal, Utah after suffering swelling in the right leg. An ultrasound Doppler was performed that showed extensive deep vein thrombosis ("DVT") going up to the groin on the right side. Dr. Memon noted that Claimant's DVT was extensive, going all the way up to the pelvic region, and causing bilateral pulmonary emboli. Dr. Memon noted Claimant Claimant was lucky to be alive as the diagnosis was significantly delayed. Dr. Memon also noted that Claimant did not have insurance and that the injury started at work, which caused the thromboembolism and that this was a case of workers' compensation. In the past, Claimant had suffered a crush injury to his right ankle with resulting surgery and two left knee surgeries. Claimant did not develop blood clots or pulmonary emboli after these injuries and treatments.

13. Claimant testified that he contacted Insurer and requested permission to return to Dr. Riethmiller, but Insurer instructed him to be seen at Meeker Family Health Center. Claimant presented to Dr. Krueger at Meeker Family Health Center February 5, 2009 with reports of sudden discomfort in his groin area after walking through deep snow. Dr. Krueger noted Claimant was eventually diagnosed with a DVT and pulmonary embolism. Dr. Krueger also noted that Claimant's mother had a history of recurrent DVT and thrombophlebitis. Dr. Krueger accepted care for Claimant and reduced his Coumadin (blood thinner) medication. Claimant consulted with Dr. Krueger on February 10, 2009 because of concerns with his leg swelling again. Dr. Krueger recommended Claimant have a repeat Doppler ultrasound to the right leg and referred Claimant to the Rangley District Hospital Emergency Room. Claimant was evaluated at the hospital by Dr. Cameron, who noted Claimant was complaining of new symptoms, including left sided chest pain. The repeat Doppler ultrasound did not show extension of the clot, but did show some improvement per the radiologist. Dr. Cameron noted that recurrent pulmonary embolism seemed unlikely, but it was not impossible and with Claimant's new left-sided symptoms, Dr. Cameron recommended the Claimant be transferred to St. Mary's Hospital in Grand Junction to perform a CT exam to exclude new pulmonary emboli.

14. Claimant was transported by ambulance from Rangely District Hospital to St. Mary's Hospital. Claimant was examined by Dr. Wedlake on February 11, 2009. Claimant reported to Dr. Wedlake that he was out in the oil fields on January 19, 2009 when he twisted his right ankle, tripped and did the splits, and tumbled down the hill. Claimant reported that his right hip started hurting and leg was hurting. He reported he went to work the next day and it took him 7-8 hours to do what would normally have been a 4-hour job. Dr. Wedlake noted Claimant went to the doctor on January 21, 2009 who diagnosed a groin pull. Dr. Wedlake noted that there

was a recommendation for an ultrasonographic evaluation. Dr. Wedlake performed a CT scan that showed the pulmonary emboli is present within a medial basilar segmental pulmonary artery on the right that was consistent with Claimant's pain distribution. Dr. Wedlake diagnosed Claimant with (1) subacute deep venous thrombosis with subsequent pulmonary emboli, bilateral, (2) family history of thrombophilia and (3) back pain and chest pain consistent with pulmonary emboli. Dr. Wedlake indicated that Claimant was to be admitted to the hospital to have observation status.

15. Dr. Riethmiller testified in this case that he saw no evidence of a blood clot in Claimant's right leg on January 21, 2009. Dr. Riethmiller noted that on examination, Claimant had normal capillary refill in the right foot. Dr. Riethmiller testified that Claimant requested that he draft the letter dated April 15, 2009 that contained additional details regarding his examination on January 21, 2009. Dr. Riethmiller opined that Claimant's DVT was caused by the trauma to his right leg on January 19, 2009 and that the DVT developed after his examination on January 21, 2009. Dr. Riethmiller testified that based on the location of the DVT, the incident in which Claimant slipped and injured his groin was the likely cause of the DVT. Dr. Riethmiller opined that the mechanism led to venous endothelial damage, and combined with venous stasis and opined that Claimant's DVT was related to his work injury.

16. Claimant was scheduled to undergo an independent medical examination ("IME") with Dr. Scott on February 25, 2009, but was unable to do so because he was in the hospital. Dr. Scott reviewed Claimant's medical records in this case and provided a summary of the case based on his review of the medical records on February 28, 2009. Dr. Scott noted that when Claimant was examined by Dr. Memon on January 31, 2009, Claimant appeared significantly sick and had severe swelling of the whole right leg. The ultrasound Doppler was performed that showed extensive DVT going up to the groin on the right side. Dr. Scott noted that Dr. Memon found that Claimant's diagnosis was significantly delayed and that her understanding of the work injury was only from Claimant's report. Dr. Scott also noted that claimant had evidence of current DVT as of February 10, 2009 and the DVT of January 31, 2009 had either not resolved or had reoccurred, probably the former. Dr. Scott noted Claimant had a family history of DVT on his mother's side of his family. Dr. Scott opined that Claimant's history of familial clotting disorder left Claimant more susceptible to a blood clotting disorder. Dr. Scott opined that because of the paucity of the exam findings from Dr. Riethmiller on January 21, 2009, he could not opine if the DVT was caused from the January 19, 2009 work injury.

17. Claimant underwent an independent medical examination ("IME") with Dr. Scott on June 3, 2009. In conjunction with the June 3, 2009 IME, Dr. Scott reviewed additional medical records that were not available at the time of his previous report, including updated records from Dr. Krueger. Dr. Scott diagnosed Claimant with a history of right leg DVT with multiple pulmonary emboli. Dr. Scott opined that Claimant had a possible right ankle sprain and right groin/hip strain due to his claimed injury on January 19, 2009. Dr. Scott noted that based upon Dr. Rithemiller's examination on January 21, 2009, it was also possible that Claimant was developing his DVT in the right leg as of January 21, 2009 and his symptoms were unrelated to

any work injury. Dr. Scott opined that is was possible that Claimant developed DVT and bilateral emboli from the alleged work injury, but based on the absence of major trauma to the lower extremity in the work injury and given the familial hypercoaguability disorder, Dr. Scott did not believe it was probable that the DVT was directly related to the January 19, 2009 incident with employer.

18. Dr. Scott testified in this matter that it was his opinion that based upon the Claimant's family history and genetic predisposition to development of DVT, he did not believe the DVT was related to the incident at work on January 19, 2009. Dr. Scott noted to several references in the medical records that Claimant's mother had developed DVT and that his mother had a venous screen installed in her groin to filter out clots that break off from migrating to her lungs. Dr. Scott opined that the mechanism of injury as described as occurring on January 19, 2009 was not a significant enough trauma to trigger Claimant's DVT. Dr. Scott testified that traumas that are significant to injure the endothelial layer of a vein are lacerations and fractures. Dr. Scott further testified that as of Claimant's examination on January 21, 2009, Claimant did not have any bruising or bleeding. Therefore, Dr. Scott opined that it was not likely that the incidents on January 19, 2009 caused any laceration or damage to the femoral, saphenous and iliac veins in Claimant's right leg. Dr. Scott opined that while two laboratory studies (Factor V Leiden and prothrombin 20212A) were negative for an inherited tendency to clot (hypercoaguablity), there were other studies that had not been conducted that can also determine a predisposition for hypercoaguability. On cross-examination, Dr. Scott admitted that while these tests may show that Claimant has a pre-existing genetic disorder for hypercoaguablity, he did not order these tests to be performed because he was not asked to do so.

19. Dr. McLaughlin performed an IME at the request of Respondents on March 3, 2009. Dr. McLaughlin noted that while Claimant denied a prior history of blood clots, he reported that his mother had blood clots in her leg. Dr. McLaughlin noted Claimant experienced a right ankle sprain, most likely on January 19, 2009 when he reported he twisted his ankle on a rock (Claimant had reported a history to Dr. McLaughlin that he stepped on something, possibly a rock, underneath the snow). With regard to Claimant's vascular disease, Dr. McLaughlin noted Claimant's pronosis was poor as he was already showing post thrombotic syndrome and veinous occlusive disorder. Dr. McLaughlin noted there was a strong family history of clotting disorders. Dr. McLaughlin also noted that Claimant's Factor V Leiden test and prothrombin gene mutation were negative, but there were other familial thrombophilia disorders that can be worked up. Dr. McLaughlin noted that these workups are usually performed when Claimant is off Coumadin, and recommended that the tests be performed. However, there is no credible evidence that additional testing was performed pursuant ot Dr. McLaughlin's recommendations.

20. Dr. McLaughlin opined that it was not probable that Claimant's current veinous occlusive disorder was related to the January 19, 2009 work injury. Dr. McLaughlin based this opinion on Claimant's family history of clotting disorder and the per-existing trauma to Claimant's right lower extremity. Dr. McLaughlin further noted that there was some question as to whether the

DVT was present when Claimant saw Dr. Riethmiller on January 21, 2009.

21. The ALJ credits the opinions of Dr. Memon and Dr. Riethmiller over the opinions of Dr. McLaughlin and Dr. Scott. The ALJ notes that the opinions of Dr. Scott and Dr. Riethmiller that the Claimant was genetically predisposed to a hypocoaguability disorder was based, in part, upon their opinions of the likely outcome of tests that had not been performed in this case. However, the evidence demonstrates that the Factor V Leiden and protuhrombin gene mutation test, intended to show possible predisposition to hypocoaguability, were both negative.

22. The ALJ credits the testimony of Claimant that he was not experiencing problems with his right leg before the slip and fall incidents on January 19, 2009 and finds that Claimant has proven by a preponderance of the evidence that the DVT is causally related to the incident on January 19, 2009 when he slipped in the snow, did the splits and rolled down the hill. The ALJ finds that the incident on January 19, 2009 either caused or aggravated Claimant's genetic predisposition to DVT and resulted in the formation of the blood clot in Claimant's leg.

23. The ALJ credits the testimony of the Claimant and Mr. -L- that Claimant timely reported his injury to his employer was not referred for medical treatment with a designated provider. Instead, Mr. -L- instructed Claimant to go to a physician of his choosing and submit the bill to the employer to be paid. The ALJ notes that employer may have intended to pay the bill directly without filing a claim with Insurer, but regardless, Claimant's treatment with Dr. Riethmiller is authorized by virtue of employer failing to refer Claimant to a physician upon being notified of the injury.

24. The ALJ finds Claimant's treatment on January 31, 2009 with Dr. Mermon and Ashley Regional Medical Center is emergency medical care related to Claimant's compensable injury, and is therefore authorized.

25. Following the hospitalization in Vernal, Utah, Insurer referred Claimant to Dr. Krueger with Meeker Family Health Center. The ALJ finds that Dr. Krueger became authorized by Insurer by virtue of this referral. Dr. Krueger referred Claimant to Rangely District Hospital on February 10, 2009 after further complaints related to the DVT. The ALJ finds Claimant's treatment with Rangely District Hospital to be within the chain of referrals from Dr. Krueger and Meeker Family Health Center. Rangley District Hospital then referred Claimant for further testing and treatment at St. Mary's Hospital. Therefore, the ALJ finds that Claimant's treatment with St. Mary's Hospital is within the chain of referrals from Dr. Krueger and Meeker Family Health Center.

26. The ALJ credits the testimony of the Claimant and the medical records and finds that Claimant was off of work as a result of the work injury beginning January 22, 2009 by virtue of the work restrictions set forth by Dr. Riethmiller. The ALJ finds that Claimant has shown that it is more likely true than not that he is entitled to TTD benefits beginning January 23, 2009, as he was paid by the employer for January 21, and January 22, 2009, even though he did not

perform work for the employer.

27. Respondents argue that Claimant is not entitled to TTD benefits in this case because he was responsible for his termination of employment for violating the no call – no show policy set forth by employer. The ALJ is not persuaded.

28. The ALJ credits the testimony of the Claimant and Mr. -L- and finds that Claimant contacted his employer on January 20, 2009 and informed his employer of his physical condition and his request for medical care. Mr. -L- confirmed that he was aware of Claimant alleging pain in his leg on January 20, 2009 and testified that Claimant contacted him on January 21, 2009 and told him he was up all night with pain in his leg and requested to go see a doctor. The ALJ finds Mr. -L- instructed Claimant to go to a physician of his choosing on January 21, 2009 (a Wednesday) and to bring the medical bill to employer for payment. Mr. -L- testified that Claimant called him on the night of January 21, 2009 and informed him he had a groin pull and would need to take it easy for a few days. Based on the testimony of Claimant and Mr. -L-, Claimant advised his employer after the medical appointment that he had been instructed not to work by Dr. Riethmiller.

29. Mr. -L- confirmed on examination that he requested Claimant go to work on January 23, 2009 (a Friday) and Claimant agreed to attempt to perform work on an area that was flat. Mr. -L- also confirmed that Claimant couldn't get to work on January 23, 2009 because of an ice storm. Mr. -L- did not talk to Claimant on Saturday or Sunday and left a phone message for Claimant on Monday, January 26, 2009 to see how things were going with regard to his injury. Mr. -L- called Claimant on January 27, 2009 and told him if he did not hear from him by the end of the day, he would be terminated. Mr. -L- also testified he paid Claimant for 8 hours of work on January 21 and January 22, 2009 "to be nice."

30. The ALJ finds that Claimant was off of work beginning January 21, 2009 pursuant to the work restrictions from Dr. Riethmiller. Mr. -L- testified that he was informed orally of these work restrictions by Claimant. Mr. -L- testified that he did not inform Claimant that he needed to present the work restrictions to employer to justify his time off from work. The ALJ also finds the testimony of employer perplexing that he would voluntarily pay Claimant for days he was not at work after a work injury on Wednesday and Thursday, but determine that he should terminate Claimant on Tuesday of the next week after not hearing from him on Monday.

31. The ALJ finds it interesting that employer paid Claimant for two days missed after a work injury, attempted to give Claimant an easy assignment on the third day that was thwarted by virtue of a closed highway, then terminated Claimant on what would have been his third day missed without pay, and did not file an employer's first report of injury until February 4, 2009.

32. Regardless, Respondents have failed to show a volitional act on the part of Claimant that would result in Claimant's termination from employment. Claimant contacted his employer on January 23, 2009 and attempted to return to work in what Mr. -L- described was an easy

assignment, but was prevented from doing so by virtue of an ice storm. There is no indication that on Monday or Tuesday of the next week that employer had conferred with Claimant to determine the extent of his continued work injury, other than to leave a voice mail message for Claimant on his company issued cell phone.

33. Moreover, pursuant to testimony from Mr. -L- and Mr. -K-, employer needed to go by Claimant's residence after he was terminated to collect the company issued cell phone and other company equipment. Employer did not demonstrate what, if any, efforts were made to go by Claimant's residence before he was terminated to determine the extent of his work restrictions, or his ability to return to work after his medical appointment with Dr. Riethmiller.

CONCLUSIONS OF LAW

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

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

4. As found, Claimant has shown by a preponderance of the evidence that the work injury on January 19, 2009 caused, aggravated or accelerated with a pre-existing condition or infirmity to produce disability and need for treatment. Therefore, the ALJ finds that Claimant's treatment for his DVT is causally related to the work related injury on January 19, 2009.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Pursuant to Section 8-43-404(5), C.R.S., Respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once Respondents have exercised their right to select the treating physician, Claimant may not change physicians without first obtaining permission from the insurer or an ALJ. *See Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996).

6. Authorization" refers to the physician's legal authority to treat, and is distinct from whether treatment is "reasonable and necessary" within the meaning of Section 8-42-101(1)(a), C.R.S. 2008. *Leibold v. A-1 Relocation, Inc.*, W.C. No. 4-304-437 (January 3, 2008). Section 8-43-404(5)(a) specifically states: "In all cases of injury, the employer or insurer has the right in the first instance to select the physician who attends said injured employee. If the services of a physician are not tendered at the time of the injury, the employee shall have the right to select a physician or chiropractor." "[A]n employee may engage medical services if the employer has expressly or impliedly conveyed to the employee the impression that the employee has authorization to proceed in this fashion…." *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985), *citing*, 2 A. Larson, *Workers' Compensation Law* § 61.12(g)(1983).

7. As found, Claimant reported his injury to his employer and was not instructed to see a specific physician or medical clinic. Therefore, pursuant to Section 8-43-404(5), C.R.S., the right to select a physician passed to the Claimant. Claimant selected Dr. Riethmiller, and his services are considered authorized and reasonably necessary to cure and relieve the effects of the industrial injury. As found, Claimant's treatment with Dr. Memon is found to constitute emergency medical services related to Claimant's industrial injury and therefore deemed authorized. As found, Respondents designated Dr. Krueger to be the authorized treating physician in February, 2009 and his treatment and referrals, including Claimant's treatment at Rangely District Hospital and St. Mary's Hospital are found to be reasonable and necessary to cure and relieve the Claimant from the effects of the industrial injury.

8. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), *supra*, requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's

inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

9. As found, Claimant has shown that it is more probable than not that his injury resulted in his inability to work, as evidence by the work restrictions from Dr. Riethmiller, from January 23, 2009 continuing through March 12, 2009.

10. Sections 8-42-105(4) and 8-42-103(1)(g), C.R.S., contain identical language stating that in cases “where it is determined that a temporarily disabled employee is responsible for termination of employment the resulting wage loss shall not be attributable to the on-the-job injury.” In *Colorado Springs Disposal v. Industrial Claim Appeals Office*, 58 P3d 1061 (Colo. App. 2002), the court held that the term “responsible” reintroduced into the Workers’ Compensation Act the concept of “fault” applicable prior to the decision in *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Hence, the concept of “fault” as it is used in the unemployment insurance context is instructive for purposes of the termination statutes. *Kaufman v. Noffsinger Manufacturing*, W.C. No. 4-608-836 (Industrial Claim Appeals Office, April 18, 2005). In that context, “fault” requires that the claimant must have performed some volitional act or exercised a degree of control over the circumstances resulting in the termination. *See Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1995) *opinion after remand* 908 P.2d 1185 (Colo. App. 1995).

11. As found, Respondents have failed to prove by a preponderance of the evidence that Claimant committed a volitional act that led to his termination of employment. The ALJ finds that Claimant was off of work pursuant to work restrictions from Dr. Riethmiller and employer terminated Claimant while he was on work restrictions. Respondents’ argument that Claimant violated the terms of the no call – no show policy are rejected by the ALJ. Employer bears some burden of determining what work restrictions are in effect for Claimant when they fail to refer the Claimant to their authorized physician for treatment, and the ALJ finds that Claimant was in contact with employer on January 21, 2009, and January 23, 2009. Claimant’s failure to speak with employer on January 26, 2009 and January 27, 2009 did not represent a volitional act by Claimant that he reasonably knew would result in his termination of employment.

ORDER

It is therefore ordered that:

1. Respondents shall pay all reasonable and necessary related medical treatment for injuries arising out of Claimant’s January 19, 2009 industrial injury pursuant to the Colorado Medical Fee Schedule. The ALJ determines that the treatment for Claimant’s DVT condition is causally

related to the January 19, 2009 industrial injury.

2. Dr. Riethmiller and Dr. Memon are determined to be authorized to treat Claimant's compensable workers' compensation claim. Dr. Krueger and Meeker Family Health Care is determined to be authorized to treat Claimant's compensable workers' compensation claim and all referrals from Dr. Krueger, including Rangely District Hospital and St. Mary's Hospital are determined to be within the chain of referrals.

3. Claimant is entitled to TTD benefits for the period of January 23, 2009 until March 12, 2009.

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

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

DATED: February 26, 2010

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-762-775

ISSUES

1 Whether Claimant proved by a preponderance of the evidence that he suffered a compensable injury involving a per-umbilical hernia arising out of and in the course and scope of his employment with employer?

2 Whether Claimant proved by a preponderance of the evidence that he suffered a compensable injury to his cervical spine arising out of and in the course and scope of his employment with employer on February 5, 2008?

3 If Claimant did prove a compensable injury, whether Claimant proved by a preponderance of the evidence that he is entitled to temporary total disability benefits for either the hernia or cervical spine injury?

4 If Claimant did prove a compensable injury, whether Claimant proved by a preponderance of the evidence that his injury resulted in the need for medical treatment to cure and relieve the effects of the industrial injury?

5 If Claimant did prove a compensable injury, what is Claimant's average weekly wage?

FINDINGS OF FACT

1. Claimant was employed with Respondent-employer beginning in 2007 as a long wall maintenance supervisor. Claimant testified that on or about May 2007 (although he was unsure of the date) he was driving into the mine with Mr. -M- and Mr. -N-, two electricians employed with employer, when he noticed a ram cylinder out of the corner of his eye. Claimant testified he stopped to move the cylinder out of the road and when he lifted the cylinder, he immediately felt pain and developed a bulge on the upper portion of his stomach above his waistline. Claimant testified he had experienced hernias in the past, but the hernias were below his waistline. Claimant testified he got back in the truck and told Mr. -M- and Mr. -N- that he believed he "pulled a hernia" and that Mr. -M- and Mr. -N- were inquisitive and asked to see the hernia. Claimant testified that this occurred in the kitchen area at work.

2. Mr. -M- testified at hearing that he would drive into the mine with Mr. -N- and removing items from the roadway was a daily occurrence. Mr. -M- testified he had a conversation with Claimant regarding a hernia in the kitchen area, but denied witnessing Claimant remove a ram cylinder and report an injury while driving into the mine. Mr. -N- also testified at the hearing. Mr. -N- testified that he would on occasion drive a pick up with Claimant and Mr. -M- into the mine. Mr. -N- testified he recalled Claimant telling him he had a hernia, but denied Claimant told him he got a hernia as a result of lifting a ram cylinder at work. Both Mr. -M- and Mr. -N- denied seeing Claimant's hernia bulge or asking to see the bulge or having Claimant report sustaining an injury after lifting a ram cylinder while driving into the mine.

3. Claimant first sought treatment for the peri-umbilical hernia on January 15, 2008 with his primary care physician, Dr. Funk. Dr. Funk noted Claimant worked as a supervisor at the local underground mine and would like a vasectomy. Dr. Funk further noted Claimant "had a peri-umbilical hernia for some time status post repair, now been more painful." Dr. Funk noted that they had been trying to get Claimant set up to see a surgeon, but Claimant had not gotten that done and it was now becoming more painful. Dr. Funk's records do not indicate that Claimant's hernia was related to Claimant's work with employer.

4. Claimant was subsequently referred by Dr. Funk to Dr. McCrackin on January 29, 2008. Dr. McCrackin reported that Claimant underwent some type of abdominal wall repair surgery as an infant while in Panama where his parents were stationed with the military, and subsequently underwent two umbilical hernia repairs with mesh, one approximately five years ago, and one approximately ten years ago. Claimant presented to Dr. McCrackin with peri-umbilical pain and tenderness, supraumbilical swelling with some associated intermittent nausea that was worse with lifting and straining. Dr. McCrackin noted Claimant had significant cervical pain from a "blown disc" at the C4 through C6 levels with crushed vertebra from chronic repetitive trauma. Dr. McCrackin recommended surgical repair of the hernia and suspected that Claimant has continued to have his hernias recur because of a diastasis making him prone to further epigastic hernias. Dr. McCrackin's medical records do not provide a history of Claimant's peri-umbilical hernia as occurring as a result of lifting a ram cylinder while at work.

5. The ALJ notes that the medical records do not document any credible evidence of Claimant

reporting an accident history consistent with the testimony he presented at hearing of lifting a ram cylinder while at work. Moreover, Claimant's co-workers fail to corroborate Claimant's testimony of his hernia occurring at work after lifting a ram cylinder. The ALJ finds Claimant's testimony that he suffered a hernia when he lifted a ram cylinder at work not credible as this testimony is not supported by the medical records, nor supported by the potential witnesses who were allegedly present when the lifting incident occurred. The ALJ notes that Claimant was unsure of the exact date of the lifting incident that purportedly resulted in the development of a hernia and did not report to his treating physicians that his hernia resulted from lifting while at work. Moreover, the testimony of Mr. -O- and Mr. -M- directly contradicted Claimant's testimony that he reported to both Mr. -O- and Mr. -M- that he developed a hernia immediately after lifting the ram cylinder while driving into the mine on May 2007. The ALJ finds and determines that Claimant has failed to show that it is more probable than not that he suffered a compensable injury on or about May 2007 when he lifted a ram cylinder at work.

6. Claimant presented testimony at hearing through his own sworn testimony and through testimony of other witnesses regarding a safety bonus program established by the mine that would pay employees from $100 per month to $1,000 per month if no injuries are reported by a crew. If one member of the crew reports an injury, the entire crew would lose their bonus. Claimant testified that the bonuses are cumulative so the longer a crew goes without a reported injury, the higher the bonus that gets paid to the crew becomes. Claimant alleges that this bonus program encourages employees to not report injuries that occur in the mine.

7. While the bonus program may establish an incentive for the employees to not report compensable injuries to their employer, and may provide an argument against a penalty for failing to timely report an injury, the ALJ does not accept this argument as establishing that Claimant had a hernia at work in May 2007, but failed to report the incident to his medical providers. The ALJ notes that Claimant reported other incidents occurring in the mine to his medical providers, including an increased neck pain with using his hard hat with head lamp in December 2006, and an incident when he fell on his head at work in October 2007.

8. Claimant also testified that he worked for several months with the hernia to arrange his schedule to come up with the best tie to schedule the hernia surgery that would result in the least amount of inconvenience for the mine. The ALJ agrees that Claimant more than likely arranged for his surgery to take place during a time that was to be convenient for his employer, but this does not explain the lack of any documented report of injury for the hernia in the medical reports other than the hernia is worse with lifting and straining.

9. The ALJ credits the records from Dr. Funk and Dr. McCrackin over the testimony of Claimant and finds that Claimant has failed to show that it is more probably true than not that he suffered a peri-umbilical hernia as a result of his employment with employer.

10. With regard to Clamiant's alleged neck injury, Claimant testified that on February 5, 2008, he was at work at approximately 2:00 p.m. supervising the long wall move that included moving shields. Claimant testified that as the shields get pulled out, the roof has a tendency to fall in

behind the miners. As a shield got pulled out, there was a large number of rocks that fell behind Claimant, startling Claimant. Due to the loud noise, Claimant jerked his head around and felt something snap in his neck. Claimant testified that the snapping sounded like a broken chicken leg. Claimant testified that he immediately felt pain in his neck and needed to be helped to the kitchen area that was approximately 100 yards away. Once in the kitchen area, Claimant got a cup of coffee and some pain medicine for his neck pain from his lunch box. Claimant testified he reported his neck pain to Mr. -P-, Mr. -Q-, Mr. -R-, and Mr. -S-.

11. Mr. -Q- testified he did not recall an incident where Claimant injured himself. However, Mr. -P- testified that he recalled an incident during the long wall move that resulted in Claimant complaining of pain, although Mr. -P- thought Claimant was complaining of back pain. Likewise, Mr. -R- recalled an incident where Claimant was brought into the kitchen complaining of neck pain. While Claimant testified that Mr. -R- drove him out of the mine on the date of his injury, Mr. -R- denied driving Claimant out of the mine. Mr. -R- testified that he was in the kitchen for 45 minutes with Claimant and Claimant appeared to be in pain. Mr. -R- did not witness the incident.

12. The day after Claimant's incident with the rocks falling behind the shield, Claimant called Mr. -S- at 4:30 a.m. and left a voice message reporting his injury. Claimant testified he believed he reported to Mr. -S- that the injury occurred at work on the voice mail. Mr. -S- testified that Claimant only reported a neck injury and not that the injury occurred at work. The ALJ infers that Claimant reported in the voice mail message that he had injured his neck the previous day, but did not specify that the injury was work related.

13. Claimant had a long history of prior neck complaints, including treatment with Dr. Knackendoffel in March 2006. Dr. Knackendoffel noted Claimant complained of tingling in his upper thoracic spine with numbness and tingling into his hands. Claimant also reported his neck was sore at times and reported he felt weak and had problems lifting things up at times. Dr. Knackendoffel noted Claimant had reduced range of motion with his neck. Dr. Knackendoffel diagnosed Claimant with bilateral arm pain with underlying cervical degenerative disk disease and evidence of nerve root irritation. Claimant returned to Dr. Knackendoffel on May 25, 2006 with complaints of numbness in both hands. Dr. Knackendoffel diagnosed Claimant with severe right carpal tunnel syndrome and moderately severe left carpal tunnel syndrome with moderate bilateral cubital tunnel syndrome. Dr. Knackendoffel also diagnosed cervical spondylosis with some degree of cervical radiculitis and recommended Claimant undergo a cervical magnetic resonance image ("MRI").

14. Claimant underwent surgery for the right carpal tunnel and cubital tunnel syndrome on June 6, 2006 under the auspices of Dr. Knackendoffel. Claimant underwent surgery for the left carpal tunnel and cubital tunnel syndrome on July 18, 2006, again under the auspices of Dr. Knackendoffel. Both of these surgeries are unrelated to any current claim for workers' compensation for Claimant.

15. Claimant returned to Dr. Knackendoffel on October 4, 2006 with complaints of bilateral

proximal shoulder traezial and neck pain. Claimant reported he was quite miserable after a workday. Dr. Knackendoffel noted that Claimant's previous radiographs demonstrate cervical degenerative disk disease. Dr. Knackendoffel diagnosed Claimant with significant trapezial myofascitis with cervical degenerative disk disease and probable C6 root radiculitis, which was intermittent. Dr. Knackendoffel recommended a course of physical therapy and a home stretching program and noted that a cervical MRI may be indicated. Claimant returned to Dr. Knackendoffel on December 6, 2006 with complaints of radicular type pain in his left arm, especially after using his hard hat with head lamp and wearing his tool belt. Dr. Knackendoffel noted examination demonstrated some radiculitis and recommended a cervical MRI.

16. Claimant underwent a cervical MRI on December 11, 2006. Dr. Knackendoffel called Claimant on December 18, 2006 and noted that the MRI suggested posterior protrusion of the C4-5 disk with moderate narrowing of the left neural foramen with some effacement of the ventral aspect of the thecal sac at the C4-5 level. Dr. Knackendoffel also noted some mild protrusion at the C5-6 level. Based on Claimant's continued complaints of left arm pain, Dr. Knackendoffel referred Claimant to Dr. Nelson for an opinion regarding an epidural steroid injection ("ESI").

17. Dr. Nelson evaluated Claimant on January 10, 2007, more than one year prior to Claimant's alleged neck injury. Dr. Nelson noted on January 10, 2007 that he had experienced neck pain for over a year that would get as bad as 9/10 and was on average 7/10. Claimant reported the pain as continuous and noted the severity had increased recently. Claimant also reported radicular symptoms through the left arm, through the medial arm, forearm and hand extending into the long, ring and small fingers. Dr. Nelson noted Claimant underwent a MRI of the cervical spine on December 11, 2006 that revealed multilevel degenerative disk disease, degenerative left sided foraminal narrowing from degenerative change from uncovertebral joints and the facet joints at C4-5. The MRI also showed mild effacement with a broad posterior protrusion of the degenerative disk material at C5-6 of the thecal sac.

18. Dr. Nelson diagnosed Claimant with among other things, severe cervical pain with radiation into the left upper extremity accompanied by hypothesia and radicular pain from the cervical spine into the occipital region contributing to tension headaches. Dr. Nelson also noted Claimant was at increased risk for cervical spinal cord and/or nerve root injury in the face of vocation and cervical central and neural forminal stenosis. Dr. Nelson recommended Claimant discontinue ibuprofen, and initiate Norco, Felxerial and Voltaren and recommended a cervical ESI. Claimant underwent the ESI on January 17, 2007 and followed up with Dr. Nelson on January 23, 2007. Dr. Nelson noted Claimant reported significant improvement with the cervicalgia and left upper extremity pain after the ESI. Dr. Nelson referred Claimant back to Dr. Knackendoffel for surgical consultation.

19. Dr. Nelson reevaluated Claimant on February 13, 2007 and reported the pain in his neck and upper arm increased in severity again approximately one week earlier. Dr. Nelson again diagnosed Claimant with multilevel cervical degenerative disk disease with disk protrusion at C5-6 with left neural forminal narrowing and C4-5 facet joint arthrosis; cervicalgia, left upper

extremity pain, recently improved, now progressing in severity with accompanying decreased cervical range of movement for unclear reason, consistent with myofascial pain syndrome; and limited ability to participate in previous vocation due to work restrictions secondary to risk of spinal-cord and peripheral nerve in jury in the cervical region. Dr. Nelson recommended Claimant discontinue the Volatren prescription to determine the effectiveness of the nonsteroidal anti-inflammatory ("NSAID"). Dr. Nelson requested a copy of work restrictions from Dr. Knackendoffel and the EMG/nerve conduction studies from Dr. Dean. Dr. Nelson noted Claimant wished to pursue surgical consultation to evaluate any indication for cervical spine decompression and indicated he would like to proceed with plans for a second cervical ESI. Claimant underwent a second cervical ESI on March 28, 2007 and Dr. Nelson recommended a pneumonic cervical traction device on March 29, 2007.

20. Claimant returned to Dr. Nelson on April 12, 2007 and reported a significant reduction in pain severity through his neck and both upper extremities following the ESI, but continued to experience bilateral lower arm and forearm pain in the ulnar distribution bilaterally. Dr. Nelson recommended Claimant discontinue the Flexeriil and initiate Cymbalta and Skelaxin. Dr. Nelson also provided Claimant with work restrictions of no lifting greater than 100 pounds and no lifting objects weighing more than 10 pounds above shoulder height on April 12, 2007.

21. Claimant returned to Dr. Nelson on July 9, 2007 with reports of increased pain severity, especially in the upper back and left side of his neck with extension into the left upper extremity, including the arm, elbow, forearm, hand and fingers. Claimant reported his left arm pain was greater than his neck pain. Claimant reported he had extensive work responsibilities, working 24 days in a row, 15 hours a day. Claimant also reported hitting the front of his helmet on a pipe recently. Dr. Nelson diagnosed "neck and upper back pain, left greater than right, consistent with myofascial pain syndrome, degenerative disc disease, disc protrusion at C5-6 with left nueral foraminal narrowing, C4-5 facet arthrosis, stable neurologic examination, but increase in myofascial pain consistent with increased time at work, decreased utilization of medications, and inability to participate with formal therapy, massage or other pain modifying modalities or interventions." Dr. Nelson prescribed Utlram, Cymbalta and Skelaxin and restarted Voltaren and recommended physical therapy.

22. Claimant was reevaluated by Dr. Nelson on August 23, 2007 and reported continued pain across his posterior lateral neck, greater on the left than right with extension into the left upper extremity, with occasionally radiating pain present through the arm, elbow, forearm and into his hand. Claimant noted that the pain severity rated from moderate to severe and increased with upright and overhead activities. Dr. Nelson noted Claimant's cervical range of motion was within functional limits but decreased bilateral and lateral function due to complaints of ipsilateral and contralateral pain. Dr. Nelson again continued to encourage Claimant to follow the prescription medication plan outlined by Dr. Nelson and requested he follow up in seven (7) weeks.

23. Claimant returned to Dr. Nelson on October 23, 2007 and noted a minor accident at work where he fell landing on his head following which he noticed increased pain in the head and

neck from approximately two days that had since returned to baseline. Claimant continued to complain of pain localized in the cervical spine greater on the right than the left that was currently 5/10 but escalated to an 8/10 on bad days. Dr. Nelson diagnosed Claimant with neck and upper back myofascial pain syndrome with underlying degenerative disc disease with a recent exacerbation with a fall landing on his back and head that had returned to baseline. Claimant returned to Dr. Nelson on November 19, 2007 with continued upper back and neck pain. Dr. Nelson continued Claimant on his current prescription medications, increased his tizanidine to treat Claimant's muscle spasm and added methadone for pain management in order to decrease the amount of short-acting opiods he was taking.

24. Claimant was examined by Dr. Nelson on December 18, 2007 with pain severity in the range of 5-9 out of 10 present 24 hours a day that increased with work, especially lifting objects over the height of his shoulders. Dr. Nelson again diagnosed Claimant with degenerative disk disease of the cervical spine with accompanying neural foraminal narrowing and C4-5 facet arthrosis with accompanying myofascial neck and upper back pain. Dr. Nelson continued Claimant on his medications and recommended he return in two months.

25. Following the incident in which the rocks crashed behind the shield on February 5, 2008, Claimant reported to the emergency room in -E- on February 6, 2008 with reports of an acute escalation of pain after he "carried a heavy belt at work yesterday". Claimant was diagnosed with chronic neck pain and degenerative disk disease of the cervical spine. Claimant underwent x-rays of the cervical spine in the emergency room that revealed huge osterophytes marginating the C3-4, C4-5 C5-6 and C6-7 levels. The radiologist noted that several of the osteophytes appear to be impinging and becoming sclerotic or reactive. The radiologist also noted that it was "possible that a fracture of an osteophyte has occurred, which would be nondiplaced in this case, but compared to the prior examination of 2005, there does note appear to be a significant interval change. No acute-appearing fractures or dislocations are apparent."

26. Claimant returned to Dr. Nelson on March 3, 2008 and reported an episode at work where he twisted his neck suddenly to the left, and felt an excruciating sharp sudden onset of pain. Claimant described to Dr. Nelson that he had a bone chip that was noted as the cause of his pain. Dr. Nelson diagnosed Claimant with neck pain with complex history and a recent pain exacerbation episode and what appears to be a new work-related incident. Dr. Nelson noted that medical records were not available for her review. Dr. Nelson referred Claimant to Dr. Dwyer.

27. Dr. Dwyer evaluated Claimant on March 10, 2008. Dr. Dwyer noted Claimant had been treating for neck pain for 18 months and reported his symptoms increased recently secondary to his work in a coal mine. Claimant reported he needs to rotate his head to keep an eye on different things in the mine. Claimant described a gradual onset of constant, aching pain at the base of his neck that was intermittently more sharp in nature. Claimant also described some constant burning pain in the posterior aspect of the left shoulder. Claimant reported previous injections would help tremendously for four or five weeks. Dr. Dwyer obtained flexion and

extension x-rays of the cervical spine that showed slightly decreased disk height at the C3-4, C4-5 and C6-7 levels with ossification anteriorly at the C3-4, C4-5, C5-6 and C6-7 levels. Dr. Dwyer noted there was no evidence of acute fracture and no instability with flexion and extension. Dr. Dwyer noted that the etiology of Claimant's pain was difficult to know with certainty and noted Claimant had a great deal of bone formation anteriorly in the anterior longitudinal ligament suggestive of a bone forming condition. Dr. Dwyer recommended Claimant undergo a repeat MRI exam to compare to his prior MRI studies.

28. Claimant underwent another MRI of the cervical spine on March 18, 2009. The MRI revealed multiple levels of degenerative disk disease and joint disease from C3 though C7 with a small disk bulge most pronounced at the C6-7 level. Dr. Dwyer reviewed the results of the MRI with Claimant on March 24, 2008 and noted desiccation of all disks through the cervical spine and large osteophytes anteriorly from the C4-C7 levels. Dr. Dwyer noted that he would need to review Claimant's previous EMG's to determine if there are any objective neurological changes and review Dr. Nelson's notes to determine what level of injections had provided Claimant with relief, but doubted that he would ever recommend surgery to address all of the degenerative changes in his spine. Claimant returned to Dr. Dwyer on April 4, 2008 and noted increase in his symptoms while working. Claimant reported he worked three days and was unable to work anymore due to significant increase in this pain. Dr. Dwyer noted that he was concerned about Claimant's significant increase in his pain with his work activities. Dr. Dwyer again noted that he was not certain that any surgery is really warranted. Dr. Dwyer noted that any minimal surgery would also require the Claimant to decrease or change his work activities in order to be fully beneficial for him and noted that it would be in Claimant's best interest to consider different work activities.

29. Claimant returned to Dr. Funk on April 9, 2008 and reported to Dr. Funk that Dr. Dwyer had recommended no further underground work where he requires wearing a helmet, tool belt and the usual apparatus of underground mining work with the risk of bumping his head. Dr. Funk noted that he did not have Dr. Dwyer's most recent evaluation and diagnosed Claimant with severe cervical degenerative joint disease with anticipated surgery. The ALJ notes that this is not consistent with the notes from Dr. Dwyer that indicated he would not recommend surgery. Dr. Funk also noted that Claimant should be considered disabled from his usual occupation at the mine secondary to his cervical degenerative joint disease. Dr. Funk wrote a "to whom it may concern" letter on April 11, 2008 regarding his opinion that Claimant would "probably have surgery for severe cervical spine degenerative joint disease" and should not return to his usual occupation until this medical issue is resolved.

30. Testimony was presented at hearing from multiple witnesses regarding Claimant's reporting of the injuries in question, and circumstances surrounding Claimant's employment. The ALJ finds based upon the medical records and the testimony of the witnesses, that Claimant had a temporary exacerbation of his neck pain while at work on February 5, 2008. Claimant argues that this incident of February 5, 2008 represents a compensable work injury because a special hazard of employment (the rocks falling) caused him to jerk his head to the left violently and resulted in his need for medical treatment. The ALJ is not persuaded.

31. First, the ALJ notes that medical records from the emergency room in -E- on February 6, 2008 do not document that Claimant jerked his head to the left violently after rocks fell behind him. Instead, the records document that Claimant was either “lifting something heavy” (the x-ray report) or “carrying a heavy belt” (the hand written notes from the emergency room”. Regardless, however, Claimant’s subsequent x-ray and MRI revealed no acute fractures or significant changes when compared to the prior x-rays and MRI.

32. The ALJ notes that when Claimant sought additional medical treatment from Dr. Dwyer after the February 5, 2008 incident, he did not report the rock falling incident as contributing to his current condition of ill-being. The only medical records that document such an accident history are Dr. Nelson’s March 3, 2008 records. However, Claimant’s subsequent treatment with Dr. Dwyer and Dr. Funk do not document such an injury occurring. As such, the ALJ finds that based upon the medical records from Dr. Nelson, Dr. Funk and Dr. Dwyer, the February 5, 2008 incident represented a temporary exacerbation of Claimant’s pre-existing condition, and not an injury pursuant to the Colorado Workers’ Compensation Act.

33. Insofar as Claimant alleges that the turning of his head to the left represented a special hazard of employment, the ALJ is likewise not persuaded. While Claimant testified that the incident caused him to turn his head violently to the left, causing immediate pain in the neck after rocks had fallen behind him, there is no indication that this incident caused an “injury” to Claimant. The ALJ notes that Dr. Dwyer does not recommend surgery and the MRI and x-rays reveal no acute fractures that could be associated with the incident. Moreover, the ALJ finds that the act of turning to look over one’s shoulder does not represent a special hazard of employment, even if Claimant were startled. Instead, the act of looking behind someone is a ubiquitous condition that can .

CONCLUSIONS OF LAW

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

2. The ALJ’s factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). A compensable industrial accident is one that results in an injury requiring medical treatment or

causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

3. As found, Claimant has failed to show by a preponderance of the evidence that he suffered a hernia as a result of a lifting injury arising out of and in the course of his employment with employer. Claimant's claim for benefits arising from the hernia (W.C. No. 4-762-776) is denied and dismissed.

4. With regard to Claimant's alleged neck injury, Claimant must show that the injury was sustained in the course and scope of his employment and that the injury arose out of his employment. The "arising out of" and "in the course of" employment criteria present distinct elements of compensability. *Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). For an injury to occur "in the course of" employment, the claimant must demonstrate that the injury occurred in the time and place limits of his employment and during an activity that had some connection with his work-related functions. *Id.* For an injury to "arise out of" employment, the claimant must show a causal connection between the employment and the injury such that the injury has its origins in the employee's work related functions and is sufficiently related to those functions to be considered a part of the employment contract. *Id.* Whether there is a sufficient "nexus" or relationship between the Claimant's employment and his injury is one of fact for resolution by the ALJ based on the totality of the circumstances. *In re Question Submitted by the United States Court of Appeals*, 759 P.2d 17 (Colo. 1988).

5. If the precipitating cause of an injury at work is a preexisting health condition that is personal to the Claimant, the injury does not arise out of employment unless a "special hazard" of the employment combines with the preexisting condition to contribute to the occurrence of the accident or the injuries sustained. *Finn v. Industrial Commission*, 165 Colo. 106, 437 P.2d 542 (1968); *National Health Laboratories v. Industrial Claim Appeals Office*, 844 P.2d 1259 (Colo. App. 1992); *Rice v. Dayton Hudson Corp.*, W.C. No. 4-386-678 (Industrial Claim Appeals Office, July 29, 1999). This rule is based upon the rationale that, unless a special hazard of the employment increases the risk or extent of injury, an injury due to the Claimant's preexisting condition lacks a sufficient causal relationship to the employment. A "special hazard" is a condition or circumstances that is not generally encountered outside the workplace. *Gates Rubber v. Industrial Commission*, 705 P.2d 6 (Colo. App. 1985); *Kidwell v. City of Denver,* W.C. No. 4-601-057 (Industrial Claim Appeals Office, December 15, 2004).

6. In this case, the ALJ determines that any incident occurring at work on February 5, 2008 represented simply a temporary aggravation of Claimant's pre-existing neck pain. The ALJ notes that Claimant had experienced several such incidents in the past, and his pain level returned to baseline. The ALJ further notes that, despite Claimant's self diagnosis that he

suffered a bone chip in his neck as a result of the incident, the MRI and x-rays taken after the incident did not reveal any acute injuries to Claimant's cervical spine. Therefore, the ALJ concludes that the incident did not result in an injury to Claimant.

7. Moreover, insofar as the rock falling incident caused any need for medical treatment, the ALJ determines that the incident was the result of a ubiquitous condition, that being the turning of the head. An otherwise compensable injury does not cease to arise out of employment because it is partially attributable to a pre-existing physical infirmity of the employee. As noted previously, to be considered a "special hazard of employment", the employment condition must not be a ubiquitous one; it must be a special hazard not generally encountered outside the work place.

8. In this case, Claimant's alleged injury was the result of Claimant quickly looking behind him. The ALJ determines that this act is ubiquitous generally occurs outside the workplace and is not a special hazard of his employment with employer.

ORDER

It is therefore ordered that:

1. Claimant's claim for benefits for an alleged hernia (W.C. No. 4-762-776) is denied and dismissed.

2. Claimant's claim for benefits for his alleged neck injury (W.C. No. 4-762-775) is denied and dismissed.

DATED: March 1, 2010

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-779-905

ISSUES

1 Whether Claimant has proven by a preponderance of the evidence that the medical treatment he received from Dr. Bohachevsky is reasonable, necessary and related to his industrial injury?

2 What is Claimant's appropriate AWW?

3 Whether Claimant has proven by a preponderance of the evidence that he is entitled to

temporary total disability ("TTD") or temporary partial disability ("TPD") benefits?

4 Whether Respondents have proven by a preponderance of the evidence that Claimant failed to timely report his injury in writing to his employer pursuant to Section 8-43-102(1)?

FINDINGS OF FACT

1. Claimant was employed as a derrick hand for employer. The parties agree that an incident occurred on July 10, 2007 involving a physical confrontation between the Claimant and Mr. -T-, Claimant's supervisor. The nature of this confrontation is in dispute.

2. Claimant testified that on July 10, 2007, he was on the derrick with the first layer of piping and was using a stick with measuring tape attached to it to measure the pipe. Claimant testified that Mr. -T- started yelling at him and told him to hurry up. Claimant testified that Mr. -T- then climbed the ladder and started pushing Claimant on the platform. Claimant testified that he and Mr. -T- were approximately 40 –50 feet off the ground at the time of the initial assault. Claimant testified that he told Mr. -T- that he did not want to work for him anymore and Mr. -T- climbed down the ladder. While Claimant testified he was pushed while on the platform, he did not allege his injuries occurred during this assault.

3. Claimant testified that after the assault on the platform, he climbed down the ladder and called -U-, another supervisor, and informed -U- what had happened on the platform. Claimant testified -U- instructed Claimant to remove himself from the situation, if possible. Claimant testified he went to the doghouse and began removing his clothes and preparing to leave when Mr. -T- came in and began pushing Claimant again, shoving him against a wall in the doghouse. Claimant testified he hit the side of the "knowledge box" - a container made of sheet metal that hung on a wall in the doghouse. Claimant testified Mr. Uniform was throwing punches that he tried to block with his arms. Claimant testified Mr. -T- grabbed Claimant's head and hit his head against the wall at least two times, when finally Mr. Victor told Mr. -T- to leave. Mr. -T- shoved Claimant one last time before leaving. Claimant finished dressing and began walking down the road where toward the closest town. Claimant testified he walked five to six miles before some other workers from another rig came along and picked Claimant up and took him to the next town. He then got a ride from another person in the town to Price, Utah, where the employees were staying at a local -G-.

4. After arriving in Price, Utah, Claimant testified he called -U- again and requested transportation back to Cortez, Colorado and for a "checkup". -U- informed Claimant that a safety agent would be in Price the next morning to pick him up and take him back to Cortez. The next day, Mr. -v-, the safety agent, arrived to take Claimant back to Cortez. Claimant asked Mr. -v- if they should report the assault to the local authorities, and Mr. -v- said, "no." Claimant testified that when he returned to Cortez, he asked -U- for a referral for medical care, but -U- told him that maybe the pain would pass. Claimant testified he continued to request medical care from -U-, and -U-, after calling Claimant a derogatory name, eventually instructed Claimant to go to a physician and to bring him the medical bill to be paid. Claimant filled out a Sheriff's

report for San Juan County Utah and faxed the report to the Utah Sheriff's office on July 12, 2007setting forth the details of the assault. According to the report, Claimant's neck and shoulder were hurt, but no medical attention was necessary.

5. Claimant testified that he worked for employer for 3-4 days after the incident, in work that included transporting a machine from Moab, Utah to Cortez, Colorado. Claimant testified that the last day he worked for employer was July 25 and 26, 2007. Claimant testified he asked -U- for work after July 26, 2007 and -U- indicated they could use a spare hand. Claimant testified that he has not worked anywhere for wages after July 26, 2007. Even though Claimant returned to work for the employer after the incident, Claimant did not receive medical treatment for his alleged work injury until after he was no longer performing work for the employer.

6. Mr. -T- testified in this matter that on July 10, 2007 Claimant was tallying tubing (measuring tubes) as the tubes are pulled out of the ground. Mr. -T- explained to Claimant how to properly tally tubes, but Claimant was not performing the work correctly. Mr. -T- went up to the platform and jumped onto the board on which Claimant was standing and bumped into Claimant as he was trying to get on the board. Mr. -T- testified he showed Claimant how to tally the tubing up on the platform and Claimant told Mr. -T- he quit. Mr. -T- testified he told Claimant that if he was quitting, he had to get off the location. Mr. -T- testified he entered the doghouse, and Claimant grabbed him around the waist. Mr. -T- testified he told Claimant to let go of him three times, and when Claimant would not let him go, he twisted Claimant around and pushed Claimant's head into a locker. Mr. -T- testified Claimant did not appear to be injured at the time of the incident and did not complain of injuries.

7. Mr. Victor testified for Claimant in this matter. Mr. Victor testified that on the day of the incident, Mr. -T- began screaming at Claimant while Claimant was on the platform and eventually, Mr. -T- climbed up to the derrick where Claimant was working and Claimant and Mr. -T- began fighting. Mr. Victor testified Claimant climbed down from the derrick and both Mr. -T- and Claimant continued fighting as they went to the doghouse. Mr. Victor testified that once inside the doghouse, Mr. -T- pushed Claimant into the wall where the knowledge box was kept and Claimant fell to the ground and put his hands over his head. Mr. Victor testified that the knowledge box was a metal box measuring approximately fourteen (14) inches long, twenty-one and a half (21 ½) inches wide, seven (7) inches in height in the back and six and a half (6 ½) inches in height in the front. Mr. Victor testified Claimant is a friend of his who has helped him financially in the past. Mr. Victor testified he no longer works for employer after being terminated sometime in the past year.

8. -U- testified that he is a tool pusher for employer. -U- testified that he knew Claimant as a good worker. -U- testified that on the date of the incident, Claimant called him and told him Mr. Uniform had assaulted him. -U- advised Claimant to leave the work site and sent a safety man to the motel where Claimant was staying in Utah to take him back to Cortez. -U- testified that Claimant told him Mr. Uniform shoved him and banged his head into a locker. -U- testified that Claimant "was nothing but trouble" and could not get along with anyone. -U- testified that Claimant got into a fight with other people at the job site and -G- where they were staying.

9. -U- testified that at the time of the incident, he received a phone call from Mr. -T- telling him that Claimant had quit and he could hear Claimant and Mr. -T- yelling at each other. -U- testified that the phone call from Mr. -T- was then cut off, and he later received a cell phone call from Claimant telling him that Mr. -T- had gone into the doghouse, pushed Claimant and shoved his head into a locker.

10. -U- also testified that Claimant later called him and told him he wanted to go to a physician. -U- testified he told Claimant to go to the doctor and to bring him the bill. -U- testified that Claimant went to the doctor, but did not bring him the bill. -U- also testified he did not report this incident to the insurance company because Claimant did not bring him the medical bill. -U- testified that if Claimant had brought him a medical bill, he would have forwarded it to the bookkeeper to be paid. -U- also testified that because Claimant never brought him a medical bill, he figured Claimant wasn't injured. -U- testified that he instructed Claimant to file for unemployment benefits when work was slow.

11. -U- wrote out a statement on letterhead for the employer regarding this incident on January 19, 2008 that was sent to Claimant's attorney. According to the written statement, -U- received a phone call from Mr. -T- telling him Claimant was going to quit and that Claimant needed to finish the week. -U- indicated he could hear Claimant and Mr. -T- yelling at each other before the phone was cut off. Moments later, -U- got a call from Claimant who told him what had happened and he told Claimant to leave the premises. -U- indicated in his letter that after the incident, Claimant worked for a period of time on a different rig before he quit his job and they did not hear from Claimant again for quite sometime. Mr. -T- indicated in his letter that sometime after the incident, Claimant contacted -U- and told him his shoulder hurts and he told Claimant to bring him the doctor's bill and "we will discuss if it's covered or not" but Claimant never brought him the bill.

12. Following Claimant's incident at work on July 10, 2007, Claimant was not seen for medical treatment until August 15, 2007 when he reported to Southwest Memorial Hospital. Claimant reported to physicians at Southwest Memorial Hospital that he was pushed against a "metal thing" approximately two months ago and still hurts. Claimant complained of pain in his left shoulder, left neck and left back. Claimant was diagnosed with a contusion and prescribed pain medication. The attending physician noted Claimant complained of tenderness in the thoracic area with left scapular trapezius tenderness, with no thoracic spine or cervical spine pain.

13. Claimant was next evaluated by Dr. Bagge, an orthopedist, on October 26, 2007. Claimant reported to Dr. Bagge that he had left arm and neck pain from an altercation at work 4-5 months ago when he got pushed into a big metal corner that impacted his head, neck and shoulder area. Claimant complained to Dr. Bagge of weakness in the left arm and was provided with a diagnosis of left arm and neck pain.

14. Claimant underwent a magnetic resonance image ("MRI") of the left shoulder on November 12, 2007 at the request of Dr. Bagge that showed no rotator cuff tears, no evidence of bursitis

and mild edema in the superior glenoid. Claimant underwent an MRI of the cervical spin on December 31, 2007, again at the request of Dr. Bagge, that revealed mild formainal narrowing on the left at C3-4 and C4-5 due to unconvertebral osteophytes. Claimant returned to Dr. Bagge on June 17, 2008 with continued complaints of headaches and shoulder pain in the posterior and anterior aspect of the shoulder, as well as down the medial side of his arm. Dr. Bagge noted that the MRI's did not reveal any condition that would be amenable to surgery and therefore, recommended physical therapy for his left upper extremity. Dr. Bagge also noted that he would consider a second opinion through workers' compensation as he did not see anything that would explain Claimant's pain.

15. Claimant returned to Dr. Bagge on November 26, 2008 with complaints of numbness on his left arm and leg that began about two (2) weeks prior. Claimant reported to Dr. Bagge that this would happen without an inciting event or trauma, and would occur occasionally, but not on a consistent basis. Dr. Bagge noted that Claimant had since returned to baseline. Dr. Bagge recommended that Claimant be evaluated by Spine Colorado in Durango to evaluate his numbness pattern and possible get a nerve conduction study. Claimant returned to Dr. Bagge on March 27, 2009 with continued complaints of neck pain, headaches, left upper extremity numbness and left lower extremity numbness. Dr. Bagge noted he did not see any neurologic impairment, and recommended Claimant see a physiatrist to see if nerve conduction studies would be worthwhile.

16. Claimant was seen by Dr. Bohachevsky on referral from Dr. Bagge on April 21, 2009. Claimant reported with complaints of pain in the left scapula with radiation into the left trapezius and upper neck that caused posterior headaches related to the assault at work on July 10, 2007. Claimant reported stabbing, burning and aching pain that is mostly in the left scapular/ rhomboid region that will radiate upward into the trapezius and into the left posterior neck causing headaches. Claimant also reported pain that radiates around into his left chest as well. Claimant reported his left arm would go numb, usually at night, along with his left leg. Claimant also reported his shoulder and neck symptoms can be increased with raising his arm or with rotation of the head toward the left. Dr. Bohachevsky noted on physical exam Claimant complained of paraspinal muscle tenderness on the left at C3-4 and C4-5 with mild trapezius and rhomboid tenderness on the left only. Dr. Bohachevsky opined that Claimant's symptoms were mostly coming from myofascial sources and Claimant may have irritation of the muscles in the rhomboid, as well as levator scapula on the left. Dr. Bohachevsky recommended physical therapy and a prescription for Flexeril to be taken at night, with Claimant taking Advil as needed throughout the day.

17. Claimant returned to Dr. Bohachevsky on June 1, 2009 and reported that while the physical therapy would help temporarily, his symptoms would all come back. Dr. Bohachevsky diagnosed Claimant with cervical pain and scapular pain and recommended Claimant undergo cervical facet medial branch blocks for diagnostic purposes. The facet medial branch blocks were performed on June 22, 2009. Dr. Bohachevsky provided Claimant with work restrictions of no lifting greater than 30 pounds as of June 22, 2009. According to the medical notes, the work restrictions were to be in effect for one month.

18. Claimant returned to Dr. Bohachevsky on June 26, 2009 and reported an immediate reduction of pain that was still better after the injections. Claimant reported no significant pain and felt the injections were very helpful. Dr. Bohachevsky noted that she suspected the cervical facet medial branch blocks will wear off eventually and the Claimant's symptoms would return, and if they did, she would recommend repeat injections for confirmatory purposes.

19. Claimant underwent an independent medical examination ("IME") with Dr. Watson on June 30, 2009. Claimant reported to Dr. Watson that he was on top of the derrick when his supervisor became angry with him, climbed up the derrick and started to push him. Claimant then went to the deck floor and went to change his clothes and was putting his pants on when the operator came up and started shoving him and struck his head against the wall three times. Dr. Watson noted Claimant was evaluated at Southwest Memorial Hospital Emergency Room for upper thoracic complaints. Dr. Watson noted that Claimant reports that he had an injury to his neck and left shoulder in addition to paresthesias and decreased sensation in his head, and left side of his face. Dr. Watson noted that Claimant reported this had been present since the time of the injuries. Dr. Watson noted that he was unable to determine whether the incident actually occurred as described by Claimant, but noted that Claimant's current symptoms are grossly inconsistent with his complaints at the time of the emergency department visit on August 15, 2007. Dr. Watson opined that it was not possible to attribute these ongoing complaints to an injury that occurred two years ago. Dr. Watson opined that with the exception of the left shoulder complaints, the symptoms Claimant currently has occurred very late to the alleged incident and there was no temporal relationship to the onset of the incident in 2007. Dr. Watson noted that Claimant's first report of injury was also confusing as Claimant reported a head injury, but no left shoulder injury and noted that it was not clear that there was any consistency in his injury.

20. Claimant returned to Dr. Scott with Durango Orthopedics Spine Colorado (the same office as Dr. Bohachevsky) on July 21, 2009. Dr. Scott noted that Claimant's left sided neck complaints started to come back in the last week or so in two places, one in the left upper neck, and the other around the left trapezius and posterior shoulder. Claimant also complained of mild tenderness to palpation over the craniocervical junction on the left with tenderness on the left at C2-3 and C4-5. Dr. Scott noted he would recommend another MRI of the left shoulder and repeat facet medical branch blocks on the left at C2-3 and C4-5 and possible radiofrequency ablation. Claimant underwent the MRI of the shoulder on July 30, 2009 that revealed (1) no rotator cuff tear; (2) mild intermediate signal involving the supraspinatus tendon distally near its attachment on the greater tuberosity; (3) mild subchondral cystic change in the superior glenoid; and (4) no labral pathology or definite SLAP tear identified.

21. Dr. Bohachevsky testified in this matter. Dr. Bohachevsky testified that on June 22, 2009 he provided Claimant with work restrictions of no lifting greater than 30 pounds. Dr. Bohachevsky testified that the work restrictions were in effect for one month pursuant to his handwriting on the form. Dr. Bohachevsky testified that it would be reasonable for those work restrictions would have been in effect since Claimant's original injury of July 2007 until the

present time.

22. Respondents presented the testimony of -Y-, a self-employed mechanic who performs some services on equipment for employer. -Y- testified that he had a conversation with Claimant in a convenience store in August 2008 when Claimant told -Y- he was no longer working for employer. -Y- testified that Claimant was in clothes that appeared dirty, as though Claimant had been working, and Claimant said he was doing “odd jobs.” -Y- testified that it looked like Claimant was working with two other people he was with, and believed Claimant later got into a truck that was used for construction, with rubbish and old wood and cinderblocks in the bed of the truck. -Y- admitted he did not see Claimant get out of the truck and didn’t know the color of the truck.

23. The ALJ credits the testimony of the Claimant that he has not worked since July 26, 2007 over the testimony of -Y-. While -Y- is a relatively neutral witness, with no reason to fabricate his testimony, his perceptions of the Claimant at the convenience store and conversations with the Claimant do not rise to the level of establishing that Claimant has worked in construction after his admitted industrial injury.

24. The ALJ finds the testimony of Mr. -T- and -U- not credible in this matter. -U- explanation regarding the referral of Claimant for medical treatment is not in line with the anticipated reaction of an employer facing a workers’ compensation claim. Specifically, regardless of whether -U- would refer the Claimant to a specific physician, or provide Claimant a list of physicians for medical care, -U- would be required to submit the medical bill to the insurance company for payment, and not to the bookkeeper. The act of the employer offering to pay for the medical treatment of an injured employee demonstrates the possibility that the employer is attempting to circumvent the requirement to report a work related injury to the insurance company.

25. Moreover, to believe -U- testimony, Claimant expressed an interest in receiving medical care to -U-, following which -U- instructed Claimant to go to a physician and bring him the medical bill. Claimant then went to the hospital for medical treatment, presumably received the medical bill, but inexplicably did not bring -U- the medical bill for payment. For these reasons, -U- testimony that he never received a medical bill in this case is also called into question.

26. The ALJ credits the testimony of Claimant’s daughter who testified that she was with her father when he took the medical bill from Southwest Memorial Hospital to -U- home in 2007.

27. Claimant has had medical treatment for prior injuries including a motor vehicle accident (“MVA”) in 1999. The MVA also involved a work injury and -U- was in the car during the accident. Claimant sought medical treatment after the MVA for neck and back pain, including right shoulder pain, left elbow pain, head pain, low back pain, right lower leg pain and abrasions. Claimant did not complain of numbness or tingling in the arms or legs. Claimant received was eventually released to return to work full duty on March 10, 1999. Claimant was also apparently involved in a logging accident in 1998 and received treatment for a right hand

injury in 2002.

28. On February 8, 2006 Claimant sustained an injury to his right arm while at work. Claimant had surgery to address the right arm fracture and also received an x-ray of the cervical spine due to complaints of right neck pain. Claimant received physical therapy from Southwest Memorial Hospital from April 18, 2006 through April 24, 2006 for left-sided neck pain.

29. The ALJ finds that any prior injury to Claimant's cervical spine had resolved before the incident of July 10, 2007 and that the assault by Mr. -T- aggravated or accelerated any pre-existing condition with regard to Claimant's cervical spine. The ALJ further finds that the incident resulted in an injury to Claimant's left shoulder and finds that the medical treatment provided by Dr. Bagge and Dr. Bohachevsky is reasonable and necessary treatment to cure and relieve the effects of the industrial injury.

30. The ALJ finds that Respondent did not timely refer Claimant for medical treatment after receiving notice from Claimant that he was requesting medical treatment. The ALJ finds that the treatment from Southwest Memorial Hospital on August 15, 2007 represents emergency medical care that was reasonable and necessary to cure and relieve the Claimant from the effects of the industrial injury. While the treatment was more than one month after the industrial injury, -U- admitted that he did not instruct Claimant where to go for medical treatment, and under the circumstances of this case, the ALJ finds that Claimant's actions in going to the emergency room in light of Respondents failure to designate a medical provider is reasonable.

31. Because Respondents failed to designate a medical provider to treat Claimant's injury, Claimant chose to be treated by Dr. Bagge. The ALJ finds that Dr. Bagge is the authorized treating physician selected by Claimant and Dr. Bohachevsky becomes authorized as within the chain of referrals from Dr. Bagge.

32. The ALJ credits the testimony and opinions of Dr. Bohachevsky over the opinions of Dr. Watson with regard to the causal relatedness of Claimant's current complaints. The ALJ finds that Claimant's neck and shoulder symptoms are causally related to his admitted work injury on July 10, 2007. The ALJ credits the opinion of Dr. Bohachevsky that Claimant had work restrictions of no lifting greater than 30 pounds as of June 22, 2009.

33. The ALJ rejects the opinion of Dr. Bohachevsky that Claimant's work restrictions would have been appropriate back to the date of Claimant's industrial injury. The ALJ notes Claimant was examined numerous times by Dr. Bagge during this period of time, but Dr. Bagge never provided Claimant with work restrictions. Moreover, Dr. Bohachevsky did not provide work restrictions for Claimant until after having evaluated Claimant on several occasions. Claimant's argument that the work restrictions set forth by the treating physician should be applied retroactively is hereby rejected.

34. The ALJ determines based upon the wage records that were entered into evidence that Claimant earned $18,543.01 in the 26 weeks between December 28, 2006 and June 28, 2007, the last pay period prior to Claimant's industrial injury on July 10, 2007. This equates to an

AWW of $713.19.

35. The ALJ determines that Claimant has established by a preponderance of the evidence that the industrial injury Claimant suffered on July 10, 2007 resulted in work restrictions of no lifting greater than 30 pounds as of June 22, 2009, and that these work restrictions have precluded Claimant from obtaining employment. Therefore, the ALJ determines that Claimant is entitled to TTD benefits beginning June 22, 2009 and continuing until terminated by law.

36. Respondents argue that Claimant is subject to a penalty of one day's compensation for failing to provide written notice of his injury pursuant to Section 8-43-102(1)(a). The ALJ is not persuaded.

37. According to the submissions at hearing, Claimant filed a workers' claim for compensation on December 2, 2008. However, it is undisputed from the testimony that employer was aware of the incident leading to Claimant's industrial injury on the date it occurred. Moreover, as testified to by -U-, employer was aware Claimant was requesting medical treatment within a few weeks of the alleged incident. The ALJ further credits the testimony of Claimant and his daughter, and finds that Claimant brought employer the medical bill from the emergency room within two months after the industrial injury. Employer, however, did not file a claim with their insurance carrier.

38. As Claimant argues in his position statement, Section 8-43-102(1)(b), C.R.S. requires Respondents to post notice of the requirement to report the injury in writing to the employer. If the notice is not posted as required under Section 8-43-102(1)(b), C.R.S., Claimant is not subject to penalties. Respondents have not established that the required notice pursuant to Section 8-43-102(1)(b) was posted in this case.

39. Claimant received unemployment benefits from the state of Colorado. There is an issue with regard to whether Claimant must repay the unemployment benefits to the state of Colorado. Insofar as Claimant did not receive unemployment benefits for the period of time in which TTD is ordered in this case, Respondents are not entitled to an offset. If, however, it is subsequently determined that Claimant is entitled to unemployment benefits during a period of time in which Claimant also is receiving TTD benefits, Respondents will be entitled to an offset.

CONCLUSIONS OF LAW

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

injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

3. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

4. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Pursuant to Section 8-42-404(5), C.R.S., Respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once Respondents have exercised their right to select the treating physician, Claimant may not change physicians without first obtaining permission from the insurer or an ALJ. *See Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996).

5. As found, Respondents did not timely refer Claimant for medical treatment and allowed Claimant to be seen at Southwest Memorial Hospital Emergency Room for reasonable emergency medical treatment. As found, employer was aware of the medical treatment at Southwest Memorial Hospital Emergency Room and did not refer the Claimant to an authorized medical provider. As found, Claimant elected to be treated by Dr. Bagge who referred Claimant to Dr. Bohachevsky. As found, the treatment rendered by Dr. Bagge and Dr. Bohachevsky is reasonable and necessary to cure and relieve the Claimant from the effects of the industrial injury.

6. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), *supra*, requires claimant to

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

7. As found, Claimant has established by a preponderance of the evidence that he was under medical restrictions that impaired his ability effectively and properly to perform his regular employment as of June 22, 2009, and that the medical restrictions impaired Claimant's earning capacity. Therefore, Claimant is entitled to TTD benefits beginning June 22, 2009 and continuing until terminated by law.

8. The ALJ must determine an employee's AWW by calculating the money rate at which services are paid the employee under the contract of hire in force at the time of the injury, which must include any advantage or fringe benefit provided to the Claimant in lieu of wages. Section 8-42-102(2), C.R.S.; *Celebrity Custom Builders v. Industrial Claim Appeals Office*, 916 P.2d 539 (Colo. App. 1995).

9. As found, Claimant earned $18,543.01 in the twenty-six (26) full pay periods prior to the industrial injury. Claimant's AWW is hereby determined to be $713.19.

10. Respondents request for penalties against Claimant for failing to timely provide Respondents with written notice of the injury is denied and dismissed. Respondents have failed to show that proper notice of the requirement to report injuries in writing pursuant to Section 8-43-102, C.R.S. was posted at the employer's premises.

ORDER

It is therefore ordered that:

1. Respondents shall pay for all reasonable, necessary and related medical treatment for Claimant's shoulder and neck injury from Dr. Bagge and Dr. Bohachevsky. Respondents shall pay for the emergency room bill from Southwest Memorial Hospital for the August 15, 2007 date of service.

2. Respondents shall pay temporary total disability benefits to Claimant beginning June 22, 2009 and continuing until terminated by statute, rule or Order based on an AWW of $713.19.

3. Respondents claim for penalties against Claimant for failing to report the injury in writing to

employer is denied and dismissed.

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

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

DATED: March 1, 2010

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-779-747

ISSUES

1 Whether Claimant has proven by a preponderance of the evidence that she is entitled to Temporary Partial Disability benefits for the period of January 1, 2008 until terminated by law?

FINDINGS OF FACT

1. This matter previously proceeded to hearing on April 14, 2009 before the undersigned ALJ after which Findings of Fact, Conclusions of Law and Order were issued by the ALJ finding the insurer liable for Claimant's injuries and dismissing a claim against a subsequent insurer after finding that Claimant did not have a substantial permanent aggravation of her underlying condition after the subsequent insurer began providing coverage for employer. That Order is currently on appeal before the Colorado Court of Appeals.

2. Claimant brings the present action arguing that she is entitled to temporary partial disability ("TPD") benefts beginning January 1, 2008. The parties had previously stipulated to an average weekly wage ("AWW") of $1,155.69 for purposes of this claim.

3. Claimant is employed as a registered dental hygienist with employer. Claimant began working for employer in 1992. Claimant's primary job duties include directing patient care, performing diagnostic x-rays, peridental therapy, sterilization duties and office paper work. In the course of performing her duties, Claimant sustained an admitted occupational disease to her upper extremities with a date of injury of June 15, 2005. Claimant began seeking treatment for her upper extremity condition on June 15, 2005 and has been under the care of her treating physicians, including Dr. Weber, since that time.

4. Claimant testified that she began reducing her hours that she worked for employer

beginning January 1, 2008 as a result of the injuries she sustained in the admitted June 15, 2005 injury. The ALJ finds that the Claimant was working under a contract of employment that paid Claimant an annual salary and required Claimant to bill 1,496 hours per year. Claimant's 1,496 hour billable requirement equated to 32 hours per week for 52 weeks, less four weeks (32 hours per week) vacation time and forty (40) hours personal time. Claimant's tax records document Claimant was able to consistently earn wages consistent with her AWW from 2003 through 2007. During this five year period, Claimant earned a low of $59,007.18 in 2006 and a high of $60,729.89 in 2007. The ALJ notes that Claimant's stipulated AWW of $1,155.69 would project to an annual salary of $60,095.88, that is within $10 of her earnings in 2004. The ALJ finds Claimant's testimony credible and persuasive and supported by the tax records entered into evidence.

5. As found previously in this case, Claimant testified that beginning in 2007, she began to decrease her hours after he upper extremity symptoms began to worsen. According to Claimant's employment records, Claimant was short hours in February, March, June, August, September and December 2007. Claimant finished 2007 approximately 14 hours short of her contracted obligations. As a result of finishing short of her contractual obligations, Claimant was required to "payback" her employer in early 2008 for her salary that was paid to her that she did not contractually fulfill during the 2007 year. The previous hearing in this matter dealt with whether the aggravation of Claimant's admitted injury was the responsibility of the new insurance carrier or the insurance carrier on the risk at the time of the June 15, 2005 injury. The ALJ at the prior hearing ordered the present insurance carrier to pay for Claimant's ongoing reasonable, necessary and related medical care, but did not address the issue of temporary disability benefits.

6. Based on having to payback her employer at the end of the year, Claimant renegotiated her contract effective January 1, 2008 to include less hours, and consequently, less salary. Claimant testified that she renegotiated her salary to avoid having to payback her employer again at the end of the year for hours she was unable to contractually fulfill. The ALJ finds that Claimant renegotiated her salary based upon her inability to meet her previous contractual obligations due to difficulties Claimant experienced as a result of her admitted injury.

7. Claimant continued to receive treatment in 2007 and 2008 with Dr. Weber. Claimant reported to Dr. Weber on May 14, 2008 that she had experienced a recent flare up of her scapulothoracic sprain and developed a knot on her right deltoid area. Dr. Weber noted Claimant had been working without restrictions and contemplated whether the benefits of Claimant's medications and acupuncture had leveled out with the effects of Claimant's medications becoming more tolerable. Dr. Weber recommended Claimant complete the neuromuscular massage and continued Claimant on her medications. Dr. Weber also issued a narrative letter on June 12, 2008 that documented Claimant's flare of her muscle spasm and tension headache on May 8, 2008. Dr. Weber noted Claimant was on no increased medication above her usual use and remained fully functional with restrictions in her job. Claimant returned to Dr. Weber on July 16, 2008 and reported that her continued work without restrictions seemed to aggravate her neck giving her migraines. Dr. Weber noted Claimant's

cervical range of motion was slightly diminished and reported that her most recent flare seemed to have resolved.

8. Claimant returned to Dr. Weber on August 27, 2008 and reported to Dr. Weber that her most recent two-year contract had reduced her hours to no more than 30 hours per week. Dr. Weber opined that Claimant's complaints were work-related, "especially with her continued work which is flaring the symptoms, certainly temporally." Dr. Weber referred Claimant to Dr. Isser Sax and Dr. Willner for consultation.

9. Claimant was evaluated by Dr. Isser-Sax on October 2, 2008 with reports of stabbing pain with numbness in the parascapular region and upper shoulders with some radiation into the right upper arm. Dr. Isser-Sax opined that claimant's pain was multi-factorial in nature with a component of cervical facet joint pain. Dr. Isser-Sax recommended diagnostic cervical facet joint nerve blocks. Claimant then returned to Dr. Weber on November 13, 2008. Dr. Weber agreed with the treatment recommendations set forth by Dr. Isser-Sax and noted that Claimant "may need to get the legal issues settled first as apparently her case is on hold." Claimant returned to Dr. Weber on November 19, 2008 and was provided with work restrictions for the first time, that limited her work to seven (7) hours per day. The ALJ notes that while Dr. Weber did not provide Claimant with work restrictions until November 19, 2008, Dr. Weber noted in his medical records that Claimant had reduced her hours with her employer to no more than 30 hours per week. The ALJ finds that Dr. Weber implicitly approved of the work restrictions as he noted that her continued work was flaring her symptoms temporarily.

10. The ALJ recognizes that this is a complex case that is further complicated by a change in insurance carriers during the course of Claimant's treatment. However, as found previously, Claimant did not suffer a substantial permanent aggravation of her condition while the new insurer was on the risk for Claimant's coverage. This case is further complicated by the fact that the treating physician made a finding that the Claimant was at maximum medical improvement ("MMI") early in Claimant's treatment (August 11, 2006). However, no final admission of liability was filed by Respondents in this case, and Claimant's case was not closed. The ALJ finds that after MMI, Claimant continued to work for employer, and continued to experience symptoms related to her admitted work injury. The ALJ finds based upon the employment records entered into evidence and Claimant's testimony, that as a result of these symptoms, as of February, 2007 Claimant began to suffer disability in the form of the inability to meet her contractual obligations to her employer. Claimant continued to struggle to meet her contractual obligations of her employment, ending up short hours in the months of February, March, June, August, September and December 2007. The ALJ credits the report of Dr. Weber dated January 12, 2009 that noted Claimant's condition has changed since she was placed at MMI on August 11, 2006, and noted that Claimant's period of increasing symptoms referred to in her office note dated June 28, 2007 continued, leading Claimant to a self-imposed reduction in hours at work in January 2008. The ALJ credits the report of Dr. Weber and finds Claimant's condition permanently aggravated by June 1, 2007 and MMI was impliedly revoked as of that time.

11. The ALJ finds that as a result of her inability to meet her contracted hours with her employer, Claimant renegotiated her employment contract to include lesser hours. The ALJ finds that this renegotiation was a result of Claimant's work injury and the effects of her work injury that left Claimant unable to complete her previously contracted quota. The ALJ finds that the employer voluntarily agreed to the renegotiated contract for the benefit of the employee and the employer, as under the previous contract, the employer had to pay Claimant more money, and have Claimant repay the employer after she was unable to meet her contractual obligations.

12. The ALJ further relies on the payroll records provided by Claimant at hearing for establishing the entitlement to temporary partial disability benefits. Claimant earned $53,644.63 from employer in 2008 under her new contract, or $1,031.63 per week. Based on Claimant's AWW of $1,155.69, Claimant is entitled to temporary partial disability benefits in the amount of two-thirds of the difference between her AWW of $1,155.69 and the $1,031.63 she earned in 2008, or $82.71 per week.

13. Claimant presented evidence that she earned $38,437.33 through the first ten months of 2009. Based on the 43 2/7 weeks Claimant worked, this equates to an AWW of $887.99, or a difference of $267.70 per week. Claimant is therefore entitled to TPD benefits in the amount of $178.47 for the 43 2/7 weeks in 2009.

14. Claimant is entitled to temporary partial disability benefits of $4,300.92 for 2008 and $7,725.20 for the first 43 2/7 weeks of 2009.

CONCLUSIONS OF LAW

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

9. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether

the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

10. 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). To prove entitlement to temporary partial disability ("TPD") benefits, claimant must prove that the industrial injury contributed to some degree to a temporary wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Thus, if the injury in part contributes to the wage loss, TPD benefits must continue until one of the elements of §8-42-106(2), *supra*, is satisfied. *Champion Auto Body v. Industrial Claim Appeals Office*, *supra.*

11. As found, Claimant has proven by a preponderance of the evidence that she her injury has led to her subsequent wage loss. Additionally, the ALJ finds that no criteria for terminating TPD has thus far been reached. Therefore, Claimant is entitled to ongoing TPD until terminated by statute.

12. Claimant earned $53,644.63 from employer in 2008 under her new contract, or $1,031.63 per week. Based on Claimant's AWW of $1,155.69, Claimant is entitled to temporary partial disability benefits in the amount of two-thirds of the difference between her AWW of $1,155.69 and the $1,031.63 she earned in 2008, or $82.71 per week. Claimant presented evidence that she earned $38,437.33 through the first ten months of 2009. Based on the 43 2/7 weeks Claimant worked, this equates to an AWW of $887.99, or a difference of $267.70 per week. Claimant is therefore entitled to TPD benefits in the amount of $178.47 for the 43 2/7 weeks in 2009.

13. Claimant is entitled TPD benefits of $4,300.92 for 2008 and $7,725.20 for the first 43 2/7 weeks of 2009

ORDER

It is therefore ordered that:

1. Respondents shall pay Claimant temporary partial disability benefits beginning January 1, 2008 and continuing until terminated by law.

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

All matters not determined herein are reserved for future determination.

DATED: February 2, 2010

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-788-688

ISSUES

1 Whether the Claimant proved by a preponderance of the evidence that he was an employee of employer?

2 Whether employer proved by a preponderance of the evidence that Claimant was engaged in an independent trade, occupation, profession or business and was free from control and direction in the performance of the service pursuant to Section 8-40-202(2)?

3 If Claimant did prove he was an employee of employer, whether Claimant proved by a preponderance of the evidence that he suffered a compensable injury arising out of and in the course of his employment with employer?

4 Whether Claimant proved by a preponderance of the evidence that he is entitled to temporary disability benefits for the period of July 22, 2008 through March 15, 2009?

FINDINGS OF FACT

1. Employer is a sole proprietorship that in operation on July 22, 2008. Employer entered into a bid contract with Mr. H for the framing and labor of a home near Pagosa Springs. The contract included labor, including assembly and installation of all walls, interior and exterior, sheathing, floor systems, interior stairs, roof systems, exterior stairs, decks and railings, fireplace chase, log entry deck, post and beam systems, exterior doors and windows. The contract also included all work performed through the rough framing completion including ice and water shield, eaves and valleys and applying felt paper over remainder of roof area, and all work performed through county inspections, including framing/hardware wall seething and roof decking – nailing inspections. The contract was entered into in late June or early July 2007. Employer testified that he got half way through the contract, and then the contract "went south." Employer subsequently sought out individuals who could complete the necessary work on the contract in an attempt to comply with the services employer contracted to perform in the contract.

2. Employer hired various individuals to complete work on the Howard contract (hereinafter "project") including Mr. V, Mr. P, Mr. B and Mr. P. Employer testified he had Mr. V and Mr. P submit bills for their work performed on the project and Employer would pay Mr. V and Mr. P directly. Employer testified Mr. V and Mr. P performed carpentry work on the project. Employer testified he did not hire employees, but only sub-contractors, and required sub-contractors to provide proof on insurance. Employer did not identify any sub-contractor who had authority to hire their own employees to work on the project. Employer testified he did not

work on the project, but arranged for various contractors to work on the project in connection with his contract with homeowners.

3. Employer testified he did not carry workers' compensation insurance.

4. Employer testified that Mr. and Mrs. H complained of the slow progress on the completion of the project. After getting complaints from the Hs about the progress on the house, employer testified he told Mr. P to increase his performance. Employer testified he did not discuss with Mr. P hiring another carpenter and did not hire Claimant as an employee. Employer testified he did hire Mr. P as a contractor and paid Mr. P directly, through Mr. P's company name, D Construction, for the hours that he worked. Employer argued at hearing that it was Mr. P who hired Claimant and Claimant was an employee of Mr. P.

5. Claimant testified he was a friend of Mr. P and was contacted by Mr. P by telephone regarding a job as a carpenter. Mr. P told Claimant he would be paid $15 per hour for the carpentry work and the job would last approximately three (3) weeks. Claimant testified he started work on July 22, 2008 and was standing on a ladder on the second floor putting ledger on the roof while holding a nail gun, putting up sheathing. Claimant testified the ladder was on plywood on the deck, but the plywood was not nailed to the deck. Claimant testified that the floor to the deck was not finished and the joyces on the deck were approximately two feet apart. Claimant testified he was three or four rungs up on the ladder and then woke up on the ground bleeding.

6. Mr. P testified that he has known Claimant for approximately six years. Mr. P is the owner of D Construction. Mr. P testified that D Construction does not hire employees and does not carry workers' compensation insurance. Mr. P testified he worked on the project for Employer for approximately one year and was originally helping Mr. V. Mr. P testified he did not bid on the project and would submit tickets to Employer and Employer would issue checks to Mr. P made out to D Construction. Mr. P testified he was paid hourly for his work on the project. Mr. P testified that, for the most part, Employer was not on the job site for the project. Mr. P testified he would receive calls from Employer regarding work being performed on the project and instructions as to what work was to be completed. Mr. P testified he had known Claimant prior to working on the project. Mr. P testified that when Employer indicated to Mr. P that they needed some additional carpentry help on the project, Mr. P recommended Claimant. Mr. P testified that through a series of telephone calls and messages, it was agreed the Employer would hire Claimant to perform carpentry work at a rate of $15 per hour, and Claimant was expected to work eight (8) hour days, forty (40) hours per week. Mr. P testified that through these messages and conversations with Employer, he believed he had authority to hire Claimant for Employer. Mr. P testified that he was not responsible for paying Claimant for the hourly worked performed by Claimant on the project, but that that money would come from Employer. Mr. P testified that after the accident he signed a document for Employer indicating he was an independent contractor.

7. Mr. P testified that on Claimant's first day on the job, Claimant followed Mr. P to the job

site. Claimant was working on a corner of the house with floor joints, standing on a ladder that was four feet off the ground. Mr. P testified he heard a clunk, turned around and saw a motion through the corner of his eye. Mr. P testified he went out and saw Claimant laying on the ground and yelled to the homeowner to call an ambulance.

8. Claimant was taken from the job site to Mercy Medical Center Emergency Room on the date of the injury by ambulance. The medical bills submitted by Claimant show at least $9,784.96 in medical expenses, with Claimant having already paid $4,989.90 out of pocket for the medical bills. The medical bills submitted by Respondents at hearing show charges for Claimant's July 22, 2008 admission at Mercy Medical Center in the amount of at least $31,252.89, without considering the fee schedule. Claimant is listed as "self employed" on the medical bills from Mercy Medical Center.

9. Claimant was admitted into the hospital with multisystem trauma after falling approximately eighteen (18) feet from a ladder. Claimant was diagnosed with a right rib fracture, right pneumothorax, right scapular fracture and left sided pelvic fracture. The admitting physician noted Claimant's reason for fall was unexplained. Claimant remained in the hospital until his discharge on July 28, 2008.

10. Claimant testified that after the accident he was unable to work until March 15, 2009, when he went to work for B Construction in Oklahoma. Claimant testified that after the injury he came under the care of Dr. Deaver. Dr. Deaver noted on August 28, 2008, he was contacted by Claimant's friend "K" who indicated he witnessed Claimant have a seizure. Dr. Deaver noted that Dr. Wilner had recommended an EEG. Claimant continued to follow up with Dr. Deaver but has not yet been placed at maximum medical improvement ("MMI").

11. After Claimant's accident, Mr. P testified that work on the project stopped for one week. Employer then hired Mr. B to work on the project with Mr. P. Mr. P did not pay Mr. B directly. Mr. B testified he was hired by employer in late July or early August 2008. Mr. B testified he signed a paper indicating he was an independent contractor. Mr. B testified he was hired by Employer and was directly by Employer based on an hourly rate of $25 per hour. Mr. B testified his work was directed by the homeowners or employer.

12. Mr. V testified he worked on the project before Claimant's injury. Mr. V testified there were design problems with the project, but that the job site was typical. Mr. V testified Employer asked him to bill leniently for the home owners and Mr. V agreed to work hourly. Mr. V testified Employer was behaving roughly as the contractor on the project.

13. The ALJ credits the testimony of Mr. P and Claimant and finds that Employer arranged for Claimant to be hired as an employee of Employer. While Employer argues that Claimant was an employee of D Construction, the ALJ notes that payment for work performed on the project was made by Employer. There is no credible evidence in the record that any of the contractors or sub-contractors retained by Employer in the project were able to hire their own employees for work on the project. Moreover, the evidence in this case shows all payments to each

individual working on the project were made by employer to the individuals or entities working on the project, including payments to Mr. V, D Construction and Mr. B.

14. Because an employer-employee relationship hinges on the finding that the individual performed services for pay for another, the question regarding who was to pay Claimant for his services is germane to determining if Claimant was an employee of Employer, or some other entity. This examination is further frustrated by the fact that Claimant was injured on the first day of his work on the project and never received payment for the services he performed prior to his injury. Therefore, the ALJ must evaluate the evidence and determine who was *going to* pay Claimant for the services he was performing at the time of the injury.

15. In this analysis, the ALJ finds it persuasive that after Claimant's injury, upon needing a replacement, Employer hired Mr. B and paid Mr. B directly for the work that was to be performed by Claimant. Moreover, the credible evidence demonstrates that all payments made on the project flowed through Employer. Therefore, the ALJ finds the testimony of Employer incredible that there was not a discussion with Mr. P regarding the hiring of Claimant prior to the Claimant's injury. Employer testified, and the testimony was corroborated by all witnesses at the hearing, that there was significant concern with regard to having this project completed at a cost most reasonable to the home owners. The ALJ finds that it is highly unlikely that one of the sub-contractors would take on the additional cost of another employee at his own expense, or at the expense of the homeowners without discussing the issue with Employer who was cutting all the checks for the work performed on the project. Finally, the ALJ notes even if Claimant were to be considered an employee of D Construction, Employer is the contractor in this case, and because D Construction did not (and does not) carry workers' compensation insurance, Employer would be considered Claimant's statutory employer under Section 8-41-401, C.R.S.

16. Based on the evidence, the ALJ finds that Employer agreed to hire Claimant to perform carpentry work and agreed to pay Claimant $15 per hour for the work performed by Claimant. The ALJ determines that the credible evidence demonstrates that Claimant was to be paid for his services by Employer and that a contract for hire existed between Claimant and Employer.

17. Employer also argues that Claimant should not be considered an employee because he was an independent contractor. The ALJ is not persuaded. To prove independence, the statute sets for a nine factor test for the ALJ to consider, including, (1) whether the person for whom services are performed does not require the individual to work exclusively for the person for whom services are performed; (2) whether the person for whom services are performed does not establish a quality standard for the individual; (3) whether the person for whom services are performed does not pay a salary or at an hourly rate instead of a fixed or contract rate; (4) whether the person for whom services are performed does not terminate the work of the service provider during the contract period unless such service provider violates the terms of the contract or fails to produce a result that meets expectations of the contract; (5) whether the person for whom services are performed does not provide more than minimal training for the individual; (6) whether the person for whom services are performed does not provide tools

or benefits to the individual, except that materials and equipment may be supplied; (7) whether the person for whom services are performed does not dictate the time of performance; (8) whether the person for whom services are performed does not pay the service provider personally instead of making checks payable to the trade or business name of such service provider; and (9) whether the person for whom services are performed does not combine the business operation of the person for whom service is provided in any way with the business operations of the service provider instead of maintaining all such operations separately and distinctly.

18. The credible evidence in this case demonstrates that Claimant was paid hourly instead of at a fixed contract rate; the Employer was able to terminate the services of Claimant at any time; tools, including the ladder Claimant fell off of, were provided to Claimant at the job site; Claimant was expected to work eight hours per day and 40 hours per week, and Claimant was to be paid personally as he did not have a trade name established for his business. The following factors appear to work against the finding of an employer-employee relationship: Claimant was not required to work exclusively for Employer; there was not an established quality standard for Claimant, Employer did not provide training for Claimant; Employer did not combine the business operation of the Claimant with his own business operation. The ALJ recognizes that there is conflicting evidence with regard to many of these factors, but determines that the credible evidence, viewed as a whole, establishes that the facts in this case as referenced above lean in favor of an employer-employee relationship being established.

19. Respondent presented the testimony of Dr. Arens. Dr. Arens is a retired anesthesiologist who is currently licensed to practice medicine in Texas. Dr. Arens testified he was a friend of Employer and was testifying as a favor to Employer. Dr. Arens did not testify as an expert. Dr. Arens testified that the medical records indicated Claimant's fall could be an epileptic episode. Dr. Arens also testified that most of Claimant's fractures were linear and his recovery time should have been approximately three (3) months. The ALJ finds Dr. Arens testimony credible, but not persuasive.

20. The medical records document that Claimant could not indicate why he fell off the ladder. The medical records also indicate Claimant suffered a seizure type experience a little over one month after the accident. However, the ALJ notes that Claimant's injuries were not caused necessarily by the fall off the third or fourth rung of the ladder, but by the fact that the ladder was set up on an incomplete deck another ten to fifteen feet off the ground. Even if Claimant fell from the ladder because of a seizure, or some other unknown cause, by virtue of Claimant being on a ladder fifteen feet off the ground, Claimant's employment placed him in a position representing a special hazard of his employment. Therefore, Claimant's injury would still be compensable, even if it were the result of a seizure or unexplained fall.

21. Finally, once Claimant has established that he suffered a compensable injury and is entitled to medical and temporary total disability benefits, ("TTD"), Claimant is entitled to receive medical benefits until he is placed at MMI by an authorized treating physician, and is entitled to receive TTD benefits until employer shows Claimant has met one of the four factors set forth at

Section 8-42-105(3). In this case, no treating physician has placed Claimant at MMI. Claimant credibly testified he returned to work on March 15, 2009 and therefore, one of the criteria for terminating TTD benefits has been met as of that date. See Section 8-42-105(3)(b), C.R.S. However, the "usual" recovery time for an individual with Claimant's injuries is immaterial to the courts determination regarding benefits.

CONCLUSIONS OF LAW

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

2. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

3. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

EMPLOYER-EMPLOYEE RELATIONSHIP

4. Section 8-40-202(2)(a) provides that any individual who performs services for pay for another shall be deemed to be an employee, irrespective of whether the common-law relationship of master and servant exists.

5. As found, Respondent-employer was in charge of finding individuals to perform the work

needed to be completed in connection with the contract between Respondent and the homeowners. In this regard, Respondent agreed to have Claimant perform carpentry work in connection with the contract. Respondent received money from the homeowners and then paid the individuals directly for the time billed for work performed on the contract. Respondent agreed to pay Claimant $15 per hour for his carpentry work. Based on these facts, the ALJ finds that Claimant has proven by a preponderance of the evidence that he was performing services for Respondent for pay. The mere fact that Claimant was not paid by Respondent for the work he performed prior to his injury does not negate the fact that he was providing services for Respondent for pay at the time of his injury.

6. Section 8-40-202(2)(a), C.R.S., provides that an individual performing services for another is deemed to be an employee:

> [U]nless such individual is free from control and direction in the performance of the service, both under the contract for performance of service and in fact and such individual is customarily engaged in an independent trade, occupation, profession, or business related to the service performed.

7. Section 8-40-202(2)(b)(II), *supra*, then sets forth nine factors to balance in determining if claimant is an employee or an independent contractor. *See Carpet Exchange of Denver, Inc. v. Industrial Claim Appeals Office*, 859 P.2d 278 (Colo. App. 1993). The nine factors include (1) whether the person for whom services are performed does not require the individual to work exclusively for the person for whom services are performed; (2) whether the person for whom services are performed does not establish a quality standard for the individual; (3) whether the person for whom services are performed does not pay a salary or at an hourly rate instead of a fixed or contract rate; (4) whether the person for whom services are performed does not terminate the work of the service provider during the contract period unless such service provider violates the terms of the contract or fails to produce a result that meets expectations of the contract; (5) whether the person for whom services are performed does not provide more than minimal training for the individual; (6) whether the person for whom services are performed does not provide tools or benefits to the individual, except that materials and equipment may be supplied; (7) whether the person for whom services are performed does not dictate the time of performance; (8) whether the person for whom services are performed does not pay the service provider personally instead of making checks payable to the trade or business name of such service provider; and (9) whether the person for whom services are performed does not combine the business operation of the person for whom service is provided in any way with the business operations of the service provider instead of maintaining all such operations separately and distinctly.

8. A document may satisfy the requirement to prove independence, but a document is not required. Section 8-40-202(2)(b)(III), *supra,* provides that the existence of any one of those factors is not conclusive evidence that the individual is an employee. Consequently, the statute does not require satisfaction of all nine criteria in Section 8-40-202(2)(b)(II) in order to prove by a preponderance of the evidence that the individual is not an employee. See *Nelson v.*

Industrial Claim Appeals Office, 981 P.2d 210 (Colo. App. 1999).

9. As found, Respondent has failed to prove by a preponderance of the evidence that the Claimant was free from direction and control in the performance of his job. The following factors weigh in favor of an employer-employee relationship over one of an independent contractor: Claimant was contracted to be paid an hourly rate; Claimant could have been terminated prior to the completion of the contract; Claimant did not provide his own tools, as the ladder he was using when he fell was on the job site; and there is no evidence Claimant was to be paid other than to himself personally. Based on these findings, the ALJ finds that Claimant was engaged as an employee of Respondent at the time of his injury, and not as an independent contractor.

INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT

10. Respondent appears to argue that Claimant's injury is not compensable as the injury was precipitated by a pre-existing condition brought by the claimant to the workplace. The ALJ is not persuaded. An otherwise compensable injury does not cease to arise out of employment because it is partially attributable to a pre-existing physical infirmity of the employee. *National Health Laboratories v. Industrial Claim Appeals Office*, 844 P.2d 1259 (Colo. App. 1992). Rather, an injury which results from the concurrence of a pre-existing condition and a special hazard of employment is compensable. *H&H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Thus, even if the direct cause of the accident is a preexisting idiopathic disease or condition, the resulting disability is compensable if the conditions or circumstances of employment have contributed to the accident or to the injuries sustained by the employment. *Ramsdell v. Horn*, 781 P.2d 150 (Colo. App. 1989). To be an employment hazard for this purpose, the employment condition must not be a ubiquitous one; it must be a special hazard not generally encountered.

11. As found, Claimant has proven that he suffered an injury arising out of and in the course of his employment when he fell from a ladder that was on the second story, falling approximately fourteen to eighteen feet. Therefore, even if Claimant were to have suffered a seizure or blackout prior to his fall, the ladder represents a special hazard of employment, making the injury compensable, even if the loss of consciousness was unrelated to Claimant's employment. *See Ramsdell v. Horn, supra.* (a fall from scaffolding after a seizure was compensable even though Claimant's seizure disorder was a pre-existing condition unrelated to Claimant's employment).

TEMPORARY TOTAL DISABILITY

12. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), C.R.S., requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in

order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

13. As found, Claimant has proven by a preponderance of the evidence that the injury resulted in Claimant being temporarily unable to resume his prior employment for a period lasting more than three work shifts. Therefore, crediting the testimony of Claimant found to be credible and persuasive, Claimant is entitled to TTD benefits from July 22, 2008 through March 15, 2009, a period of 33 5/7 weeks.

PENALTIES FOR FAILURE TO INSURE

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

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

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

ORDER

It is therefore ordered that:

1. Respondent-employer shall pay for all reasonable necessary and related medical treatment designed to cure and relieve the Claimant from the effects of his industrial injury, including but not limited to his treatment with Mercy Regional Medical Center and Dr. Deaver, pursuant to the Colorado Medical Fee Schedule. Respondent-employer shall reimburse Claimant his out of pocket expenses for payments made by Claimant to the medical providers.

2. Any medical provider who has rendered care for Claimant in regard to this case is prohibited from seeking to recover the costs of said care from Claimant pursuant to Section 8-42-101(4), C.R.S. 2008.

3. The ALJ finds that the treatment provided by Mercy Regional Medical Center and Dr. Deaver is authorized as the treatment from Mercy Regional Medical Center constituted emergency treatment and Respondent failed to designate a physician willing to treat the Claimant pursuant to Section 8-43-404(5)(a).

4. Respondent-employer shall pay Claimant temporary total disability benefits beginning July 22, 2008 and continuing through March 15, 2009. Respondent-employer is entitled to an offset for any monies previously paid to Claimant for the periods of time Claimant was disabled. Respondent-employer is also entitled to a statutory offset for Claimant's receipt of Social Security Disability benefits, if any, during Claimants period of TTD.

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

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

a. Deposit the sum of $30,031.53 with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to: Division of Workers' Compensation/Trustee. The check shall be mailed to the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: Sue Sobolik/Trustee; or

b. File a bond in the sum of $30,013.53 with the Division of Workers' Compensation within ten (10) days of the date of this order:

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

(2) Issued by a surety company authorized to do business in Colorado. The bond shall guarantee payment of the compensation and benefits awarded.

7. IT IS FURTHER ORDERED: That the Respondent-Employer shall notify the Division of Workers' Compensation of payments made pursuant to this order.

8. IT IS FURTHER ORDERED: That the filing of any appeal, including a petition to review, shall not relieve the employer of the obligation to pay the designated sum to the trustee or to file the bond. §8-43-408(2), C.R.S.

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

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

DATED: February 1, 2010

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-802-014

ISSUES

1 Whether Claimant has proven by a preponderance of the evidence that she suffered an injury arising out of and in the course of her employment?

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

FINDINGS OF FACT

1. Claimant is presently employed by Employer and has worked in the paint department since the date Employer purchased the business in August, 2008. She worked in the same or similar positions at the same location under its previous ownership since July, 1999.

3. Claimant's duties include customer service, ordering and stocking in the paint department, mixing paint and cashiering when needed. She works full-time. She generally has a day off on Tuesday, and when the store is closed on Sunday. Claimant's supervisors are the store manager, J E, the assistant store manager, T H, and the floor manager, M C.

4. On Tuesday, July 21, 2009, Claimant testified she spent her day off with her daughter. They drove to Durango for her daughter's orthodontic appointment and to do some shopping. Claimant recalls nothing unusual occurring, and no event happening that would or did cause back pain or a back injury. She had no symptoms of back pain that day, or the following morning.

5. On Wednesday, July 22, 2009, Claimant testified she started work at 8:00 a.m. and did her usual work. This included assisting a customer with a special order of two 5-gallon buckets of paint, which needed to be mixed in the electric mixer. Because of a previous on-the-job injury to her right shoulder, while working at the same store under its previous owner in 2006, Claimant was limited in her lifting abilities. She routinely would get lifting help from co-workers, and occasionally from customers. She was helped by co-workers to lift the paint buckets for this special order.

6. As Wednesday was delivery day, the Employer received pallets of merchandise on that day. Some pallets were loaded with shrink-wrapped merchandise. There were also tote boxes packed with merchandise to be shelved. Claimant's tasks included stocking paint department items from the receiving department onto the display areas in the paint department. This stocking procedure involved unloading totes, which had been pushed from the receiving department to the paint department on carts.

7. Stocking duties also included unloading and shelving paint department items from pallets. The pallets were delivered into the store's receiving area already packed and shrink wrapped, and were loaded with larger items than those in the totes. The loaded pallets were moved from the receiving department to the different store departments by pulling them with a wheeled hydraulic hand jack.

8. About 4:00 p.m. on July 22, 2009, Claimant was asked by Ms. H, of the receiving department, to help her move a loaded paint department pallet from receiving to the paint department. The pallet was loaded with items such as 5-gallon containers of asphalt sealer, 5-gallon containers of paint, and rollers. The pallet was loaded high, above the height of Ms. H, who is 4'11", and Claimant, who is 5'2" tall. Ms. H pulled the pallet jack handle and Claimant pushed the pallet. Claimant pushed with her left shoulder and arm in a slightly twisted manner so that her previously injured right shoulder and arm was not pushing much of the weight. Claimant recalls that she first had to clear the aisle of the pathway for the pallet in front of the double doors from the receiving department by "scooting" lawn and garden chemicals and other items which were in the way, so they were out of the way, and then went to the rear of the pallet to begin pushing. Because of a slight downward slope in the floor, moving the pallet required pushing up the slight slope. The pallet had to be moved the entire length of the store and the entire width of the store because the paint department is located in the western corner of the store diagonally across from the receiving department located in the back east corner of the store. Assistant store manager Mr. H testified the store measured approximately 100' by 200'.

9. Claimant testified this was the first and only time she has ever helped Ms. H move a pallet. She testified that after the pallet was left in the paint department, she was called to help do cashiering, and she recalls working to unload the pallet towards the end of the work day. Claimant does not recall any specific pain or physical distress symptoms in her low back that day after pushing the pallet.

10. Claimant spent the evening after work with her family making supper and doing nothing active, and went to bed. During the early morning, she awoke with pain in her back in the area of her shoulder blades, and then slept fitfully. When she tried to get up out of bed in the morning, she could not at first because of pain and cramping in her back, and into her left flank, and around into her ribs. Claimant testified she was eventually able to get up and prepare for work. She went to work, walking slowly, and as she was clocking in by the manager's office, secretary/bookkeeper Ms. S, saw something was wrong with Claimant and

asked her what had happened. Claimant told her she must have pulled something in her back. Ms. S responded by saying Claimant needed to report this to the assistant store manager, Mr. H. Claimant tried to speak to Mr. H, but was never able to speak with him before her workday ended on Thursday, July 23.

11. Claimant testified her back continued to bother her that day while at work, and she took 800 mg. of Ibuprofen about every three hours. The pallet in the paint department had been put away, and she spent the day doing other paint department tasks and helping customers.

12. On Thursday, July 23, during the evening, Claimant's back continued to hurt. Claimant used Icy Hot patches and took Ibuprofen. She spent the night on the couch because it hurt to lie down in bed.

13. Claimant went to work on Friday, July 24, still in pain. She waited by Mr. H's office to talk to him about her back, but she was called to return to the floor before he was available to her. During her breaks, she treated her back with ice packs, and took Ibuprofen. She spoke with Ms. S about needing to talk to Mr. H. Claimant did not meet with him in the morning, and he had left the store early Friday afternoon, before Claimant was able to meet with him. Mr. H testified he could not recall if he left early on July 24, 2009, but acknowledged that he occasionally left the store early on Fridays, and that it was possible that he would have left early that day.

14. On Friday night, Claimant's back continued to hurt, and she treated her back again with positioning and pills. On Saturday, July 25, Claimant worked her usual shift, and her back continued to hurt, and she continued to treat it as before. Claimant testified she did not report the injury to her supervisors that day, because Mr. H was not at work, and Mr. E was not at the store.

15. Claimant stayed at home Sunday, using Ibuprofen and Theragesic ointment to treat her back symptoms.

16. Claimant went to work on Monday, July 27, determined to meet with Mr. H and to get permission to see a doctor. She tried again to see Mr. H, and told him she needed to meet with him. They eventually met about 4:30 p.m., when she went into his office and said she must report her back injury. Mr. H filled out the Employer's First Report of Injury. Mr. H noted the injury as "back strain" due to "lifting buckets of paint," on July 22, 2009, although Claimant testified she also told him about her helping Ms. H push the loaded pallet. The form was not given to Claimant to review or sign. Mr. H referred Claimant to get medical care from Dr. Bricca at Pagosa Springs Family Medicine. Respondents stipulated that Pagosa Springs Family Medicine was the authorized treating provider.

17. Claimant saw Dr. Bricca at Pagosa Springs Family Medicine the next day, July 28, 2009. She had previously seen Dr. Bricca for other maladies. His report has nine lines of history, including ". . . She spent the day helping unload paint products, as well as pushing

heavy pallets of paint." The history in his narrative and on the W.C. 164 form is generally consistent with Claimant's testimony. Claimant denied any similar symptoms in the past, and told him she had not experienced pain the day of the strenuous activity, but was unable to get out of bed the next morning. Dr. Bricca's objective testing showed left lumbar tenderness, limited trunk movement and his assessment was, "Probable low back strain." Dr. Bica prescribed Oxycodone, and Soma and recommended heat and ice.

18. On August 3, 2009, Claimant returned to Dr. Bricca and reported the spasming had "virtually resolved" but continued to complain of burning and tingling in the right back, and she continued to have tenderness and limited range of motion with some radiating pain. Dr. Bricca prescribed physical therapy. He ordered a lumbar x-ray, which showed degenerative changes with no acute findings. Dr. Bricca re-evaluated the Claimant on August 17, when she reported feeling better, and August 28, 2009, and released her to work on August 31, 2009, with restrictions of 4 hour maximum stand, walk, sit and no lifting above 10 pounds and no push/ pull above 20 pounds."

19. On September 8, 2009, Dr. Estes, who replaced Dr. Bricca at Pagosa Springs Family Medicine, released Claimant to work four hours/day with ten (10) pound lifting restrictions. Her diagnosis was mid-thoracic back pain/spasm. On September 29, 2009, Dr. Estes increased Claimant's workday to six (6) hours with the same lifting restrictions, and on October 19, 2009, Dr. Estes released Claimant to 6-8 hours/day with the same lifting restrictions. As of the hearing date, Claimant was working six hours per day.

20. The ALJ finds that the medical care provided Claimant by Pagosa Springs Family Medicine was reasonably necessary to cure and relieve the effects of the back injury, which occurred on July 22, 2009.

21. Insurer initially paid for the medical care at Pagosa Springs Family Medicine. Claimant testified that her most recent medical appointments were not paid by workers' compensation because of disputes over the compensability of the claim. Claimant paid Pagosa Springs Family Medicine $30 per visit for two recent visits. As of the hearing date, Claimant had received the prescribed medications to treat her back from the City Market Pharmacy at no cost to her, and had not yet had physical therapy because it was not authorized and she could not afford to pay what it would cost her.

22. Claimant testified she did not remember a low back/sacral injury in 1993, while working for a different employer, and that she had no back symptoms or back complaints while working in her position in the paint department at the store since 1999 through July 22, 2009.

23. Respondents presented the testimony of Mr. H, the assistant manager for the employer. Mr. H testified that Claimant's job duties did not include unloading trucks or moving pallets of products. Mr. H testified that he unloaded approximately 90% of the paint pallet in the paint department in July, 2009, and moved and stocked all of the heavy products including the five gallon buckets of paint.

24. Respondents presented the testimony of Ms. H, the receiving clerk for employer. Ms. H testified that her job duties include checking in merchandise, moving pallets of product with a pallet jack, loading and delivering totes of product and assisting in the stocking of product generally. Ms. H testified that she did not request the assistance of Claimant in moving the pallet on July 22, 2009. Ms. H testified that she has requested assistance from other employees of employer in moving the pallets, but never from Claimant. Ms. H did admit that if she asked for help moving the pallet, Ms. H would continue to pull the pallet jack while her assistant would push the pallet, as described by Claimant in her testimony.

25. Respondents presented the testimony of Ms. U, the head bookkeeper/secretary for employer and former co-owner of the business at the same location. Ms. U testified that when Claimant clocked in on or about July 23, 2009, Claimant was walking in an awkward manner. Ms. U testified she inquired as to how Claimant was feeling and Claimant reported that she had hurt her back the previous day. Ms. U testified Claimant said she did not know how she hurt herself and did not report that she injured herself at work. Ms. U testified that a few days later she overheard Claimant telling another co-employee that she hurt herself moving freight. Ms. U joined in the conversation and said to Claimant, “I thought you said you hurt your back away from work.” Ms. U did not explain why she believed Claimant allegedly said she hurt her back “away from work.”

26. The ALJ finds the testimony of Claimant regarding the incident pushing the pallet to be credible. Claimant’s testimony is generally consistent with the accident history reported to Dr. Bricca on July 28, 2009. While Claimant’s testimony is in direct conflict with the testimony of Ms. H, the ALJ finds that Claimant’s report of how she pushed the pallet is supported by Ms. H’ description of how she would have an employee assist her in moving the pallet. The ALJ further finds that Claimant is more likely to recall if such an incident occurred rather than Ms. H. Moreover, Ms. H acknowledged that she may have requested other employees to assist her in the manner described by Claimant, but simply denied ever having Claimant assist her in such a manner.

27. The ALJ finds that Claimant attempted to report the incident to Mr. H on July 23 and July 24, 2009. Mr. H testified that he may have left early on July 24, 2009. Claimant finally was able to report the injury to Mr. H on July 27, 2009, after the weekend. The ALJ notes that despite these efforts, Claimant was still unable to report the incident to Hr. H until 4:45 p.m. Claimant’s testimony that she attempted to report the injury to her employer was supported by the testimony of Ms. U, who noted that with the change in ownership, it was no longer her responsibility to fill out forms, and directed Claimant to speak with Mr. Heilier to report the injury.

28. The ALJ finds that Claimant has sustained an injury to her back on July 22, 2009 while in the course and scope of her employment. As noted above, the ALJ finds the care provided claimant by Dr. Bricca and Dr. Estes of Pagosa Springs Family Medicine was reasonable and necessary to cure and relieve Claimant from the effects of the July 22, 2009 injury.

CONCLUSIONS OF LAW

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

13. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

14. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

4. As found, Claimant's testimony is credible and persuasive and supported by the medical records. The ALJ concludes that Claimant has established by a preponderance of the evidence that the incident pushing the product on July 22, 2009 resulted in Claimant's need for medical treatment.

5. As found, Claimant sustained an injury to her back on July 22, 2009 while in the course and scope of her employment.

6. C.R.S. § 8-42-101(1)(a) requires Employer to furnish such medical care as may reasonably be needed at the time of the Injury and thereafter during the disability to cure and relieve the employee from the effects of the injury. The care provided and recommended to claimant by Pagosa Springs Family Medicine is reasonably needed to cure and relieve the

Claimant's back injury and symptoms therefrom. Employer and Insurer are liable for this care.

ORDER

1. Claimant sustained an injury to her back on July 22, 2009, while in the course and scope of her employment with Employer.

2. Insurer shall pay for the reasonable and necessary medical care provided and prescribed to Claimant by, and at the referral and/or recommendation of, Pagosa Springs Family Medicine.

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

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

DATED: February 26, 2010

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-773-081

ISSUES

The issues determined herein are temporary disability benefits, average weekly wage and imposition of attorney's fees on Respondents for endorsing issues not ripe for hearing.

FINDINGS OF FACT

1. Claimant was injured initially on December 10, 2007. Claimant suffered from a rib fracture that was not detected at the time of being examined for this injury.

2. Claimant continued to suffer from pain subsequent to his medical release that was able to continue working for the Respondent-Employer as a truck driver.

3. Claimant's injury from December 10, 2007 worsened September 18, 2008, when the Claimant was working on the tarp that covers his truck.

4. The Respondent-Employer referred Claimant back to the workers compensation medical facility used by the Respondent-Employer.

5. PA-C Pedigo examined the Claimant on September 25, 2008, and under the direction of Dr. Zuehlsdorff, put Claimant on restrictions. The PA-C's Progress Note references the fact that the Claimant was off work secondary to the pain syndrome. The note also states that the Respondent-Employer was keeping the Claimant from driving as a result of this injury. The PA-C prescribed Vicodin because the Claimant was not working at the time.

6. On September 26, 2008 Claimant was released from the care of the medical facility because Dr. Zuehlsdorff concluded that the Claimant's current symptoms were not related to his on-the-job injury. Dr. Zuehlsdorff did not indicate that there was any positive change in the Claimant's condition or indicate that Claimant's restrictions were changed, only that he was releasing the Claimant because it was not work related.

7. Dr. Richman assumed treatment of the Claimant on September 16, 2009. Dr. Richman opines that the Claimant's pain condition is causally related to his work injury on December 10, 2007. Dr. Richman's opinion is credible.

8. Dr. Struck's opinion that Claimant's symptoms are not casually related to the work injury on December 10, 2007 is not credible.

9. Claimant was unable to work due to the restrictions placed on him. The Respondent-Employer was unable to provide modified duty and told Claimant he could work only if he could perform full duty. The Claimant was unable to do so. Thus, Claimant was off work due to disability caused by his work-related injury.

10. Claimant's testified that his average weekly wage was $1038.46. His testimony is credible.

11. ALJ Friend found that the issues of maximum medical improvement and permanent partial disability as endorsed in Respondent's Application for Hearing were not ripe. The Respondents' issues of maximum medical improvement, permanent impairment and Respondents' ability to file a Final Admission of Liability were stricken by ALJ Friend's order dated October 19, 2009. Respondents conceded at the hearing that these issues were not ripe.

CONCLUSIONS OF LAW

1. Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused Claimant to leave work, and Claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. *PDM Molding, Inc. v. Stanberg,* 898 P.2d 542 (Colo. 1995). The opinion of the Division Independent Medical Examiner is not entitled to any presumptive weight with respect to the issue of temporary disability benefits. *See Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Public Service Co. of Colorado v. Industrial Claim Appeals Office*, 40 P.3d 68 (Colo. App. 2001). *See Sholund v. John Elway*, W. C. No. 4-522-173 (October 22, 2004); *aff'd Sholund v. Industrial Claim Appeals Office,* No. 04CA1338 (Colo. App.

July 7, 2005)(not selected for publication) (ALJ is not required to give the DIME physician's rating "presumptive effect" on the question of whether the industrial injury is a significant causative factor in the Claimant's inability to earn wages). As found, Claimant satisfied his burden of proof by showing by a preponderance of the evidence that he is entitled to TTD benefits flowing from the December 10, 2007 injury beginning September 25, 2008 and continuing until terminated by law.

2. The objective of wage calculation for the average weekly wage is to reach a fair approximation of the Claimant's actual wage loss and diminished earning capacity. *Campbell v. IBM Corp.,* 867 P.2d 77 (Colo. App. 1993). The Administrative Law Judge under normal circumstances has broad discretion in calculating the employee's average weekly wage according to the facts of the case to fairly determine the Claimant's weekly wage. *Williams Bros. v. Grimm,* 88 Colo. 416, 297 P. 1003 (1931). Claimant has proven by a preponderance of the evidence that his AWW is $1038.46 a week.

3. Section 8-43-211 (2)(d), C.R.S. requires an assessment of attorney fees and costs if a person requests or sets a hearing on any issue that is not ripe for adjudication. *BCW Enterprises, Ltd. v. Industrial Claim Appeals Office*, 964 P.2d 533 (Colo. App. 1997).

ORDER

It is therefore ordered that:

1. Respondents shall pay Claimant temporary total disability benefits for the period from September 25, 2008 until terminated by law.

2. Claimant’s average weekly wage is $1038.46.

3. Respondents are responsible for Claimant’s attorney’s fees for preparation on issues for hearing that were not ripe.

4. Claimant’s attorney shall provide Respondents with an affidavit indicating the time spent and the fees charged. If there is a dispute either party may file an application for hearing to have the dispute resolved by an ALJ.

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

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

DATE: March 3, 2010 /s/ original signed by:

Donald E. Walsh

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-704-125

ISSUES

The issues to be determined by this decision include disfigurement, and whether Claimant has overcome the Division IME doctor's opinion on permanent partial disability (PPD) and maximum medical improvement (MMI) specific to the left shoulder by clear and convincing evidence.

FINDINGS OF FACT

1. Claimant injured his right shoulder on April 19, 2006.

2. Claimant developed left shoulder complaints while being treated for his right shoulder problems.

3. The DIME physician, Dr. William Griffis, performed two Division examinations, one on July 15, 2008 (right shoulder) and the second on January 21, 2009 (left shoulder).

4. Dr. Griffis placed Claimant at MMI for the right shoulder effective March 7, 2008. Dr. Griffis concluded there were no apportionment issues and Claimant did not require any maintenance care.

5. Dr. Griffis awarded 23% right upper extremity impairment (right shoulder) or 14% whole person impairment.

6. Dr. Griffis placed Claimant at MMI for the left shoulder effective January 21, 2009. Dr. Griffis concluded that Claimant did not require any maintenance care specific to the left shoulder.

7. The DIME physician, Dr. William Griffis, awarded 21% left upper extremity impairment (left shoulder) or 13% whole person impairment.

8. Dr. Griffis combined the two upper extremity impairment whole person impairment ratings and arrived at 25% whole person impairment.

9. Dr. Griffis testified that he has not seen any medical reports or records to change his opinion on MMI or impairment for either shoulder.

10. Respondents filed a final admission admitting to the DIME physician's impairment rating

and MMI dates.

11. At hearing, Claimant admitted to the MMI date on right shoulder. He admitted he had not received any examination or treatment on the right shoulder since 2008.

12. Claimant was unaware as to left shoulder MMI.

13. Dr. Christopher Jones, who performed the left shoulder surgery, testified that he has not reviewed any medical records from Dr. William Griffis.

14. Dr. Jones had not examined Claimant since April 2009.

15. Dr. Jones has never performed an independent medical examination for workers' compensation.

16. Dr. Jones has not and was not recommending surgery. Dr. Jones testified that the proposed scope was basically “a fishing expedition.”

17. Dr. Jones’ opinions on treatment of Claimant in April 2009 did not cast doubt upon Claimant’s condition at the time of the DIME in January 2009 and Dr. Griffis did not change his opinion during his deposition.

18. Claimant has failed to establish by clear and convincing evidence that he was not at MMI on January 21, 2009 when Dr. Griffis examined him.

19. Claimant withdrew his request concerning overcoming the DIME’s opinion on permanent partial disability.

20. Claimant sustained a disfigurement consisting of arthroscopic surgery scars on the right shoulder, one located near the armpit and two additional scars adjacent to each other, each scar being one-half inch in diameter.

21. Claimant sustained a disfigurement consisting of arthroscopic surgery scars on the left shoulder, one located toward the front of the shoulder being three inches in length, and an additional scar towards the back of the shoulder being one-half inch in diameter.

22. Respondents shall pay Claimant a total of $1,200.00 for Claimant’s disfigurements. Respondents may reduce that amount by any payments previously paid for disfigurement.

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

CONCLUSIONS OF LAW

1. Sections 8-42-107(8)(b)(III) and (c), C.R.S. (2007), 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 is highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

2. The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

3. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

4. 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).

5. The ALJ finds the DIME physician's opinion on the MMI date to be credible and finds insufficient medical or other evidence to establish by clear and convincing evidence that the DIME physician's opinion was clearly wrong. Claimant has failed to overcome the DIME physician's finding on MMI.

6. The ALJ finds the DIME physician's opinion on the impairment rating to be credible and finds insufficient medical or other evidence to establish by clear and convincing evidence that the DIME physician's opinion was clearly wrong. Claimant has failed to overcome the DIME physician's finding on impairment.

ORDER

It is therefore ordered that:

1. Claimant's claim to overcome the DIME physician on MMI is denied and dismissed.

2. Claimant's claim to overcome the DIME physician on impairment rating is denied and dismissed.

3. Claimant's claim for disfigurement benefits is granted.

4. Respondents shall pay Claimant a total of $1,200.00 for Claimant's disfigurements. Respondents may reduce that amount by any payments previously paid for disfigurement.

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

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

DATE: March 3, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-770-359

ISSUES

Whether the Claimant must overcome the Division IME physician's opinion on impairment by clear and convincing evidence, and if so has she succeeded in doing so?

FINDINGS OF FACT

1. The Claimant sustained an injury to her low back while employed as a nutrition service worker for the employer, Penrose Hospital. On August 26, 2008, Claimant completed an incident report and indicated that after working for approximately a month, she began having pain in her right arm and back.

2. The Claimant was seen by Dr. Kiernan on August 27, 2008 and diagnosed with a right shoulder strain and thoracolumbar strain. His objective examination on that date showed the Claimant had full forward flexion and her extension was limited to 50%. Dr. Kiernan returned the Claimant to modified-duty work with restrictions and referred her to physical therapy.

3. Claimant attended physical therapy beginning August 27 through October 9, 2008. Throughout the physical therapy notes, the physical therapists noted pain behaviors. On

September 2, 2008, the therapist noted she was “unable to decipher where/what is causing pain and/or the burning/tingling. Patient able to move around while sitting, but difficulty with supine to sit to stand.” “Patient with a lot of neurological symptoms with PT unable to decipher the cause of pain as all results are painful.” Also on September 2, 2008, the physical therapist indicated, “patient also saying she needs a doctor’s note so she doesn’t have to work again; very lethargic walking and running into walls.” On September 25, 2008, the physical therapy notes indicate, “patient with significant pain behaviors with transfers on and off treatment table. However, observed casually to see patient taking off and on shoes and standing without difficulty or pain behaviors.” On October 9, 2008, physical therapy notes indicate, “recommend trial chiropractor as patient feels confident that chiropractic can help; if symptoms persist, would recommend FCE with validity tests to assess symptom magnification”. It was also noted that the Claimant had inconsistent range of motion. She had 20° of full bending when asked for range of motion. When distracted, she had full forward bend.

4. The Claimant was seen on August 29, 2008, by Dr. Kiernan, who noted that, the Claimant was now mentioning having been struck in the back by cart a week before the onset of her pain. Dr. Kiernan also noted that the Claimant walked into the clinic and walked back into the room with “J” and did so at a brisk pace. Claimant turned quickly to the right to enter the room and then to the left to enter Exam Room #1. When asked to perform a sit/stand maneuver, Claimant indicated she was not able to do that because of pain, but, with encouragement, Claimant sat deep into the chair, holding her hands so that they were not engaged with the activity, leaned fully forward, essentially touching her chest to her knees and able, by changing her center of gravity, to stand up briskly. Dr. Kiernan also observed the Claimant’s combined thoracolumbar rotation during the course of discussion to be full. Dr. Kiernan indicated that he believed the Claimant had myofascial pain associated with little more than performing fairly strenuous physical activities.

5. Dr. Schwender saw the Claimant on September 3, 2008. He also noted exaggerated pain behaviors. When unobserved, the Claimant moved more smoothly than when she was being observed, specifically the movements of getting in and out of the chair. Dr. Schwender testified that he also observed pain behaviors similar to those observed by Dr. Kiernan. Dr. Schwender noted that, on September 3, 2008, when he examined the Claimant, her range-of-motion measurements were worse. It was his personal experience that, most often, individuals are worse the day after the injury than the day of the injury, but from that point on, there is improvement. It was atypical for someone to have full function the day after the injury and then progressively worsen over time.

6. On September 16, 2008, Dr. Walsh treated the Claimant. He noted that the Claimant had no improvement, she walked in a very careful manner to avoid pain and at a very slow pace, was unable to carry any objects without pain, had difficulty holding or lifting objects, had not attended work and was unable to hold her head in an upright position for any period of time. Dr. Walsh observed the Claimant walking with a shuffled gait secondary to pain and supporting herself on the wall as she walked. When sitting in a chair, the Claimant would lie with her head on her side writhing in pain secondary to discomfort. Dr. Walsh’s examination

revealed tenderness over both SI joints with no palpable muscle spasm being appreciated.

7. On September 18, 2008, the Claimant underwent an MRI of her cervical, thoracic and lumbar spines. The MRIs were negative with regard to any herniations or acute injury.

8. On September 18, 2008, video surveillance shows the Claimant walking with a labored gait. However, later in the videotape, the Claimant is walking with a smooth gait, carrying bags in both hands.

9. On September 27, 2008, the video surveillance shows the Claimant for approximately two hours getting in and out of her car, walking briskly in an unsupported manner, holding her head in an upright position, using her arms, lifting boxes, standing in an upright position, bending over boxes in a sustained position and cutting boxes using a box cutter.

10. On October 2, 2008, Dr. Ross saw the Claimant. Dr. Ross noted that the Claimant had 3 out of 5 positive Waddell's tests. Dr. Ross recommended EMG's.

11. EMG's of Claimant's lower extremities were performed on February 24, 2009. The EMG's were normal.

12. On March 9, 2009, EMG's were performed of the Claimant's upper extremities, which were normal.

13. Dr. Schwender also testified that he reviewed the video surveillance of September 18 and 27, 2008. He testified that the videotape activities were inconsistent with the evaluations performed by both him and Dr. Walsh in September 2008.

14. Dr. Walsh saw the Claimant on September 23, 2008 and noted that the Claimant walked with an antalgic gait. When he entered the room, the Claimant appeared to be sitting upright, but immediately put her head to the side and sighed in pain. She had pain behaviors when transitioning from standing to sitting on the table. However, when asked to remove her shoes, she promptly stepped off the table, removed her shoes and stepped back on. She had excellent cervical range of motion, no spinal tenderness and she complained of pain with palpation of the trapezius distribution, but no spasming. Dr. Walsh noted that sensation testing to light touch was inconsistent in her lower extremity and, at times, reporting a stocking-like distribution with decrease in sensation in her right foot and lower leg.

15. On January 19, 2009, Dr. Schwender saw the Claimant and noted that she was somewhat teary during the interview and exam, which was not consistent with her essentially benign examination.

16. On February 4, 2009, Dr. Schwender noted that the Claimant was pleasant and jovial when escorted back to the room by the medical assistant; however, when he entered the exam room, the Claimant appeared to have an expression of pain on her face. However, her

gait, stance and examination was normal.

17. Dr. Schwender placed the Claimant at maximum medical improvement on March 24, 2009. Dr. Schwender provided the Claimant with a 27% whole person impairment.

18. Claimant underwent a Division IME with Dr. Susan Santilli on June 24, 2009. Dr. Santilli also noted significant pain behaviors. Claimant would cry much of the time and writh in pain often. Claimant's pain behavior would stop for a short time when she was intent on a subject matter. She seemed to be short of breath during the entire examination. Dr. Santilli observed that the Claimant was able to lean forward, grab a tissue, she was able to take her shoes off and put them on, she was able to bend forward and reach for her shoes, her gait was often irregular and flailing as if she was going to fall, but Claimant was always able to reach out for a chair or table for support. However, as Claimant walked out of the front office, the irregular gait diminished.

19. Dr. Santilli also noted that the Claimant’s bilateral grip strength was barely perceptible, but there was no coolness or atrophy noted. Claimant’s sensation revealed numbness in a glove and stocking distribution over the left lower extremity. Claimant’s entire left arm and hand were numb, although she cried in pain with light touch to the area. Dr. Santilli also noted that the Claimant did not have any signs of muscle spasm or trigger points in either the cervical or lumbar area. Axonal spinal compression caused severe pain throughout her back. Straight-leg raises in a supine position were nearly impossible. However, Dr. Santilli noted that, when she supported the Claimant’s leg at the knee, the Claimant would forcibly push down when Claimant approached 30°. However, in a sitting position with distraction, the straight leg was nearly 90° without pain. Dr. Santilli also noted that the Claimant cried with light touch when the inclinometer was placed on her back.

20. Dr. Santilli agreed that the Claimant had reached MMI as of March 24, 2009. She also indicated that the Claimant’s presentation revealed pain behaviors and discrepancies consistent with a high level of symptom magnification. Dr. Santilli noted that, with the presentation of the severe pain complaints on the day of the examination, with a high degree of medical probability, the Claimant would not be able to perform even simple tasks without aid, such as getting out of bed, dressing, bathing or even cutting her food. Therefore, based on a reasonable degree of medical probability, Dr. Santilli believed the Claimant’s range of motion was not a true representation of her condition and did not use the range of motion measurements for purposes of impairment. Dr. Santilli provided the Claimant with a 7% whole person impairment.

21. At the deposition of Dr. Santilli on December 8, 2009, Dr. Santilli reviewed the video surveillance. She testified that, what she observed during her Division IME examination was inconsistent with the Claimant’s presentation in the video one month post injury. Dr. Santilli specifically stated that, based on her review of the records and examination, the Claimant’s lack of range of motion was due to Claimant’s deliberate conduct rather than the industrial injury. Based on her training it is left to the discretion of the examining physician to determine

whether the findings or measurements at the time of examination are a true assessment of impairment. Dr. Santilli indicated that she did not use the range of motion measurements for impairment purposes because the range of motion measurements did not accurately reflect Claimant's disability or her ability to function. Dr. Santilli did not believe the mechanism of injury supported such total severe loss of functioning.

22. Dr. Santilli also testified that, based on her Level II training, she is not to rate where there is no anatomic or physiologic basis for the rating. Dr. Santilli specifically testified that she did not specifically use the Waddell's findings to disregard the rating, but it was one piece of information that she used in conjunction with her observations as well as observations of other physicians.

23. Dr. Schwender in his deposition of December 14, 2009 agreed that the use of Waddell's signs as part of the information in assessing the Claimant was appropriate. Dr. Schwender also testified consistent with Dr. Santilli's testimony, that pain with placement of the inclinometer and Claimant's flailing gait had no anatomical or physiological basis. He also noted that when he saw her on March 24, 2009, her gait was normal and that he could not explain such a dramatic change in three months. Dr. Schwender testified that Dr. Santilli's findings with regard to Claimant's upper and lower extremities were inconsistent with the normal EMG findings and there was no anatomical or physiological basis for Claimant's inability to use her upper extremities in a normal manner. Dr. Schwender agreed that based on the Level II training and *AMA Guides* that the physician is not to rate those complaints that have no anatomical or physiological basis.

24. He further agreed that the purpose of the Division IME process is for the DIME physician to objectively exam the Claimant. He also agreed that based on the *AMA Guides* and Level II training course that the physician is allowed to disregard the range of motion measurements and findings if they are inconsistent with the examination. Dr. Schwender specifically stated that during the Level II training course, the doctor is advised that if the observed patient behavior is substantially inconsistent with the patient's range of motion measurements the physician can indicate that the impairment would not include those measurements, but the physician must explain the rationale in the report. He also indicated that he agreed that Dr. Santilli's report was consistent with findings of symptom magnification found by other physicians.

CONCLUSIONS OF LAW

1. Section 8-42-107(8)(b.5)(II) C.R.S provides:

> …If an employer or a self-insured employer disputes the findings regarding permanent medical impairment, including a finding that there is no permanent medical impairment, the parties to the dispute may select an independent medical examiner in accordance with §8-42-107.2. The findings of any such independent examiner shall be overcome only by clear and convincing evidence.

2. Section 8-42-107(8)(c) provides:

> …For purpose of determining levels of medical impairment, physicians shall not render a medical impairment rating based on chronic pain without anatomic or physiologic correlation. Anatomic correlation must be based on objective findings…

3. The Division IME must apply the *AMA Guides* when evaluating the Claimant's permanent medical impairment §8-42-107(8)(c), C.R.S. The IME physician's rating then becomes binding on the parties unless overcome by clear and convincing evidence. Section 8-42-107 (8)(c), provides that the party seeking to overcome the Division IME physician's rating has the burden of proof. *Lambert and Sons v. Industrial Claims Appeal Office, 927 P2d. 1333 (Colo. App. 1998).* Whether the IME physician has properly applied the *AMA Guides* and whether the rating has been overcome by clear and convincing evidence, questions of fact for determination by the ALJ.

4. The *AMA Guides Third Edition Revised* and Section 1.2 page 3 provides "The key to an effective and reliable evaluation of impairment is review of the office and hospital records maintained by the physicians who have provided care since the onset of the medical condition." The same provision goes on to state that if the examiner's impairment evaluation is not consistent with the findings in the medical records, "the step of determining the percentage of impairment is meaningless and should not be carried out until…further clinical investigation resolves this disparity. Here Dr. Santilli provided a reasonable explanation as to why she disregarded the range of motion measurements even though they were valid. Both she and Dr. Schwender agree that pursuant to the Level II training course, discretion is given to the Division IME, or the ATP to disregard the range of motion measurement if it is not an accurate depiction of the Claimant's disability. Dr. Santilli acted properly by invalidating Claimant's range of motion measurements, which were at odds with the medical records and her own clinical observations. Based on the evidence in the records as well as the videotape, the Claimant's complaints and presentation were inconsistent and nonphysiological. Dr. Santilli specifically stated that the Claimant's range of motion was the result of Claimant's deliberate conduct and not the effects of the industrial injury. See *Villalobos – Chaparro v. Benny's Concrete*, W.C. 4-356-868, decided January 4, 2001.

5. Therefore, Dr. Santilli correctly applied the *AMA Guides* in determining the 7% whole person impairment. Respondents have admitted for that 7% whole person impairment, and it is Claimant's burden to overcome that rating by clear and convincing evidence.

6. Based upon the totality of the credible evidence produced, both lay and medical, the ALJ concludes that Dr. Santilli's opinions are credible and supported by additional credible medical evidence. The ALJ finds medical evidence to the contrary to be incredible and unpersuasive. In light of the Claimant's burden to overcome Dr. Santilli's opinion on impairment by clear and convincing evidence, it is apparent to the ALJ that Claimant has failed to elicit such evidence.

ORDER

It is therefore ordered that:

1. Claimant's request to overcome the DIME opinion on impairment is denied and dismissed.

2. Respondents shall pay permanent partial disability pursuant to Dr. Santilli's rating.

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

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

DATE: March 3, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-787-168

ISSUES

Whether Respondent's have overcome the opinion of the DIME physician, Dr. Katharine Leppard, M.D., that Claimant is not at MMI.

Whether Claimant is entitled to an award of temporary total disability benefits beginning March 27, 2009 and continuing until terminated in accordance with statute, rule or order.

FINDINGS OF FACT

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

1. Claimant sustained an admitted compensable injury to her low back on December 22, 2008. Insurer filed a Final Admission of Liability on June 23, 2009 admitting to 5% whole person impairment based upon reports of the authorized treating physician, Dr. Frank Polanco, M.D., dated June 5 and March 26, 2009 placing Claimant at MMI as of March 26, 2009. The Final Admission admitted for an Average Weekly Wage of $425.10. Claimant subsequently requested a DIME and Dr. Leppard was selected as the physician to perform the DIME.

2. The parties stipulated to the following facts at hearing:

- Respondents agreed that if Claimant desires to proceed with spinal fusion surgery as recommended by Dr. Leppard, they will approve the procedure.

- Claimant has contacted Dr. Sung to set up an appointment for a surgical consultation scheduled for February 11, 2010.

- Respondents agree that if they are unsuccessful in their attempt to overcome the DIME, Respondents will pay TTD for any period that Claimant is determined not to be at MMI from March 27, 2009 until Claimant is placed at MMI.

- Claimant has not worked since she was let go by the Respondent/ Employer, due to her restrictions.

3. Dr. Katharine Leppard, M.D. evaluated Claimant on October 6, 2009 for the DIME and prepared a written report of that date. Dr. Leppard stated in her report that she recommended Claimant see an orthopedic surgeon to determine if Claimant was a candidate for an L4-5 disc fusion surgery. Dr. Leppard opined in her report that she did not feel Claimant was at MMI, but, if she (Claimant) did not pursue the L4-5 disc fusion Claimant would be at MMI at that point. In her report Dr. Leppard further opined, and it is found, that Claimant had plateaued with conservative treatment options and that no further therapy or injections would be effective.

4. Dr. Polanco referred Claimant to Dr. Roger Sung, M.D., an orthopedist, for evaluation. Dr. Sung evaluated Claimant on December 24, 2009 and gave an assessment of L4-5 discogenic low back pain with large annular tear. Dr. Sung opined, and it is found, that fusion surgery was a reasonable option.

5. Dr. Leppard testified that she did not feel Claimant was at MMI. Dr. Leppard noted that Claimant had seen a neurosurgeon and because most neurosurgeons do not believe in fusion she recommended Claimant be seen by an orthopedic spine surgeon before closing Claimant's case. Dr. Leppard opined, and it is found, that there is no treatment, other than surgery recommended by Dr. Sung, that would significantly improve Claimant's condition.

6. Dr. Leppard was specifically questioned by Respondent's counsel concerning her opinion on whether the Claimant was currently at MMI, but then would no longer be at MMI if and when Claimant decided to proceed with surgery. Dr. Leppard responded that a decision had to be made regarding surgery and that Claimant would be at MMI if she opted not to pursue the surgery. Dr. Leppard further testified "That's where I would leave it." (Dr. Leppard deposition: p. 7, ll. 6 – 15).

7. Dr. Leppard testified that 30 days would be a reasonable time for Claimant to decide if she was going to proceed with surgery. Dr. Leppard opined that based upon this time-frame Claimant would be at MMI as of January 24, 2009 if she opted not to proceed with

surgery. (Dr. Leppard deposition: p. 9, l. 24 – p. 10, l. 11; p. 11, ll. 13 – 18).

8. Dr. Leppard testified that to her maximum medical improvement meant that everything that medically can be done to improve a patient's condition had been completed.

9. The ALJ resolves the conflicts in Dr. Leppard's opinions regarding whether Claimant is at MMI in favor of Dr. Leppard's opinion that Claimant has not reached MMI and will not reach MMI until Claimant opts not to proceed with the surgery recommended by Dr. Sung.

10. Respondent's have failed to prove by clear and convincing evidence that the opinion of the DIME physician, Dr. Leppard, that Claimant is not at MMI is wrong. Respondent's have failed to overcome the DIME physician's opinion regarding MMI by clear and convincing evidence.

CONCLUSIONS OF LAW

11. 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. X-ray*, 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.

12. 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).

13. Where a DIME physician offers ambiguous or conflicting opinions concerning the issue of MMI the ALJ is to resolve the ambiguity and determine the DIME physicians' true opinion as a matter of fact. In so doing, the ALJ is to consider all of the DIME physicians' written and oral testimony. *Andrade v. Industrial Claim Appeals Office*, 121 P.3d 328 (Colo. App. 2005). Once the ALJ determines the DIME physician's opinion, the party seeking to overcome that opinion bears the burden of proof by clear and convincing evidence. Dazzio v. Rice & Rice, Inc., supra; X-ray v. Hudick Excavating, Inc., W. C. No. 4-524-162 (November 5, 2004). The burden of proof may shift in a situation where the deposition testimony of the DIME physician is considered as part of the DIME physician's overall "finding". U v. North & Air Package Express Services, W. C. No. 4-492-570 (February 16, 2005). As found, the ultimate opinion of Dr. Leppard is that Claimant is not at MMI, and will not be at MMI until she opts not to proceed with surgery. Thus, the burden of proof rests with Respondents.

14. 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. 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.

15. Maximum Medical Improvement is defined as at 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."

16. When a course of treatment has a reasonable prospect of success and a claimant willingly submits to such treatment, a finding of maximum medical improvement is premature. *Reynolds v. Industrial Claim Appeals Office,* 794 P.2d 1080 (Colo. App. 1990). Respondents argue that based upon the authority in *Reynolds,* supra, Claimant should be found to be at MMI until she submits to the surgery recommended by Dr. Sung. The ALJ disagrees. Respondent's argument misinterprets the Court's holding in *Reynolds.* In *Reynolds,* the Court held that since the record established that surgery could improve the claimant's condition a finding of maximum medical improvement was premature and unsupported by the evidence. *Reynolds,* supra at 1082. The *Reynolds* Court did not hold that Claimant was to be found at MMI until a decision to proceed with surgery was made.

17. Respondents argue that Dr. Leppard was clearly erroneous in her opinion that Claimant is not at MMI based upon the legal definition of MMI. As stated above, the definition of MMI found in Section 8-40-201(11.5), C.R.S. contains two components or requirements for a finding of MMI. First, that the condition resulting from the injury be stable. Second, that no further treatment is reasonably expected to improve the condition. The use of the conjunctive "and" in the definition of MMI found in Section 8-40-201(11.5), C.R.S. connotes that both stability of the condition and the absence of further treatment reasonably expected to improve the condition must be present in order for MMI to exist. Here, there is no dispute that Claimant's condition is stable, i.e. that her condition has plateaued with conservative care. However, it is also not disputed that further treatment, in the nature of surgery, is reasonably expected to improve Claimant's condition, should she elect to proceed with the surgery. Because the second component of the legal definition of MMI is not present Dr. Leppard correctly concluded that Claimant was not at MMI. It has been held that the claimant's willingness to undergo particular forms of treatment may affect a determination of whether the claimant is at MMI. This is true because the "stability" of the claimant's condition may depend on the claimant's willingness to undergo treatment which offers a reasonable prospect for improving the condition. *Atkins v. Centennial School District R-1,* W.C. Nos. 4-275-987; 4-445-

718; 4-218-062; 4-468-808, (February 7, 2002). In this case there is no persuasive evidence that Claimant is unwilling to undergo the surgery recommended by Dr. Sung. Thus, Claimant's remains not at MMI until she evidences an unwillingness to proceed with the recommended surgery. Dr. Leppard specifically rejected Respondents' suggestion that Claimant be placed at MMI as of March 29, 2009 and then taken off MMI once she elects to proceed with surgery. Dr. Leppard's opinion in this regard is consistent with the legal definition of MMI found in Section 8-40-201(11.5), C.R.S. and the holding in *Reynolds,* supra because there remains additional treatment that can reasonably be expected to improve Claimant's condition. As found, Respondents have failed to overcome the DIME physician's opinion regarding MMI by clear and convincing evidence.

18. As stipulated by Respondents, because Claimant has not reached MMI Claimant is entitled to temporary total disability benefits beginning March 27, 2009 and continuing until terminated in accordance with statute, rule or order. Based upon the admitted Average Weekly Wage of $425.10 Claimant is entitled to temporary total disability benefits at the rate of $283.40 per week.

ORDER

It is therefore ordered that:

1. Respondents have failed to overcome the opinion of the DIME physician on the issue of MMI by clear and convincing evidence. Claimant is not currently at MMI.

2. Insurer shall pay Claimant temporary total disability benefits at the rate of $283.40 per week beginning March 27, 2009 and continuing until terminated in accordance with statute, rule or order.

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: March 3, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-685-777

ISSUES

The issue for determination is liability for treatment for Claimant's cervical radiculopathy, right ulnar neuropathy, and headaches.

FINDINGS OF FACT

1. On March 9, 2006, Claimant suffered an admitted injury to his right shoulder. Claimant sought treatment on March 9, 2006, and complained of upper extremity pain and tingling in his first, second and third digit. Claimant denied neck pain. Claimant had normal range of motion of the cervical spine. There was no bony point cervical spine tenderness or paraspinal tenderness on palpation.

2. Claimant first began experiencing and reporting neck pain only on the right side of his neck. Six months after the injury, Claimant continued to only report right-sided neck pain.

3. Claimant underwent CT scans of the right humerus and right forearm. The CT scans reflected "no acute abnormality." The CT scans showed "marked degenerative change of the elbow joint with large osteophytes."

4. April 6, 2006, Claimant's elbow pain was improved. Claimant complained of neck, upper back, and right shoulder pain. Claimant had full cervical range of motion. Joel Boulder, M.D., stated that Claimant suffered from degenerative disc disease, especially at the C5-C6 level. Dr. Boulder opined that Claimant suffered "cervical degenerative disk disease, which is not work-related but could be related to the cause of his pain in his upper back."

5. On April 21, 2006, Mark Failinger, M.D., noted that Claimant experienced shoulder pain that occasionally shoots toward the neck, but never originates in the neck and shoots down. Dr. Failinger noted the "neck does not seem to hurt."

6. On July 13, 2006 Todd Alijani, M.D., opined that Claimant's neck pain and headaches were not related to the right shoulder injury. Dr. Alijani stated, "I cannot fully explain his neck and headaches."

7. A July 17, 2006, cervical MRI showed spondylotic disc bulging and multilevel degenerative disc disease with disc bulging at C5-6. A November 7, 2008, CT scan showed degenerative conditions.

8. Claimant suffers from severe degenerative changes in the right elbow. The testimony of John J. Raschbacher, M.D., that severe degenerative changes do not occur from an acute injury is credible and persuasive. Elbow pain is a symptom of degenerative disease in the elbow. Claimant suffers from degenerative changes in the right elbow and a previous right elbow fracture.

9. Claimant suffered a slip and fall on ice in 2003. Claimant began experiencing headaches

following the 2003 incident. Claimant testified the headaches he is currently experiencing are "similar but less frequent and less severe than the headaches" he experienced after the 2003 incident. Claimant told Dr. Leach in July 2006 that some of the current headache symptoms are related to the 2003 slip and fall.

10. Dr. Raschbacher's testimony that Claimant reported he previously experienced headaches following the 2003 slip and fall is credible. Dr. Raschbacher noted other contributing factors to the cause of the Claimant's headaches, such as depression and emotional problems.

11. In 2007, Claimant relocated from Colorado and began treating with John A. Sazy, M.D., and Patrick Donovan, M.D. Dr. Donovan prescribed the Claimant Imitrex for headaches. Dr. Sazy recommended a right ulnar nerve submuscular transposition and an ACDF of C4/5 and C5/6.

12. Dr. Raschbacher stated that the medical records do not support symptoms consistent with a cervical spine injury or an ulnar neuropathy injury were reported at the time of March 6, 2006 accident. The medical records support an absence of those injuries. The opinion of Dr. Raschbacher is credible and persuasive. The reports and testimony by Dr. Raschbacher that the Claimant's right elbow, neck complaints and headaches are not related to Claimant's March 9, 2006, accident are credible and persuasive. The source of Claimant's pain and discomfort in his neck is the degenerative disease of the cervical spine and nerve root impingement.

13. Claimant did not express symptoms of a cervical spine injury within 48-72 hours of the fall. Dr. Raschbacher credibly testified "with an acute injury" of the shoulder, "if there were significant neck involvement from the injury, I'd expect symptoms the day of the injury or sometimes delayed by a couple of days; as I said, maybe 48 to 72 hours….So the take-away message from this is that it looks like he had a normal range of motion and had not cervical tenderness, essentially had a normal neck exam on the date of the injury. So I wouldn't expect that to be so had there been significant aggravation of the neck or involvement of the neck from the trauma." Dr. Raschbacher credibly testified that, absent the degenerative changes in the cervical spine, Claimant would not suffer from the cervical symptoms.

14. Claimant's February 26, 2009, MRI reflects Claimant suffers arthritis in the neck, which "also fits with his right-sided symptomatology." Dr. Raschbacher credibly testified Claimant suffers from a "bone spur which is called a spondylitic disk bulge, which is part bone spur, part disk" that is "eccentrict to the right side, meaning it's a little bit more pronounced on the right side." Dr. Raschbacher persuasively testified the objective physical findings, and Claimant's subjective complaints, are consistent with the February 26, 2009, MRI findings which reflect the source of Claimant's complaints are the degenerative disease of the cervical spine. Claimant's medical records and the testimony Dr. Raschbacher do not show that the March 9, 2006, fall permanently exacerbated Claimant's pre-existing cervical degenerative disk disease.

15. Dr. Raschbacher persuasively testified right-sided neck pain following a right shoulder injury does not result in a finding the Claimant's current neck symptomatology is related to the March

9, 2006, fall. Neck pain is a common complaint following a shoulder injury. The symptoms initially reported by Claimant could be accounted for by an intrinsic shoulder joint injury.

16. Dr. Raschbacher credibly testified that neither Dr. Kent, nor Dr. Alijani, two shoulder surgeons, evaluated the neck as a possible pain generator prior to Claimant's shoulder surgery. Dr. Raschbacher stated, "if the shoulder surgeon - - the orthopedic doctor thinks there may be a complicating factor, they will, in general, not pursue the shoulder surgery but will require or insist that the neck be worked up…."

17. Dr. Sazy's opinions that Claimant's cervical complaints and right ulnar neuropathy are related to the March 9, 2006, accident are unsupported by the medical evidence. Dr. Sazy's statement "[b]y definition, work place injuries are evaluated based on areas of the body that the patient reports as causing pain as a result of the event" is not persuasive. Dr. Raschbacher credibly testified that Dr. Sazy provided no analysis that would pass for a causation assessment. Dr. Raschbacher is more persuasive than Dr. Sazy.

18. Dr. Raschbacher's testimony that Claimant's symptomatic cervical degenerative disk disease was not permanently exacerbated by the March 9, 2006 accident is credible. There is no persuasive evidence to support the symptomatic cervical degenerative disk disease developed due to the March 9, 2006 accident.

19. An elbow fracture is a known risk factor for developing neuropathies. Dr. Raschbacher credibly testified that a direct blow to the right elbow can cause right ulnar neuropathy. The medical records do not support the right ulnar neuropathy is related to the March 9, 2006, accident. Dr. Raschbacher credibly stated that the medical evidence does not support a diagnosis of work-related left ulnar neuropathy. Claimant did not suffer symptoms of ulnar neuropathy within weeks to months following the March 9, 2006, accident.

20. The right ulnar neuropathy is not work-related. There is not persuasive evidence that Claimant suffered a degenerative elbow condition with a superimposed acute injury. Dr. Raschbacher credibly testified that, even in the absence of the March 9, 2006, accident, Claimant may have developed right ulnar neuropathy based upon his previous history of right elbow fracture.

21. The cause of Claimant's headaches is the non work-related cervical degenerative disease.

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. X-ray,* 197 Colo. 306, 593 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo.App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. § 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. § 8-43-201, C.R.S.

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

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

4. The ALJ resolves any conflict in the testimony or evidence presented at hearing in favor Respondents. Claimant has failed to prove by a preponderance of the evidence that he sustained injuries on March 9, 2006, to his cervical spine and right ulnar nerve. Claimant also failed to prove the headaches are related to the March 9, 2006, accident.

5. An insurer is liable for medical care that is reasonably needed to cure and relieve an injured worker from the effects of the compensable injury. Section 8-42-101(1), C.R.S.

6. It is more probably true than not the Claimant suffers from a cervical degenerative disc disease which did not become symptomatic for a considerable amount of time following the March 9, 2006, accident. Claimant's complaints of right-sided neck pain following the March 9, 2006 fall are inconsistent with symptoms for the C4/5 and C5/6 alleged cervical injury. Claimant's medical records, and Dr. Raschbacher's testimony, do not support a finding the Claimant's pre-existing cervical degenerative disk disease was exacerbated by the March 9, 2006 fall. Claimant failed to report symptoms consistent with the cervical radiculopathy or a cervical injury until a considerable amount of time after the March 9, 2006, accident. The ALJ is persuaded Claimant's headaches are unrelated to Claimant's work-related fall.

9. Claimant's medical records and Dr. Raschbacher's testimony do not support a finding the right ulnar neuropathy is work-related. Dr. Raschbacher credibly testified that, even in the absence of the March 9, 2006, accident, Claimant may have developed right ulnar neuropathy based upon his previous history of right elbow fracture.

10. Claimant has not established by a preponderance of the evidence that he sustained injuries to his cervical spine and right elbow. Claimant's headaches are not related to the March 9,

2006. Claimant is not entitled to benefits for these conditions. Claimant has failed to prove by a preponderance of the evidence that the cervical spine surgery or right ulnar transposition surgery as reasonable or necessary to cure or relieve from the effects of this compensable accident injury. Insurer is not liable for the Imitrex because the headaches are not related to the admitted right shoulder injury.

ORDER

IT IS THEREFORE ORDERED THAT Insurer is not liable for medical benefits for Claimant's cervical condition, right elbow condition, or headache complaints.

Matters not determined herein are reserved for future determination.

DATED: *March 4, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-728-318

ISSUES

1. Whether Respondents have demonstrated by a preponderance of the evidence that the Division Independent Medical Examination (DIME) physician erroneously determined that Claimant had not reached Maximum Medical Improvement (MMI) and assigned Claimant a 10% lower extremity impairment rating.

2. Whether Respondents have proven by a preponderance of the evidence that Claimant is not entitled to receive Temporary Total Disability (TTD) benefits for the period December 10, 2008 until terminated by statute because Claimant's Authorized Treating Physician (ATP) determined that she had reached Maximum Medical Improvement (MMI) and released her to regular employment on December 10, 2008.

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

FINDINGS OF FACT

1. Claimant worked for Employer as a cook supervisor at a long-term care facility. On June 25, 2007 she suffered an admitted industrial injury to her right foot when a resident in an electric wheelchair ran over her foot.

2. Employer referred Claimant to Concentra Medical Centers for treatment. When conservative measures failed, Claimant was referred to orthopedic surgeon Scott G. Resig, M. D. at Denver-Vail Orthopedics, P.C. for an evaluation.

3. On October 19, 2007 Dr. Resig performed surgery on Claimant's right foot and ankle. Because the surgery failed to relieve Claimant's foot pain she underwent a second surgery on March 26, 2008. The surgeries involved a repair of Claimant's Achilles tendon and bone grafts from Claimant's knee onto her foot.

4. Despite her two foot surgeries Claimant continued to suffer persistent right foot pain. On June 4, 2008 Claimant visited ATP John Burris, M.D. at Concentra Medical Centers for an evaluation. Dr. Burris recommended physical therapy and rehabilitation to reduce the swelling in Claimant's right foot. He delineated work restrictions consisting of no lifting in excess of 15 pounds, no walking or standing longer than two to four hours per shift and no climbing stairs or ladders.

5. Claimant continued to receive treatment from Dr. Burris. On August 14, 2008 Claimant visited Dr. Burris for an examination. Dr. Burris remarked that Claimant's second surgery had been objectively successful but that her subjective complaints exceeded the objective findings. He also noted that Claimant's pain complaints were motivated by a desire not to return to work. Dr. Burris commented that Claimant was approaching MMI and directed her to follow-up with Dr. Resig to make sure he did not have any additional recommendations.

6. On October 7, 2008 Claimant visited Dr. Resig for an evaluation. He determined that she had reached MMI but suffered impairment because of ankle range of motion deficits. Dr. Resig recommended additional stretching exercises.

7. On October 21, 2008 Claimant returned to Dr. Resig and requested additional right ankle surgery. He responded that Claimant only needed to have her orthotics adjusted and sought to "avoid surgery at all costs." Nevertheless, Claimant never followed up with Dr. Burris' recommendation to have her orthotics adjusted.

8. On October 22, 2008 Claimant visited Dr. Burris for an examination. He noted that Claimant exhibited no objective findings. Dr. Burris determined that Claimant had reached MMI but awaited comments from Dr. Resig regarding Claimant's functional gain from additional surgeries. He remarked that a third surgical procedure would not change Claimant's functional outcome and recommended orthotics for Claimant's foot problems. Dr. Burris commented that Claimant "seems to resist going back to any type of work activities and secondary gain is clearly the motivation given her lack of objective findings and insistence on work restrictions." He continued Claimant's work restrictions of no prolonged standing or walking longer than tolerated.

9. On December 10, 2008 Claimant returned to Dr. Burris for an evaluation. He concluded that Claimant had reached MMI without impairment. Dr. Burris also released Claimant to full

duty. He commented that a third surgery was unlikely to change Claimant's functional outcome and her continued pain complaints were motivated by secondary gain factors. Dr. Burris noted that Claimant had repeatedly failed to schedule her final appointment with Dr. Resig.

10. On December 16, 2008 Claimant again visited Dr. Resig for an examination. He remarked that Claimant was unable to dorsiflex her right foot on examination but was able to dorsiflex her foot while walking. Dr. Resig noted that he had recommended an orthotics adjustment at Claimant's last appointment but she had not yet obtained new orthotics. He concluded that it was unlikely that surgery would improve Claimant's condition.

11. On December 17, 2008 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Burris' December 10, 2008 MMI determination.

12. On February 19, 2009 Claimant again visited Dr. Resig for an evaluation. She commented that she was still suffering right foot discomfort. Dr. Resig remarked that there was no other treatment that he could offer but that he would contact an individual to make arrangements regarding Claimant's orthotics adjustment. He noted that Claimant asked him to continue her limited standing restrictions but responded that he was "not comfortable with handling her work restrictions" and recommended a follow-up with her Workers' Compensation physician.

13. Claimant objected to the December 17, 2008 FAL and sought a DIME. On March 25, 2009 Claimant underwent a DIME with orthopedic surgeon Frederick Coville, M.D. He concluded that Claimant had not reached MMI. Dr. Coville explained that Claimant required surgery of the "metatarsalgia of the third metatarsal by condylectomy or osteotomy of the third metatarsal." Dr. Coville noted that, if Claimant did not undergo additional surgery, she suffered a 10% right lower extremity impairment rating based on range of motion deficits.

14. On December 2, 2009 Claimant underwent an independent medical evaluation with David R. Hahn, M.D. He noted that it was possible that "she might have some sort of a distal metatarsal procedure that could alleviate the [third] metatarsal head a bit." However, he was concerned about a possible transfer lesion if a metatarsal osteotomy was performed. Dr. Hahn also noted that Claimant's orthotic was missing a metatarsal pad and thus failed to offload pressure in the metatarsal area of her right foot. His "final opinion" was thus "to try to do everything possible to get the best possible orthotic for her foot that would offload this area and make her foot as comfortable as possible before giving any consideration to a surgical endeavor." Dr. Hahn remarked that finding the best orthotic could take six months to one year.

15. Respondents have demonstrated that it is more probably true than not that Dr. Coville erroneously determined that Claimant had not reached MMI. On March 25, 2009 Claimant underwent a DIME with orthopedic surgeon Dr. Coville, M.D. He concluded that Claimant had not reached MMI and explained that she required a third surgery on her right foot. However, Dr. Coville's opinion is less persuasive than the opinions of doctors Burris, Resig and Hahn that a third surgery was not reasonable or necessary and that Claimant simply required an orthotics

adjustment to relieve her right foot condition. On October 22, 2008 Dr. Burris remarked that a third surgical procedure would not change Claimant's functional outcome and recommended orthotics for Claimant's foot problems. On December 10, 2008 Dr. Burris determined that Claimant had reached MMI and reiterated that a third surgery was unlikely to change her functional outcome. During Claimant's treatment with Dr. Resig she specifically requested a third right ankle surgery. He responded that Claimant only needed to have her orthotics adjusted and sought to "avoid surgery at all costs." Nevertheless, Claimant never followed up with Dr. Burris' recommendation to have her orthotics adjusted. Dr. Hahn determined that Claimant might benefit from a third surgery on her right foot but was concerned about a possible transfer lesion if a metatarsal osteotomy was performed. He commented that Claimant's orthotic was missing a metatarsal pad and thus failed to offload pressure in the metatarsal area of the right foot. Dr. Hahn's final opinion was thus to try to obtain an orthotic for Claimant's foot that would offload the metatarsal area and make her foot as comfortable as possible "before giving any consideration to a surgical endeavor." Therefore, Respondents have proven that Claimant reached MMI on December 10, 2008 without impairment.

16. Because Claimant reached MMI on December 10, 2008 she is not entitled to recover additional TTD benefits.

17. Claimant underwent a disfigurement evaluation at the hearing. As a result of Claimant's right foot surgeries in this matter she incurred scarring from her right leg onto her foot. The disfigurement consists of the following: (1) a one and one-half inch scar below her right kneecap; (2) a two inch scar on the back of her right leg; (3) a three inch scar on her right foot; and (4) a dime-sized scar on her right ankle. The disfigurement is serious, permanent and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $900.00.

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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See*

Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

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

The DIME Opinion

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). 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). However, the increased burden of proof required by DIME procedures is only applicable to non-scheduled impairments and is inapplicable to scheduled injuries. *In Re Maestas,* W.C. No. 4-662-369 (ICAP, June 5, 2007); *see* §8-42-107(8), C.R.S., *Delaney,* 30 P.3d at 693. Because Dr. Coville assigned Claimant a scheduled 10% right lower extremity impairment rating, his opinion is not entitled to increased deference. Respondents thus need only produce a preponderance of the evidence to overcome Dr. Coville's findings regarding Claimant's date of MMI and impairment rating.

5. As found, Respondents have demonstrated by a preponderance of the evidence that Dr. Coville erroneously determined that Claimant had not reached MMI. On March 25, 2009 Claimant underwent a DIME with orthopedic surgeon Dr. Coville, M.D. He concluded that Claimant had not reached MMI and explained that she required a third surgery on her right foot. However, Dr. Coville's opinion is less persuasive than the opinions of doctors Burris, Resig and Hahn that a third surgery was not reasonable or necessary and that Claimant simply required an orthotics adjustment to relieve her right foot condition. On October 22, 2008 Dr. Burris remarked that a third surgical procedure would not change Claimant's functional outcome and recommended orthotics for Claimant's foot problems. On December 10, 2008 Dr. Burris determined that Claimant had reached MMI and reiterated that a third surgery was unlikely to change her functional outcome. During Claimant's treatment with Dr. Resig she specifically requested a third right ankle surgery. He responded that Claimant only needed to have her orthotics adjusted and sought to "avoid surgery at all costs." Nevertheless, Claimant never followed up with Dr. Burris' recommendation to have her orthotics adjusted. Dr. Hahn determined that Claimant might benefit from a third surgery on her right foot but was concerned about a possible transfer lesion if a metatarsal osteotomy was performed. He commented that Claimant's orthotic was missing a metatarsal pad and thus failed to offload pressure in the metatarsal area of the right foot. Dr. Hahn's final opinion was thus to try to obtain an orthotic for Claimant's foot that would offload the metatarsal area and make her foot as comfortable as possible "before giving any consideration to a surgical endeavor." Therefore, Respondents

have proven that Claimant reached MMI on December 10, 2008 without impairment.

Temporary Total Disability Benefits

6. Section 8-42-103(1), C.R.S. requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subsequent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997). To demonstrate entitlement to TTD benefits a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that she left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The term "disability," connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earning capacity as demonstrated by claimant's inability to resume her prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999).

7. Section 8-42-105(3), C.R.S. provides that TTD benefits shall continue until respondents demonstrate that claimant has reached MMI, returned to work, was released by the attending physician to regular employment, or was released by the attending physician to modified employment and failed to accept a written offer of modified employment. §8-42-105(3), C.R.S. As found, because Claimant reached MMI on December 10, 2008 she is not entitled to recover additional TTD benefits.

Disfigurement

8. Section 8-42-108, C.R.S. provides that a claimant may obtain additional compensation if she is seriously disfigured as the result of an industrial injury. As found, as a result of Claimant's right foot surgeries in this matter she incurred scarring from her right leg onto her foot. The disfigurement consists of the following: (1) a one and one-half inch scar below her right kneecap; (2) a two inch scar on the back of her right leg; (3) a three inch scar on her right foot; and (4) a dime-sized scar on her right ankle. The disfigurement is serious, permanent and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $900.00.

ORDER

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

1. Respondents have overcome Dr. Coville's DIME opinion that Claimant had not reached MMI and suffered a 10% lower extremity impairment rating.

2. Claimant's request for TTD benefits from December 10, 2008 until terminated by statute is denied and dismissed. Claimant reached MMI on December 10, 2008 without impairment.

3. Respondents shall pay Claimant a disfigurement award in the amount of $900.00.

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

DATED: March 4, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-802-546

ISSUES

1 Did claimant prove by a preponderance of the evidence that treatment for his lower back condition and bilateral knee surgery recommended by Dr. Thomas are reasonable and necessary to cure and relieve the effects of his injury?

2 Did claimant prove by a preponderance of the evidence that he is entitled to temporary disability benefits?

FINDINGS OF FACT

1. Employer operates a concrete and masonry construction business. Claimant's date of birth is July 6, 1950; his age at the time of hearing was 59 years. Claimant worked some 15 years for employer, most recently as an equipment operator.

2. Claimant sustained an injury arising out of the course and scope of his employment on April 16, 2009. Claimant was working on the 5th story of a building under construction. Claimant was waiting for the crane operator to lower a tub full of concrete mud onto a pallet jack. When the crane operator was positioning the tub on the pallet jack, the tub shifted sideways against the upper thighs of claimant's legs, pressing him backward against a safety railing. Coworkers were able to reposition the tub.

3. Claimant's supervisor transported him the Emergency Department of Swedish Medical Center (ER), where claimant reported that a drum filled with cement had fallen into him and pinned him up against a wall. The ER physician recorded claimant's chief complaint as an injury to the left foot and bilateral thighs. Claimant reported moderate pain and an injury to his lower back. On physical examination, the ER physician documented abrasion and large bruising of claimant's anterior legs and feet. The ER physician ordered x-ray studies of the bilateral femurs, left foot, and lumbar spine. The x-ray studies were negative for any fracture.

Lumbar spine x-ray studies were negative for acute pathology and instead showed age-related degenerative disk disease (DDD) of the lumbar spine. The ER physician diagnosed contusions of the legs and back. The ER physician discharged claimant home in good condition.

4. Claimant returned to work the following day on April 17th and continued working until late July of 2009.

5. Claimant sought follow up care through his primary care physician, Janet Javier, M.D. In June of 2009, Dr. Javier referred claimant for magnetic resonance imaging (MRI) studies of his bilateral feet, bilateral knees, and lumbar spine. Dr. Javier also referred claimant to Podiatrist Daniel Macfarlane, D.P.M., and to Orthopedic Surgeon Herbert J. Thomas, M.D.

6. Dr. Macfarlane evaluated claimant on June 30, 2009. Claimant was reporting bilateral foot pain, with weakness and poor balance. According to Dr. Macfarlane, x-ray studies and the MRI studies of claimant's feet revealed no obvious pathology to explain claimant's symptoms. Dr. Macfarlane recommended physical therapy to help claimant with range of motion, muscle strengthening, and balance. Dr. Macfarlane also provided claimant with information regarding medications he could use to better manage neuropathic pain. Claimant declined to use such medications. There is no mention in Dr. Macfarlane's report that claimant was complaining of back pain on June 30, 2009.

7. In a letter to Dr. Thomas dated July 14, 2009, Dr Javier noted that claimant had been having pain in his knees and feet. Dr. Javier also reported that claimant was in a standing position when he was injured and that the barrel had rolled over the front of his legs.

8. Dr. Thomas examined claimant's knees on July 23, 2009. According to Dr. Thomas, the MRI studies of claimant's knees revealed bilateral medial meniscal tears and moderate arthritis. Dr. Thomas recommended bilateral knee surgery, involving arthroscopy, medial meniscectomy, and chondroplasty. In his July 23rd report, Dr. Thomas does *not* clearly opine whether the recommendation or need for surgery was due to claimant's work-related incident. On the M164 form dated July 23rd, Dr. Thomas failed to respond to the question asking whether the objective findings were consistent with the alleged mechanism of injury. Dr. Thomas imposed temporary work restrictions, including lifting up to 15 pounds and no crawling, kneeling, squatting, or climbing.

9. After the evaluation by Dr. Thomas, claimant continued working until July 28, 2009. On July 31, 2009, Dr. Thomas altogether released claimant from work. The Judge infers that Dr. Thomas assumed claimant should be off work to undergo the surgery he recommended.

10. On September 2, 2009, claimant filed his Workers' Claim for Compensation. Respondents referred claimant to Brian J. Beatty, D.O., who first examined him on September 17, 2009. In his initial report dated September 17, 2009, Dr. Beatty noted:

> The patient states that his injury dates back to 4-16-09 while working. He was

> apparently 5 stories up on a building pouring concrete when the crane was lowering large bucket of cement onto a pallet jack which apparently was broken and the bucket rolled off the pallet jack eating (sic) the patient in his lower legs knocked him back again (sic) some bars. He had the sudden onset of lower leg pain and has developed back pain since that time …. He has had x-rays done as well as MRI … apparently he has a torn meniscus in both of his knees. He was sent to Dr. Thomas, an orthopedic surgeon and is currently awaiting authorization for surgery. He continues to have pain involving his low back which radiates into his right buttocks and leg ….

On the accompanying M164 report, Dr. Beatty provided a diagnosis of lumbar strain and bilateral knee meniscus tear. During a follow-up appointment on October 1, 2009, claimant reported to Dr. Beatty that he was then having numbness and tingling in his legs bilaterally. As of October 1st, claimant had not worked for employer for nearly 2 months.

11. Dr. Beatty referred claimant to Physiatrist Barry A. Ogin, M.D., who first evaluated claimant on October 8, 2009. Dr. Ogin reported:

> [Claimant] has fairly diffuse pain complaints with non-dermatomal distribution of numbness and tingling down his legs …. Although he certainly has pathology in his knees, it seems that the majority of this may be pre-existing. **I am not sure how heavy weight pressed on his upper thighs would necessary cause his meniscal tears.** [Claimant] denies … having any knee pain prior to his work injury, and has had knee persistently afterwards. On the other hand, he has diffuse leg pain since the injury, which I really cannot explain on a physiologic basis.

(Emphasis added). In light of the diffuse pain complaints, Dr. Ogin determined that a pain psychology evaluation was warranted.

12. Dr. Ogin referred claimant to Suzanne Kenneally, Psy.D., for a psychological evaluation. Dr. Kenneally evaluated claimant on November 5, 2009. Dr. Kenneally's psychological testing indicated a conscious contribution to claimant's pain symptoms and report. Dr. Kenneally advised:

> All treaters are advised to obtain objective measures of the patient's reported symptoms when possible.

13. Dr. Beatty reevaluated claimant on November 10, 2009, noting claimant's symptoms were about the same. Claimant reported some pain and leg numbness. On physical examination, Dr. Beatty found some ongoing tenderness to palpation involving the paralumbar musculature bilaterally. Dr. Beatty concluded that claimant appeared to display some signs of symptom magnification.

14. At respondents's request, Physiatrist Allison M. Fall, M.D., performed an independent medical examination of claimant on November 13, 2009. Dr. Fall testified as an expert in the

area of Physical Medicine and Rehabilitation. On physical examination of claimant, Dr. Fall observed nonphysiologic findings, including pain behaviors, overreaction, greater than 3 of 5 positive Waddell's signs, superficial tenderness to palpation, inconsistencies on straight-leg-raise testing. Dr. Fall noted that claimant appeared to self-limit the range of motion of his lumbar spine. Dr. Fall explained than Dr. Ogin also observed nonphysiologic findings on physical examination and that Dr. Beatty diagnosed symptom magnification.

15. Dr. Fall persuasively testified that claimant's lumbar spine complaints are alike unsupported by physical examination findings and inconsistent with claimant's mechanism of injury. Regarding the mechanism of injury, Dr. Fall testified:

> First of all, he was basically standing in place when … something heavy rolled onto him and caused abrasion to his thigh and … toes, so obviously it was a crushing-contusion type of injury. **But there was really no mechanism of injury for the lumbar spine.** He was pressed up against some bars on the back.
>
> And then, again, the examination, there's nothing localizing or focal found on examination.
>
> ****
>
> And the symptoms, there's no explanation that can be given for the symptoms that he's having. It's nonphysiologic.

(Emphasis added). Dr. Fall thus opined that treatment for claimant's lower back complaints is not reasonable, necessary, or related to the mechanism of injury on April 16, 2009.

16. Dr. Fall also opined that surgical intervention for claimant's bilateral knees is unrelated to his accident while working for employer; Dr. Fall stated:

> [Claimant's] MRIs show multicompartmental – meaning not just in one area – degenerative changes. And meniscus tears … are also considered degenerative changes and can occur on a degenerative basis. They don't have to be acutely traumatic, and they don't even have to be symptomatic.
>
> So he's got bilateral knee … degenerative changes, and at least on my exam, had diffuse complaints of pain, nothing pinpointing any particular area.
>
> ****
>
> If the surgery is to treat the meniscus tears, **there was no mechanism of injury to cause meniscus tears in this case**.

(Emphasis added). Crediting Dr. Fall's testimony, the Judge finds it more probably true that the meniscal tears in claimant's bilateral knees are the result of a degenerative condition unrelated

to the accident at employer on April 16, 2009.

17. Claimant failed to show it more probably true than not either that medical treatment for his lower back condition or that bilateral knee surgery recommended by Dr. Thomas is reasonable and necessary to cure and relieve the effects of his injury at employer on April 16, 2009. Dr. Fall's medical opinion is persuasive. Crediting Dr. Fall's opinion, the Judge finds it more probably true that the meniscal tears in claimant's bilateral knees are a result of long-standing degenerative changes, and not an acute result of the accident on April 16, 2009. Crediting Dr. Fall's opinion, the Judge finds claimant failed to show it more probably true that treatment for his lower back complaints is reasonable, necessary, or related to the mechanism of injury. Crediting Dr. Fall's medical opinion, the Judge finds it more probably true that claimant sustained contusions to his legs and lower back as a result of the accident at employer. Claimant thus failed to prove by a preponderance of the evidence that treatment for his lower back condition or for his bilateral meniscal tears is reasonable, necessary, or related to the accident at employer on April 16, 2009.

18. Claimant failed to show it more probably true than not that his wage loss after July 31, 2009, is the result of injury from the accident at employer on April 16, 2009. The Judge is unpersuaded that Dr. Thomas released claimant from work because of the effects of the contusions to his legs and lower back as a result of the accident at employer.

CONCLUSIONS OF LAW

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

A. Medical Benefits:

Claimant argues he has proven by a preponderance of the evidence that treatment for his lower back and bilateral knee surgery recommended by Dr. Thomas are reasonable and necessary to cure and relieve the effects of his injury. The Judge disagrees.

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

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

> Every employer … shall furnish … such medical, hospital, and surgical supplies, crutches, and apparatus as may reasonably be needed at the time of the injury …

> and thereafter during the disability to cure and relieve the employee from the effects of the injury.

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

Here, the Judge found claimant failed to show it more probably true than not either that medical treatment for his lower back condition or that bilateral knee surgery recommended by Dr. Thomas is reasonable and necessary to cure and relieve the effects of his injury at employer on April 16, 2009. Claimant thus failed to prove by a preponderance of the evidence that this treatment is reasonable and necessary to cure and relieve the effects of his injury.

The Judge credited the medical opinion and testimony of Dr. Fall as persuasive in finding it more probably true that the meniscal tears in claimant's bilateral knees are the result of long-standing degenerative changes, and not an acute result of the accident on April 16, 2009. The Judge further credited Dr. Fall's medical opinion in finding that claimant failed to show it more probably true that treatment for his lower back complaints is reasonable, necessary, or related to the mechanism of injury.

Finally, the Judge credited Dr. Fall's medical opinion in finding it more probably true that claimant sustained contusions to his legs and lower back as a result of the accident at employer.

The Judge concludes that claimant's request for an award of medical benefits for treatment for his lower back condition and for surgical treatment to repair his bilateral meniscal tears should be denied and dismissed.

B. Temporary Total Disability Benefits:

Claimant argues he has proven by a preponderance of the evidence that he is entitled to temporary disability benefits. The Judge disagrees.

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

restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998).

The Judge found claimant failed to show it more probably true than not that his injury from the accident at employer on April 16, 2009, proximately caused his wage loss after July 31, 2009. Claimant thus failed to prove by a preponderance of the evidence that he is entitled to TTD benefits from July 31, 2009, ongoing.

The Judge was unpersuaded that Dr. Thomas released claimant from work because of the effects of the contusions to his legs and lower back as a result of the accident at employer. Dr. Thomas instead released claimant from work in anticipation of surgical repair of his meniscal tears, which the Judge found were unrelated to the mechanism of injury on April 16, 2009.

The Judge concludes that claimant's request for an award of TTD benefits from July 31, 2009, ongoing, should be denied and dismissed.

ORDER

1. Claimant's request for an award of medical benefits to provide for treatment for his lower back condition and for surgical treatment to repair his bilateral meniscal tears is denied and dismissed.

2. Claimant's request for an award of TTD benefits from July 31, 2009, ongoing, is denied and dismissed.

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

DATED: _March 4, 2010_

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-800-425

ISSUES

Whether Claimant sustained a compensable injury in the nature of a left inguinal hernia on July 22, 2009.

If compensable, whether Claimant is entitled to an award of medical benefits for the

treatment received from Denver Health Medical Center and whether Denver Health Medical Center should be considered to be the authorized treating provider.

If compensable, whether Claimant is entitled to an award of temporary total or temporary partial disability benefits beginning July 22, 2009 and continuing.

At hearing, the parties stipulated that if the claim was found compensable Claimant's Average Weekly Wage is $800.52.

FINDINGS OF FACT

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

1. Claimant, whose proper legal name is ___, was employed by Employer doing drywall and framing construction work. Claimant used the name ___ for purposes of his work at Employer.

2. Claimant testified that his injury occurred on July 22, 2009 when he was moving 4-foot by 10-foot sheets of drywall weighing 60 pounds from the 3rd (third) floor of a building to the 2nd (second) floor. Claimant testified that as he was coming down the stairs carrying one of the drywall sheets he turned on the stairs and felt pain in the left inguinal area of his groin.

3. Claimant testified that he mentioned this incident to his supervisor, -AB-, and continued working until he could no longer stand the pain. Claimant testified that he notified Mr. -AB- that he couldn't work and that Mr. -AB- then directed him to seek medical care through the emergency room at Denver Health Medical Center.

4. Claimant testified that when he presented to the emergency room at Denver Health Medical Center he was asked if he had lifted anything heavy and that he had told them he had.

5. Claimant presented to the emergency room at Denver Health Medical Center on July 22, 2009. At the emergency room Claimant was initially seen for a medical screening evaluation by Lia Wells, RN. Nurse Wells obtained a history that Claimant reported left hip pain for 4 (four) days and denied trauma or falls. Claimant was then referred to urgent care where he was evaluated by Dr. Andy Mannsfeld, M.D. The urgent care physician obtained a history that Claimant had pain in his groin and left testicle that had started 4 (four) days ago with a gradual increase in pain. Neither Nurse Wells nor Dr. Mannsfeld obtained a history that Claimant had been involved in any heavy lifting.

6. Steve O'Brien is a foreman at Employer and was a supervisor of Claimant in July 2009. Mr. O'Brien maintains records of the dates that employees work on the various projects for Employer. Mr. O'Brien testified, and it is found, that Claimant last worked for Employer on July 21, 2009. Mr. O'Brien's testimony in this regard is supported by the wage records from Employer for the week of July 21 through 27, 2009 showing that Claimant

received only 8 hours of pay for that week.

7. Claimant's testimony that he sustained an injury to his groin/left inguinal hernia and left testicle on July 22, 2009 as the result of carrying a sheet of drywall while working for Employer on that date is not credible or persuasive.

8. Claimant has failed to prove by a preponderance of the evidence that he sustained a compensable injury on July 22, 2009 in the course of his employment with Employer.

CONCLUSIONS OF LAW

9. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 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*.

10. 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*.

11. 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).

12. In order to recover benefits a claimant must prove that he sustained a compensable injury. A compensable injury is one which arises out of and in the course of employment. Section 8-41-301(1)(b), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origins in an employee's work-related functions. There is no presumption that an injury which occurs in the course of a worker's employment arises out of the employment. *Finn v. Indus. Comm'n,* 165 Colo. 106, 437 P.2d 542 (1968). 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. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989).

13. The evidence must establish the causal connection with reasonable probability, not medical certainty. *Ringsby Truck Lines, Inc. v. Industrial Commission, 491 P.2d 106 (Colo.*

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

14. Claimant's testimony concerning the date and mechanism of his alleged injury is inconsistent with the history obtained by the nurse and physician at Denver Health Medical Center on the same day that Claimant alleges his injury occurred. Claimant testified his injury occurred on July 22, 2009 yet the history obtained at Denver Health Medical Center on that date, in two separate encounters with medical staff, clearly reflected that the injury began four days earlier. That would place the date of injury as July 18, 2009, a Saturday. There is no persuasive evidence in the record that Claimant would have been working on July 18, 2009 for Employer. The history obtained by the medical personnel at Denver Health Medical Center also contained no mention of any specific incident or heavy lifting as testified to by Claimant. In addition, Claimant's testimony that he was injured working for Employer on July 22, 2009 is rebutted by the credible testimony of Steve O'Brien and the wage records from the Employer.

15 As found, Claimant has failed to sustain his burden of proving by a preponderance of the credible evidence that he sustained an injury on July 22, 2009 arising out of and in the course of his employment with Employer. Claimant's testimony is not credible.

ORDER

It is therefore ordered that Claimant's claim for compensation and benefits, including medical benefits, for an injury on July 22, 2009 to his left groin, inguinal hernia and left testicle is denied and dismissed in its entirety.

DATED: March 5, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-809-083

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUE

The sole issue to be determined by this decision concerns whether the Claimant sustained a compensable injury or occupational disease to her shoulders and elbows on or about March 1, 2009.

FINDINGS OF FACT

1. The Employer employed the Claimant as a salesperson beginning in October 2006. She reported an occupational disease in her shoulders on November 13, 2009, alleging that "[m]oving furniture around the store is the cause of shoulder pain." Claimant confirmed in her testimony that she was alleging an occupational disease that occurred over time. Claimant never mentioned or reported a specific incident regarding her shoulders until she was examined by her own independent medical examiner (IME) Alan Lichtenberg, M.D., on January 25, 2010. At that time, she stated no one had ever asked her to think about the first time she experienced pain. The report of Allison Fall, M.D., who performed an IME for insurance carrier eleven days prior to Dr. Lichtenberg's IME, states that "[s]he is not able to indicate a particular activity with which she associated the pain." Claimant never amended her claim for workers' compensation to include a claim for a specific injury.

2. Claimant reported to Dr. Lichtenberg, for the first time, that she had lifted a 50-60 pound mirror by herself. At hearing, she stated that she had carried this mirror 100 feet to the showroom floor. Claimant provided a detailed description of this event at the hearing, despite her testimony that she had not thought about this event until Dr. Lichtenberg questioned her. Claimant demonstrated on the stand how she carried the mirror with her arms straight out in front of her at approximately shoulder height. She described the mirror as being approximately four feet long and thirty to thirty-six inches high, weighing approximately fifty pounds.

3. Dr. Fall, who performed an IME for the Respondents, observed Claimant's testimony at hearing. Dr. Fall testified that based on her experience and the many hours spent herself in the gym, it would be nearly impossible for even a body builder to perform the feat of moving a fifty pound mirror in the manner the Claimant described. It is, therefore, improbable that the Claimant, who admittedly does absolutely nothing physical outside of work, would be able to lift and carry a mirror as she described. Upon specific questioning, Dr. Fall testified that she could not even imagine the Claimant performing this feat. The ALJ, therefore, finds that the Claimant's testimony regarding moving of the mirror is not credible.

4. Claimant's supervisor until May 2009 was -BC-, store manager. Claimant stated that her job duties were to match items for customers, "sometimes" to arrange pieces on the floor, put together design plans, and select colors of wood and fabric. She did not do any assembly of furniture. The manager, the helper and "sometimes" the Claimant would move items from the back room to the floor for sale.

5. -BC- stated that he observed the salespeople on the floor during the workday. He observed that the Claimant did minimal moving of heavy items. She primarily moved lamps, accessories and knickknacks to decorate vignettes on the showroom floor. Also, the Claimant was occasionally involved in scooting items of furniture maybe five inches at a time to adjust their position on the floor. She did not move or position heavy furniture by herself. The helper was available, as well as the male staff members, to move heavy items to the floor or around the floor. The helpers worked at the store full time. Claimant was not hesitant to ask the helpers or other workers to move heavy items and availed herself of such assistance on a regular basis. -BC- denied that the Claimant would ever be asked to carry a fifty lbs. mirror by herself or that he ever witnessed her doing so. Further, in the three years he was her supervisor, he never witnessed the Claimant carry an item weighing that much. Claimant never reported a work related shoulder condition to him at all. -BC- was persuasive and credible. His testimony renders Claimant's testimony regarding the mirror improbable and lacking in credibility.

6. The Claimant presented testimony from -CD-, who worked as a helper from December 2008 to May 2009 when he quit voluntarily. -CD- stated that he observed the Claimant hanging pictures on the walls approximately five times in the five months he worked there. He did not recall seeing her carry the large mirror in January. He also testified that he saw her a "few times" helping with moving merchandise to the front. The ALJ finds that -CD-' testimony does not render the Claimant's testimony regarding the mirror-moving more probable.

7. The Claimant stated that she experienced pain in her shoulders lifting the mirror and that "she knew at that point she had pushed her shoulders too far." She did not, however, report the incident to her Employer. This testimony is also inconsistent with her statement to Dr. Lichtenberg that she had never thought of a specific incident prior to his questioning. Additionally, her testimony is also inconsistent with the findings on the MRIs (magnetic resonance imaging) of degenerative fraying and tears in the bilateral shoulder musculature. Dr. Fall's opinion confirms that these findings are not acute and are degenerative in nature, taking years to develop. There are no specific acute tears noted on the diagnostic exams. Further, Dr. Fall was of the opinion there is no evidence of any new or acute injury. The ALJ finds that Dr. Fall's testimony in this regard renders Claimant's testimony concerning an "acute" injury unlikely. Her testimony that only Dr. Lichtenberg asked specific enough questions to elicit the memory of the mirror carrying incident is not credible considering the Claimant's own conflicting testimony that when the incident occurred she realized she had pushed her shoulders too far. It simply does not add up. The more likely explanation is that the Claimant "remembered" this mirror incident when multiple physicians stated opinions that her shoulder condition simply was not related to her regular work duties as a furniture salesperson.

8. Despite this alleged specific incident, no such specific injury reported to the first physician from whom she sought treatment for this condition. Claimant first sought treatment from her own personal care physician on January 28, 2009. Claimant reported bilateral

shoulder pain **with no injury,** pain with range of motion reaching overhead or extended reaching behind her, and no change in sensation to her hands. The ALJ observes that Dr. Lichtenberg's report notes bilateral upper extremity paresthesias that began in January 2009. This notation, however, is inconsistent with the medical reports of the practitioners who examined her in January 2009.

9. The absence of any new or acute injury on the diagnostic tests is also supported by the IME report of Dr. Lichtenberg, who found pre-existing bilateral shoulder degenerative disease. Although Dr. Lichtenberg was of the opinion that there were "probable new or increased tears in the rotator cuff," he gave no basis for this statement and pointed to nothing specific on the MRI exams that would support such a statement. Further, Dr. Lichtenberg was of the opinion that the Claimant likely has thoracic outlet syndrome, which Dr. Fall specifically denies. Dr. Fall stated that she saw absolutely no evidence of thoracic outlet syndrome on her examination. Dr. Lichtenberg did not point to any specific medical evidence of this condition. Dr. Fall testified specifically that her physical examination produced no evidence of this condition. Because Dr. Fall explained her findings based on her specific exam, Dr. Fall's testimony is more credible and persuasive on this issue.

10. The Claimant's testimony that the pain occurred as the result of a specific incident is inconsistent with the reports she gave to all the physicians who treated or evaluated her for this injury, with the exception of her own IME two months after the alleged incident. She reported to Robert L. Thomas, M.D., an orthopedic referral from her PCP (primary care physician), that the pain began insidiously. A designated workers' compensation provider first evaluated the Claimant was first evaluated on November 17 2009 after reporting the incident to the Employer. The history given to Jeffrey Gerber, M.D., was that she was unsure when the pain started but she was having "progressive pain" in January. Dr. Gerber found that the findings on MRI were degenerative in nature and stated the opinion that these were not related to her work duties.

11. Apparently, the Claimant was dissatisfied with this opinion and was therefore sent for a second opinion from the alternate designated provider, Susan Morrison, M.D. The Claimant advised Dr. Morrison that she initially thought that her chair positioning was to blame for the pain. She also told Dr. Morrison that she had to move heavy furniture and unload trucks of furniture. She reported a lot of heavy moving, pushing, pulling, lifting and carrying. She did not report a specific lifting incident. Based on this history, Dr. Morrison stated the opinion that Claimant's condition was related to her work. Claimant told the physical therapists that her pain was of insidious onset. The only provider who ever received a history other than the pain simply coming on insidiously is Claimant's IME, Dr. Lichtenberg. The Claimant's histories of injury are rife with inconsistencies.

12. -DE-, the Employer's human resources manager, handled the first reporting of the injury to the Insurance carrier on behalf of the Employer. -DE- stated that for approximately two months prior to the Claimant reporting the alleged injury in November 2009, the Claimant had

been emailing -DE- and calling her on the telephone asking numerous questions about the health insurance coverage, vacation time, paid medical leave, short term disability and deductibles for the insurance plan. For the duration of this email discourse, the Claimant continually referred to possible shoulder surgery without ever once mentioning this to be allegedly related to her employment. -DE- prepared a summary of events and conversations that transpired during this period of time. (Resp. Exh. J, Bates pgs. 35-36.) The summary reflects that it was prepared on November 13, 2009, the same day the Claimant called -DE- to report the condition as work related. Claimant stated to her that the physical therapist and she had been talking trying to figure out what had caused the shoulder problem and "decided it must have been work related" since the Claimant did not do anything outside work. The Claimant never mentioned the alleged mirror-lifting incident and indicated that the therapist and she were discussing how the condition arose since she did not have an accident or incident that could have caused the injury. The Claimant had never mentioned any work relatedness of the condition during the time she was discussing with -DE- the lack of paid time off for surgery and the amount of money this surgery would cost the Claimant under the existing health insurance plan.

13. Dr. Lichtenberg did not testify at hearing. His report, admitted into evidence, includes a one-page document titled "Qualifications for Alan Lichtenberg, M.D". This document establishes that Dr. Lichtenberg has not been board certified in any area for approximately twenty years, and was never board certified in occupational medicine, the area in which he holds himself out as an expert. Dr. Lichtenberg was at one time board certified in family practice, but this certification lasted only from 1978 through 1990. Dr. Lichtenberg is Level II accredited with the Division of Workers' Compensation.

14. By contrast, Dr. Fall is board certified in physical medicine and rehabilitation and is Level II accredited. Dr. Fall testified as an expert in the field of physical medicine and rehabilitation. Dr. Fall's testimony in this case was persuasive and credible. Dr. Fall's opinion is that the Claimant's shoulder condition is simply degenerative and is not related to the Claimant's employment. She explained that absent a traumatic injury, the type of occupational activities which would lead to such a condition would be significant repetitive pushing and moving of weight or force over shoulder height. An example of this would be workers who install drywall or perform carpentry overhead for significant periods every day. An occasional task performed over shoulder height would not result in this condition or aggravate the underlying condition in any way. Dr. Lichtenberg mistakenly referred to the Claimant's job as repetitive. He provided no explanation as to why or how he considered her work duties to be repetitive. Yet Dr. Fall stated that there was absolutely nothing about the Claimant's job description that could be considered repetitive for the purpose of determining the relatedness of an occupational disease to her work duties. The positioning of the Claimant's chair and counter have absolutely no bearing, medically, on the development of degenerative rotator cuff tears or fraying. The ALJ finds Dr. Fall's opinion in this regard more credible than the opinion of Dr. Lichtenberg.

15. Dr. Fall explained that bursitis is simply inflammation and can occur with or without rotator cuff tears. It is a common finding in patients who exhibit degenerative shoulder conditions such as the Claimant's. Another finding that was indicative of a degenerative condition was the degeneration noted in the humeral head, which takes a lot of time to develop. The finding of "fraying" is also considered a classic sign of simple degeneration. Claimant's prior diagnosis of fibromyalgia would account for the tender points, and the Claimant still has some findings indicative of the prior diagnosis of fibromyalgia.

16. Dr. Fall's opinion is that the Claimant has a degenerative condition in both shoulders. This finding is extremely common in patients of the Claimant's age. The normal progression of this condition would be for the Claimant to insidiously begin experiencing pain with range of motion overhead and particularly reaching behind, as if to retrieve a wallet from a back pocket. These are exactly the symptoms that occurred and prompted the Claimant to seek treatment. Dr. Fall's opinion is that the Claimant's condition is simply degenerative with the normal progression of age and is completely unrelated to the non-repetitive work the Claimant performed for the Employer. The ALJ finds Dr. Fall's opinions in this regard credible and persuasive.

17. The Claimant has never filed a claim for a specific injury in this case, and her claim for occupational disease went forward to hearing on February 9, 2010 without her amending her claim to include a specific injury claim. The credible and persuasive testimony of Dr. Fall established that the Claimant proved no causal connection between her job duties and her shoulder condition. Claimant's duties are not the type of occupational tasks that result in rotator cuff degeneration or tears or any of the conditions diagnosed in the Claimant's shoulders.

18. The testimony of Claimant's rebuttal witness, -CD-, basically establishes that approximately one time per month he observed the Claimant hang or move a picture or mirror. He testified the top edge of such pictures would be hung at six to seven feet. The Claimant testified the pictures or mirrors were 30 to 36 inches tall. The Claimant did not produce evidence that hanging such a sized picture at such a height would in fact be above her shoulder height. Further, even if it were, this does not constitute the necessary repetitive duties that Dr. Fall described as being required to produce such a condition from an occupational standpoint. Dr. Lichtenberg has no opinion on this issue.

19. A reasonable interpretation of the evidence at hearing is that the Claimant had a degenerative shoulder condition and was treating with her personal physicians, facing potential surgery and unpaid time off work. She then filed the workers' compensation claim alleging an occupational disease. During some discussion with Dr. Lichtenberg, the details of which are not known to the ALJ, the Claimant "recalled" a very specific incident occurring approximately one year prior, which she asserts was the sole aggravating factor of this underlying condition. Yet, even if this explanation were accepted as true and found credible, the Claimant still has not met her burden of proof in the face of the credible medical evidence, coupled with the

inconsistencies in the Claimant's histories to medical providers. It is equally as likely that, even if the Claimant's testimony were accepted as true, which it is not, the pain she felt while lifting the mirror was simply a symptom of the underlying condition. Just because the Claimant's pain may have been felt at work does not mean that her work was causing the underlying condition. Correlation does not equal causation. Even Dr. Lichtenberg does not state exactly what the new injury was that he alleged was caused by the work duties. His report simply states in a conclusory manner that there was a "permanent aggravation" (a legal, workers' compensation phrase) but gives no specific explanation of what he believes that aggravation to have been. Since there is no expert testimony from Dr. Lichtenberg, his report must be taken at face value, and at face value it does not provide evidence that would meet the Claimant's burden of proof.

20. The Claimant has argued specific provisions of the Division of Workers' Compensation Medical Treatment Guidelines (MTG), but the provisions of the MTG were not offered into evidence in this case and are not considered persuasive evidence herein. Dr. Lichtenberg's report purports to quote the MTG, but there is no credible evidence to persuade the ALJ that the comments in the Claimant's IME report are correct and accurate. The fact that the MTG note that bursitis is often a sequelae of an occupational strain does not mean that presence of bursitis establishes that the Claimant has an occupational strain. It simply means if an occupational strain is present, then a finding of bursitis might be considered as also related to that occupational condition since it "often" occurs with a strain. Presumably, and according to Dr. Fall's testimony, bursitis would also be a sequelae of non-occupational tendonopathy, strains or rotator cuff tears.

21. The Claimant has failed to prove, by preponderant evidence, that the hazards of her employment caused, intensified, or, to a reasonable degree, aggravated the disability for which she sought compensation. There is no persuasive evidence that an occupational exposure to a hazard was a necessary precondition to the development of an occupational disease. In addition to the proof factors required for an accidental injury the "peculiar risk" test is an added factor; 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. Claimant has not met her burden of proof on this issue.

22. Finally, the Claimant has not provided any persuasive evidence that she sustained an injury to her bilateral elbows. Dr. Fall was of the opinion that it does not make any medical sense that the Claimant would sustain injury to her elbows in the epicondylar area as a result of "overcompensating" for a shoulder injury. The pain the Claimant described was caused by repetitive extension of the wrists, which is not an activity that would be performed to compensate for shoulder movements. There are no persuasive medical opinions relating this alleged condition to the Claimant's employment. Even Dr. Lichtenberg does not render an opinion that this condition is related to her work or her shoulders in any way.

23. There was no industrial injury or occupational disease that aggravated or accelerated Claimant's preexisting condition that produced disability.

Ultimate Finding

24. The Claimant has failed to carry her burden of proof, by a preponderance of the evidence of establishing a compensable injury or occupational disease. Her testimony that only Dr. Lichtenberg asked specific enough questions to elicit the memory of the mirror carrying incident is not credible considering claimant's own conflicting testimony that when the incident occurred she realized she had pushed her shoulders too far. It simply does not add up. As found above, the more likely explanation is that the Claimant "remembered" this mirror incident when multiple physicians stated opinions that her shoulder condition simply was not related to her regular work duties as a furniture salesperson. As previously found, the testimony of Dr. Fall as to the relatedness of the Claimant's condition and the likely cause of her symptoms is credible and is given more weight than that of Dr. Lichtenberg. The Claimant also failed to carry her burden for both her shoulders and her elbows, should be denied and dismissed.

CONCLUSIONS OF LAW

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). As found, the inconsistencies in Claimant's medical histories, the fact that she began claiming an occupational disease that she later "remembered" to be traceable to the specific "mirror-lifting" incident is lacking in credibility. Coupled with the fact that Dr. Lichtenberg and Dr. Morrison relied on this history in rendering work-relatedness opinions, the underpinnings of their medical opinions are undermined and rendered as lacking credibility. As found, Dr. Fall's opinion that Claimant's condition was **not** work-related is more credible than the opinions to the contrary, thus, supporting a conclusion that Claimant's condition is not work-related.

Burden of Proof

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury. §§ 8-43-201 and 8-43-210, C.R.S. (2009). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. X-ray,* 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, the Claimant has failed to meet her burden of proof.

Compensability

c. For a claim to be compensable under the Workers' Compensation Act, a claimant has the burden of proving that (s)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. (2009); *In re Swanson,* W.C. No. 4-589-645 [Industrial Claim Appeals Office (ICAO), 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, supra*; *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 ALJ. *Faulkner* at 846. As found, the Claimant has failed to establish causal relatedness to work activities.

d. The test for distinguishing between and accidental injury and an occupational disease is whether the injury can be traced to a particular time, place and cause. *Campbell v. IBM Corp.*, 867 P.2d 77, 81 (Colo. App. 1993). "Occupational disease" is defined by §8-40-201(14), C.R. S. (2009) 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.

As found, the Claimant has failed to prove an occupational disease.

e. A claimant is required to prove that the alleged occupational disease was directly or proximately caused by the employment or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251, 252 (Colo. App. 1999). Moreover, §8-40-201 (14), C.R.S. (2009), imposes proof requirements in addition to those required for an accidental

injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819, 824 (Colo. 1993). A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* This is not, however, the applicable test. §8-40-201 (14), C.R.S. (2009), imposes proof requirements for occupational diseases in addition to those required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. As found, the Claimant has not met her burden of proof on this issue.

f. If an industrial injury or occupational disease aggravates or accelerates a preexisting condition and thereby produces the disability for which compensation is sought, the respondents are liable for medical treatment necessitated by the aggravation or acceleration. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). As found, there was no industrial injury or occupational disease that aggravated or accelerated Claimant's preexisting condition that produced disability.

ORDER

IT IS, THEREFORE, ORDERED THAT: Any and all claims for workers' compensation benefits are hereby denied and dismissed.

DATED this_____day of March 2010.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-741-836

ISSUES

1 Did the claimant waive the request for ongoing medical benefits after maximum medical improvement by failing to raise it at a hearing concerning permanent partial disability benefits?

2 Was the claim for ongoing medical benefits after maximum medical improvement closed by the claimant's failure to raise it at a hearing concerning PPD benefits?

3 Are the respondents required to file a final admission of liability admitting for the impairment rating issued by the DIME physician?

4 If the claim for ongoing medical benefits is not closed, did the claimant prove by a preponderance of the evidence that he is entitled to such benefits?

FINDINGS OF FACT

On November 9, 2007, the claimant was involved in a motor vehicle accident and sustained admitted work-related injuries. After a treating physician placed the claimant at maximum medical improvement (MMI), an Application for Division Independent Medical Examination (DIME) was filed. Dr. Franklin Shih, M.D., was selected as the DIME physician.

Dr. Shih performed the DIME and on March 13, 2009 issued his DIME report. Dr. Shih found the claimant was at MMI as of September 15, 2008, with a 12% whole person impairment rating and an 8% scheduled impairment rating.

On April 2, 2009, the respondents filed an Application for Hearing listing the issues of permanent partial disability (PPD) benefits, safety rule violation, and overcoming the DIME with respect to the impairment rating. On April 7, 2009, the claimant filed a Response to Application for Hearing listing the issues of safety rule violation, overpayment, and overcoming the DIME with respect to the impairment rating. The claimant did not endorse any issues related to medical benefits. Specifically, the claimant did not list the issue of entitlement to ongoing medical benefits after MMI (*Grover* medical benefits). A hearing on these pleadings was scheduled for June 4, 2009. On May 12, 2009, the respondents filed and served on claimant's counsel a Case Information Sheet (CIS) indicating that the issues to be raised at hearing would include PPD, overcoming the DIME with respect to the impairment rating, and a safety rule violation.

After filing his Response to Application for Hearing the claimant did not file a subsequent motion to endorse the issue of *Grover* medical benefits for hearing. The claimant failed to present persuasive evidence that he took action of any kind to raise or endorse the issue of *Grover* medical benefits during the proceedings prior to the hearing.

Based on the Application for Hearing, the response and the CIS filed by the respondents, the ALJ infers that claimant and his counsel were fully apprised that the scheduled hearing would

address and finally resolve the claimant's right to PPD benefits by determining the degree of permanent impairment and the exact amount of benefits to be awarded based on the issues of safety rule violation and "overpayment."

A hearing was held before ALJ Harr on June 4, 2009. At the commencement of the hearing counsel for the respondents advised the court that the respondents considered the DIME physician's impairment rating to be correct and were no longer seeking to overcome it. Nevertheless the hearing proceeded on other issues pertinent to determining the ultimate award of permanent partial disability benefits including the alleged safety rule violation and a "credit" for previously paid temporary total disability benefits. At the hearing counsel for the claimant did not seek to add issue of *Grover* medical benefits.

On June 19, 2009, ALJ Harr entered a Corrected Summary Order resolving the issues litigated on June 4, 2009. The order addressed all issues associated with PPD benefits raised by the parties including the nature, extent and amount of the award. Specifically, ALJ Harr denied the respondents' claim that the PPD award should be reduced based on the alleged safety rule violation. However, ALJ Harr ordered that respondents should pay PPD benefits based on the DIME physician's impairment rating, but with the provision that the respondents were entitled to "offset the overpayment of $5,362.82 against permanent partial disability benefits due claimant under this order." The order also required the respondents to pay interest on past due PPD benefits.

There is no credible or persuasive evidence that the claimant sought review of ALJ Harr's order by requesting Specific Findings of Fact and Conclusions of Law. Thus, ALJ Harr's Order became final with respect to the issue of PPD benefits.

On July 9, 2009, the respondents filed a Final Payment Notice with the Division of Workers' Compensation. That Final Payment Notice delineates the basis for the PPD payments. The claimant has not filed a Petition to Reopen and reopening was not an issue at the hearing held on January 14, 2010.

On or about October 6, 2009, the claimant filed an Application for Hearing seeking an award of "medical benefits" and listing the issue of "failure to file Final Admission of Liability within 30 days of the date they failed to contest the rating." At hearing on January 14, 2010, claimant's counsel made clear that the claimant is seeking an award of *Grover* medical benefits.

CONCLUSIONS OF LAW

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

WAIVER OF RIGHT TO CLAIM GROVER MEDICAL BENEFITS

The respondents contend the evidence establishes that the claimant waived the right to claim *Grover* medical benefits by failing to raise the issue at or before the hearing held by ALJ Harr on June 4, 2009. The ALJ agrees with this contention.

Waiver is an affirmative defense to a claim for *Grover* medical benefits. Consequently, the respondents bear the burden of proof to establish that the claimant waived the right to such benefits. *See Johnson v. Industrial Commission,* 761 P.2d 1140 (Colo. 1988).

Waiver is the intentional relinquishment of a known right and may be implied when a party engages in conduct that manifests the intent to relinquish the right or acts inconsistently with its assertion. *Johnson v. Industrial Commission, supra.*

In *Hanna v. Print Expediters, Inc.,* 77 P.3d 863 (Colo. App. 2003), the court, citing *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988), and *Milco Construction v. Cowan,* 860 P.2d 539 (Colo. App. 1992), stated that “the right to future medical benefits may be waived if not requested at the time permanent disability is heard.” 77 P.2d at 866. The reason for this rule is that, although the right to medical benefits may extend beyond the date of MMI as held in *Grover*, the claimant is still required to present substantial evidence that future medical treatment will be necessary to prevent deterioration of the injury-related conditions or relieve the ongoing effects of the injury. *See Holly Nursing Care Center v. Industrial Claim Appeals Office,* 992 P.2d 707 (Colo. App. 1999). Since MMI is the date at which treatment is no longer expected to *improve* the claimant’s condition, and is also the date at which the claimant’s condition is stable and permanency may be determined, it is logical for the courts to require that the right to *Grover* medical benefits be adjudicated in connection with the hearing on PPD. *See* § 8-40-201(11.5), C.R.S.

The ALJ finds and concludes the claimant waived the right to claim *Grover* medical benefits by failing to raise it at the hearing concerning PPD held before ALJ Harr on June 4, 2009. Because the hearing held before ALJ Harr was set to address several issues underlying and pertinent to the final award PPD benefits, the claimant was required to raise and present evidence on the issue of *Grover* medical benefits or waive the issue. *Hanna v. Print Expediters, Inc., supra*. The ALJ notes that *Hanna* is a published decision that clearly established the law of this state more than five years ago. The claimant, despite receiving formal notice of the issues to be resolved at the June 4 hearing (including PPD) failed to raise the issue of *Grover* medical benefits in any pre-trial pleading or at the hearing. The fact that the respondents ultimately decided not to contest the impairment rating issued by the DIME physician did not change the ultimate issue of PPD, nor did it mislead the claimant concerning the finality of ALJ Harr's decision with respect to the PPD issue. The parties proceeded to hearing on claimant's entitlement to PPD benefits and the ALJ's Order addressed and awarded PPD benefits. The ALJ finds that because claimant did not raise the issue of *Grover* medical benefits in any pleading or at the hearing, he waived it by his conduct.

ARGUMENT THAT RESPONDENTS WERE OBLIGATED TO FILE FINAL ADMISSION OF LIABILITY

Relying principally on § 8-42-107.2(4), C.R.S., the claimant argues that the respondents were required to file a Final Admission of Liability (FAL) in order to close the issue of *Grover* medical benefits. The apparent thrust of this argument is to establish a legal basis for allowing the claimant to "contest" the FAL and obtain *Grover* medical benefits. The ALJ disagrees with this argument.

As a general matter, an order that becomes final by exhaustion of or the failure to exhaust statutory review proceedings precludes "any further proceedings to increase or decrease benefits beyond those granted by the order" absent a reopening of the award. *Feeley v. Industrial Claim Appeals Office,* 195 P.3d 1154 (Colo. App. 2008); *Peregoy v. Industrial Claim Appeals Office,* 87 P.3d 261 (Colo. App. 2004). Here, the law required the claimant to raise the issue of *Grover* medical benefits in connection with the June 2004 hearing on PPD, and the claimant's failure to do so resulted in a waiver of the right to claim such benefits. The fact that ALJ Harr's order contains a clause reserving issues not determined amounts to mere surplus in this case because the order addressed PPD and the cases cited above require a claimant to litigate the issue of *Grover* medical benefits in connection with an award of PPD benefits.

The claimant did not seek review of ALJ Harr's order as permitted by § 8-43-215, C.R.S., and it became final pursuant to §8-43-301(1), C.R.S. Therefore, the statute and interpretive cases establish that the issue of *Grover* medical benefits was closed independently of whether or not the respondents filed an FAL. Section 8-42-107.2(4) is simply irrelevant to the issue of *Grover* medicals under the facts of this case.

In any event, the ALJ concludes that § 8-42-107.2(4) and the pertinent regulations cannot be

interpreted as requiring that the respondents file an FAL under the circumstances of this case. Words in statutes should be given their plain and ordinary meanings so as to carry out the legislative intent. Further, statutes should be read in their entirety to give consistent, harmonious and sensible effect to all their parts. *Peregoy v. Industrial Claim Appeals Office, supra.*

The plain language of § 8-42-107.2(4) does not create an unending duty to file an FAL. The plain language of the statute merely provides a time line in which the insurer must elect whether to file an FAL based on the DIME physician's determinations, or seek a hearing to challenge one or more of the DIME's findings. In this case the respondents complied with the statute by requesting a hearing to challenge one or more of the findings. The fact that the respondents ultimately abandoned the challenge to the DIME does not mean that they were then required to abandon their other arguments concerning the PPD award and file an FAL.

In any event, § 8-42-107.2(4) cannot reasonably be read as requiring the respondents to file an FAL if they dispute the ultimate award of PPD benefits, but do not dispute the DIME physician's particular determinations concerning MMI and/or the impairment rating. Rather, § 8-43-207(1), C.R.S., permits a party to seek a hearing to "determine any controversy concerning any issue arising under" the Act. *See Paint Connection Plus v. Industrial Claim Appeals Office,* __ P.3d __ (Colo. App. No. 09CA0598, January 7, 2010). Reading § 8-42-107.2(4) to require the respondents to either file an FAL or contest some specific finding of the DIME might prevent the respondents from raising a number of issues related to the PPD award that have nothing to do with the DIME physician's determinations (such as a safety rule violation). Alternatively, it might encourage respondents to protect their right to raise PPD issues unrelated to the DIME by manufacturing a challenge to the DIME physician's determinations. Such an interpretation would not provide a consistent and harmonious interpretation of the Act. *See also,* WCRP 5-5 (F) (within 30 days after mailing of DIME report insurer shall admit liability consistent with report or file an application for hearing).

ORDER

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

1. The claim for *Grover* medical benefits is denied and dismissed.

2. The claimant's request that the respondents be compelled to file an FAL is denied and dismissed. The ALJ need not, and does not reach the question of whether *Grover* medical benefits would be appropriate as a substantive matter.

DATED: March 5, 2010

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-452-382

ISSUES

The issues to be determined by this decision concern medical benefits, overpayment of indemnity benefits, and recovery of overpayment. Specifically with regard to medical benefits, the issues are authorized provider, reasonably necessary and related to injury.

FINDINGS OF FACT

1. Claimant sustained a compensable injury to his back on January 22, 2000. Following a prior hearing in this matter, an Order was entered by Edwin L. Felter, Jr., Administrative Law Judge, on May 11, 2009, that Respondents pay Claimant permanent total disability benefits. Consistent with said Order, Respondents filed an Amended Final Admission of Liability on June 4, 2009 admitting liability for permanent total disability benefits and reasonable, necessary and related medical benefits.

2. Claimant continues to receive psychological treatment by John Mark Disorbio, Ed.D., has twice-weekly massage therapy sessions with Ellen Davis and sees Christopher B. Ryan, M.D., his primary authorized treating physician, for follow-up visits.

3. Dr. Ryan placed Claimant at maximum medical improvement from a physical perspective on July 3, 2007. In his physical MMI/impairment rating report, Dr. Ryan indicates that "a few more sessions with Dr. Disorbio would be appropriate [and Claimant] should continue his massage therapy with Ellen Davis weekly." Medical reports from Dr. Disorbio document 12 psychological treatment sessions from the date Claimant was declared to be at maximum medical improvement from a physical perspective through March 10, 2008.

4. A prior hearing was held before Bruce C. Friend, Administrative Law Judge, on April 22, 2008, on the issue of medical benefits, including the reasonableness and necessity of psychological treatment provided by Dr. Disorbio. The Summary Order resulting from that hearing stated, in pertinent part, as follows:

> John M. Disorbio, Ed.D. has provided psychological treatment to Claimant for a compensable injury. He began to treat Claimant in August 2004. The treatment he has provided was reasonably needed to cure and relieve Claimant from the effects of the compensable injury. However, frequent regular treatment is no longer reasonably needed. Insurer is only liable for such future treatment over the next six months as is necessary to taper Claimant from such treatment. After six months,

the only treatment that will be reasonably needed is a very occasional visit based on urgent need.

5. A review of Dr. Disorbio's reports after November 1, 2008, show that he treated Claimant on at least 18 occasions, but that the treatment Claimant received was based on an "urgent" need. The records are replete with references to Claimant's volatility, extreme anger, lack of impulse control, and inability to control his emotions. Therefore, the treatment provided by Dr. Disorbio from November 5, 2008 to September 29, 2009, is reasonable and necessary to treat Claimant for the admitted work-related injury, and Respondents are liable for the expenses associated with said treatment.

6. L. Barton Goldman, M.D., a Level II accredited physical medicine and rehabilitation specialist, performed independent medical evaluations and record reviews to provide opinion testimony on reasonably necessary maintenance care. He opined that Claimant's volatility is not under control, that his treatment with Dr. Disorbio should be discontinued, and that any future psychological treatment should be redirected under a maintenance plan that is more appropriate for the Claimant. This opinion is credible and persuasive. Respondents have proven by a preponderance of the evidence that the continued treatment provided by Dr. Disorbio is not reasonable and necessary or in Claimant's best interest. Therefore, Respondents are not responsible for Dr. Disorbio's current treatment.

7. Dr. Ryan increased the frequency of Claimant's massage therapy to twice a week in January 2008. The increased frequency was to only last one month, but there is no follow-up report by Dr. Ryan regarding frequency until a progress note dated April 2, 2009, which reads, "Stan is absolutely adamant today that the massage treatments twice a week are the only thing that keeps him going physically." Dr. Ryan testified by deposition that he may get copies of the massage therapist's reports "from time to time" and that he talked with the therapist a couple of times during the period from October 2007 through April 2009. He did not know when his last prescription for massage therapy was, noting that he did not keep track of it.

8. Dr. Goldman opined that during the period from August 1, 2006 through April 1, 2009, Claimant had 131 massage therapy sessions with Ellen Davis, 82 of which occurred after Claimant was placed at physical MMI on July 3, 2007. He opined that some sessions of massage therapy would be considered reasonably necessary, but that 82 sessions since MMI would be an extraordinary number for maintenance care. He observed that Dr. Ryan had not met the requirement of providing documentation and rationalization for this extraordinary number of massage therapy sessions. Dr. Goldman opined that it is extremely important for the primary authorized treating physician to communicate with a massage therapist and correlate with particular treatment goals to see if they are being attained. There is no evidence to support massage therapy as being physically therapeutic to Claimant, according to Dr. Goldman. He opined, however, that there might be times in the future where limited massage therapy would be appropriate. Dr. Goldman's opinion is credible and persuasive on this issue. Respondents have proven by a preponderance of the evidence that Claimant's twice weekly

massage therapy sessions with Ellen Davis are not reasonable and necessary, and they are not responsible for these massage therapy sessions.

9. Dr. Ryan's post physical-MMI treatment plan on July 3, 2007, was to continue Claimant on Avinza, Dilaudid, Lamictal, Valium and Ambien CR, in addition to psychological counseling sessions with Dr. Disorbio and massage therapy with Ellen Davis. According to Dr. Ryan's deposition testimony, he is currently prescribing Claimant 90mg of Avinza (oral morphine) twice a day, 8mg of Dilaudid four times a day, 10mg of Valium four times a day, 200mg of Provigil once a day and 10g of Kristalose once a day. He also endorsed ongoing massage therapy twice a week and supportive psychotherapy by Dr. Disorbio as part of medical maintenance.

10. Dr. Goldman opined that if Claimant's pain medications were effective and appropriate, his pain level would be less. He noted that Claimant has not shown any improvement or stabilization. According to Dr. Goldman, Claimant's condition seems to be worsening. He agrees with Dr. Robert Kleinman (IME psychiatrist, who also testified) that the opioids, benzodiazepines, muscle relaxants and medical marijuana are substantially contraindicated in the treatment of this Claimant, that Claimant's pain complaints are between 7-9/10, even though he is at twice the threshold of narcotic analgesics, and that Claimant's current morphine equivalent dose is more than two times what it was when he started treating with Dr. Ryan. Dr. Goldman opined that the treatment plan of Dr. Ryan and Dr. Disorbio is not helping the Claimant, but actually worsening his condition; that Claimant, in a rehabilitative or inpatient detox setting, needs to be weaned off his opioids to, at the very minimum, about half the total dosage that he is receiving presently; and that the medical marijuana needs to be weaned and discontinued, as it is "probably making [Claimant's] moods, anger and volatility more polarized and aggravated." Dr. Goldman's opinions are credible and persuasive. The treatment plan recommended by Dr. Goldman is reasonable and necessary and related to Claimant's admitted injuries. The medical maintenance plan prescribed by Dr. Ryan is not reasonable and necessary and not in Claimant's best interests. Respondents are not responsible for Dr. Ryan's treatment under his current medical maintenance plan.

11. When Claimant relocated to Arizona, Dr. Ryan referred him to Dr. Allen Corbett. Dr. Corbett in turn referred Claimant to a pain specialist, Dr. Pattabi Kalyanam for chronic pain management. Dr. Corbett also referred Claimant to Bronson Chiropractic for massage therapy. These providers are within the chain of referral and are authorized. Respondent shall pay their expenses. At the December 3, 2009 hearing, the parties stipulated that Dr. Stephen Borowsky is designated as the authorized treating physician in Arizona.

12. Respondents are not responsible for the emergency room charges from Swedish Medical Center on June 5, 2009. Claimant presented to the emergency department at Swedish Medical Center on that date with a chief complaint of lower extremity pain. He reported right leg swelling in calf and pain of 4 hours duration. The clinical impression was right

lower leg pain/ strained right calf. There are no credible and persuasive records from Swedish Medical Center, Dr. Christopher Ryan or any other medical provider to suggest that the emergency room visit was in any way related to the on-the-job injury that Claimant sustained on January 22, 2000.

13. In February 2002, the parties reached an agreement whereby Claimant's average weekly wage was $671.80 and TTD rate was $447.87 beginning February 5, 2002. For an unknown reason, the prior insurance carrier, which was later ordered liquidated, began paying TTD at the rate of $559.23. This TTD rate is incorrect. Upon liquidation of the prior carrier, the Colorado Insurance Guaranty Association through Western Guaranty Fund Services began adjusting the claim and continued paying Claimant at the incorrect TTD rate of $559.23 until April 3, 2005. The claims examiner from Western Guaranty Fund Services, Michael Kramish, testified that due to the volume of new files when an insurer is liquidated and in an effort to keep indemnity benefits flowing to the injured worker, the Guaranty Association routinely continues paying indemnity benefits at the same rate as the insolvent insurer. However, once the error was discovered, Colorado Insurance Guaranty Association, through Western Guaranty Fund Services, filed an Amended General Admission of Liability on April 6, 2005, claiming an overpayment of $18,465.05 and stating, "We will take this overpayment from any future permanent disability assigned." No objection was filed to the Amended General Admission of Liability.

14. On June 4, 2009, Colorado Insurance Guaranty Association, through Western Guaranty Fund Services, filed an Amended Final Admission of Liability for permanent total disability consistent with ALJ Edwin Felter's Order dated May 11, 2009. The Amended Final Admission reflects an overpayment with an explanation on page 2 as to how the overpayment was calculated. Mr. Kramish testified that he calculated the indemnity benefit due to the Claimant retroactive to the date of loss in January 2000. He then calculated the total indemnity benefits paid by Fremont Indemnity and Colorado Insurance Guaranty Association. Subtracting Claimant's entitlement to indemnity benefits of $180,653.20 for TTD, TPD and PTD through August 17, 2008 from the total paid by Respondents for that period of time ($197,111.57), he noted an overpayment of $16,458.34. Due to error, mistake or inadvertence, Claimant has been overpaid and unjustly enriched in the amount of $16,458.34. Respondents are entitled to recover the overpayment at the rate of $25.00 per week.

15. On January 15, 2006, Claimant was awarded Social Security Disability benefits. According to the Notice of Award attached to the January 26, 2006 Amended General Admission of Liability, Claimant began receiving SSD in the amount of $1,127.40 beginning June 2003 and a lump sum payment of $30,599.00 on January 21, 2006, which represented money due for June 2003 through December 2005. Respondents are entitled to the SSD offset and have taken the offset as indicated in the January 26, 2006 Amended General Admission of Liability and subsequent Final Admission of Liability.

CONCLUSIONS OF LAW

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

B. 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).

C. Respondents are liable for medical treatment that is reasonably necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. See *Colorado Compensation Insurance Authority v. Nofio*, 886 P.2d 714 (Colo. 1994); Snyder v. Industrial Claim Appeals Office, 942 P.2d 1337 (Colo. App. 1997). Claimant bears the burden of proof to establish the right to specific medical benefits by a preponderance of the relevant evidence. See Valley Tree Service v. Jimenez, 787 P.2d 658 (Colo. App 1990). A determination of whether a particular treatment is reasonable and necessary to treat the industrial injury is a question of fact for the ALJ, and the ALJs resolution should not be disturbed if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. See *City and County of Denver School District 1 v. Industrial Commission*, 682 P.2d 513 (Colo. App. 1984). Substantial evidence is that quantum of probative evidence that a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence. *Durocher v. Industrial Claim Appeals Office*, 905 P.2d 4 (Colo. App. 1995).

D. "Authorization" refers to the physician's legal status to treat the injury at the Respondents' expense. Popke v. Industrial Claim Appeals Office, 944 P.2d 677(Colo. App. 1997). A referral by an authorized treating physician to another medical provider makes the provider to whom the Claimant was referred an authorized treater as well.

E. An "overpayment" includes money received by a claimant that exceeds the amount that should have been paid or that the claimant was not entitled to receive. Section 8-40-201(15.5), C.R.S. Respondents have the burden of proving an entitlement to recover an overpayment Rocky Mountain Cardiology v. ICAO, 94 P.3d 1182, 1186 (Colo. App. 2004). Under Section 8-43-207(1)(a), C.R.S., the ALJ is empowered to require repayments of overpayments.

F. The evidence establishes that the psychological treatment provided by Dr. Disorbio from November 5, 2008 to September 29, 2009 is reasonable and necessary to treat Claimant for the admitted work-related injury. Therefore, Respondents are responsible for the expenses associated with that treatment.

G. The Respondents have proven by a preponderance of the evidence that treatment by Dr. Disorbio after September 29, 2009, is not reasonable and necessary or in Claimant's best interest. Therefore, Respondents are not responsible for this treatment.

H. Respondents have proven by a preponderance of the evidence that Claimant's twice-weekly massage therapy sessions with Ellen Davis are not reasonable and necessary. Therefore, Respondents are not responsible for the twice-weekly massage therapy sessions with Ellen Davis.

I. Respondents have proven by a preponderance of the evidence that the medical maintenance plan prescribed by Dr. Ryan is not reasonable and necessary and not in Claimant's best interest. Therefore, Respondents are not responsible for Dr. Ryan's treatment under his current medical maintenance plan. To the contrary, Respondents have proven by a preponderance of the evidence that the treatment plan recommended by Dr. Goldman is reasonable and necessary and related to Claimant's admitted injuries.

J. Claimant has failed to prove by a preponderance of the evidence that the emergency room charges that he incurred from Swedish Medical Center on June 5, 2009, are related in any way to the on-the-job injury that he sustained on January 22, 2000. Therefore, Respondents are not responsible for these emergency room charges.

K. Claimant was referred by Dr. Ryan, an authorized treating physician, to Dr. Allen Corbett, Dr. Pattabi Kalyanam and Bronson Chiropractic. As such, these providers are within the chain of referral and are authorized. Therefore, Respondents shall pay their expenses. The parties subsequently stipulated that Dr. Stephen Borowsky is designated as the authorized treating physician in Arizona. Therefore, Respondents are responsible for Dr. Borowsky's expenses as well.

L. Respondents have proved by a preponderance of the evidence that, due to error, mistake or inadvertence, Claimant has been overpaid and unjustly enriched in the amount of $16,458.34. Respondents are entitled to recover this overpayment at the rate of $25.00 per week by reducing ongoing permanent total disability benefits until said overpayment is fully recovered.

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

ORDER

It is therefore ordered that:

a. Respondents are liable for the psychological treatment Claimant received from Dr. Disorbio during the period from November 5, 2008 to September 29, 2009. Respondents are not liable for treatment provided by Dr. Disorbio after September 29, 2009.

b. Respondents are not liable for Claimant's twice-weekly massage therapy sessions with Ellen Davis.

c. Respondents are not liable for treatment by Dr. Ryan under his current medical maintenance plan. Respondents are liable for medical care Claimant receives pursuant to the treatment plan recommended by Dr. Goldman.

d. Respondents are not liable for the emergency room charges from Swedish Medical Center on June 5, 2009.

e. Respondents are liable for expenses associated with treatment provided by Dr. Allen Corbett, Dr. Pattabi Kalyanam, Dr. Stephen Borowsky and Bronson Chiropractic.

f. Respondents shall recover their overpayment of $16,458.34 by reducing Claimant's periodic permanent total disability benefits by the amount of $25.00 per week until the overpayment is fully recovered.

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

DATED: March 5, 2010

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-779-083

ISSUES

Claimant filed an Application for Hearing requesting a hearing on compensability, medical benefits and several additional issues.

Based upon the conclusion below that the claim is not compensable, the ALJ does not address the other issues.

FINDINGS OF FACT

1. Claimant provided six exhibits for consideration. None of the exhibits were specifically relevant to the issue as to whether or not the Claimant had any injury that arose out of and in the course of his employment with Respondent-Employer.

2. There were no contemporaneous medical records provided by Claimant that had any relevance to an injury that would have arisen out of and in the course of his employment with the Respondent-employer.

3. Claimant testified on his own behalf. He testified that the Respondent-Employer lost his file with all of the information in it. He stated that Dr. Charles Johnson was his doctor.

4. Claimant testified that he was terminated because he wanted the kitchen to be clean. He cannot understand why a company wouldn't help you when you are in crisis.

5. At the conclusion of Claimant's case, Respondents moved for a directed verdict.

CONCLUSIONS OF LAW

1. The Claimant has the burden of proving by a preponderance of evidence that he sustained an injury arising out of an in the course of his employment with Respondent-Employer. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985).

2. The Claimant did not address the fundamental issues to show that he had an injury that arose out of and in the course of his employment with Respondent-Employer.

3. As the Claimant failed to bring forth sufficient evidence for a prima facie case, this Administrative Law Judge is constrained to grant the motion for a directed verdict and dismiss the case.

ORDER

It is therefore ordered that: Claimant's request for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

DATE: March 8, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-621-871

ISSUES

1. Whether Claimant has demonstrated by a preponderance of the evidence that her emergency room visits on July 22, 2007, February 17, 2009 and February 23, 2009 were reasonable and necessary to cure or relieve the effects of her industrial injury.

2. Whether Claimant has presented substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of her industrial injury or prevent further deterioration of her condition pursuant to *Grover v. Industrial Comm'n.,* 759 P.2d 705 (Colo. 1988).

STIPULATION

The parties agreed that Respondents will be financially responsible for all of Claimant's emergency room visits for her right ankle condition with the exception of the following: (1) North Colorado Medical Center on July 22, 2007; and (2) McKee Medical Center on February 17, 2009 and February 23, 2009.

FINDINGS OF FACT

1. On August 24, 2004 Claimant suffered an admitted industrial injury to her right ankle during the course and scope of her employment with Employer.

2. On November 5, 2004 Claimant underwent right lateral ligament reconstruction surgery. On March 15, 2005 she underwent an arthroscopic debridement to repair her right ankle condition.

3. On August 9, 2005 Authorized Treating Physician (ATP) Roger Sobel, M.D. concluded that Claimant had reached Maximum Medical Improvement (MMI). He assigned her a 14% right lower extremity impairment rating and noted "no further treatment is planned in the foreseeable future."

4. On March 21, 2006 Claimant underwent a Division Independent Medical Examination (DIME) with Robert I. Kawasaki, M.D. Dr. Kawasaki agreed that Claimant had reached MMI on August 9, 2005 and assigned a 10% right lower extremity impairment rating. He recommended one year of Ibuprofen for Claimant and remarked that she did not require any additional diagnostic workup.

5. On August 27, 2008 Respondents filed an Amended Final Admission of Liability (AFAL) consistent with Dr. Kawasaki's MMI and impairment determinations. The AFAL also

specified that Claimant would “need to continue range of motion and strengthening for the right ankle and Ibuprofen on an as needed basis.”

6. Claimant testified that as a result of her industrial injury she has suffered chronic pain, swelling and weakness in her right ankle. She explained that her right ankle folds underneath her foot after walking for a few steps. Claimant remarked that her right ankle condition has required her to make numerous emergency room visits.

7. The medical records reveal that Claimant visited emergency rooms on July 15, 2004, December 25, 2005, December 29, 2005, June 12, 2006, April 16, 2007, July 22, 2007, February 15, 2009, February 17, 2009, February 23, 2009, August 20, 2009 and September 15, 2009. With the exception of Claimant’s emergency room visits on July 22, 2007, February 17, 2009 and February 23, 2009 Respondents did not dispute that Claimant’s treatment was reasonable and necessary to cure or relieve the effects of her industrial injury.

8. On July 22, 2007 Claimant sought medical treatment at North Colorado Medical Center for a right thigh strain and sacrum contusion. Claimant explained that she suffered her injuries when she stepped into an open space on the deck of her home. She commented that an electrician had removed the rear deck steps when working on her residence. Upon realizing that the steps had been moved Claimant attempted to stop walking but her right ankle gave out. She then fell into the area where the steps had been located.

9. On February 17, 2009 Claimant visited McKee Medical Center because of right leg swelling and pain. She was diagnosed with cellulitis in her right leg. Physicians prescribed several medications to combat the infection that was causing the condition. On February 23, 2009 Claimant again visited McKee Medical Center for continued cellulitis symptoms. Claimant explained that physicians advised her that she suffered from cellulitis because of chronic right ankle swelling and decreased circulation in the area.

10. Claimant has demonstrated that it is more probably true than not that her emergency room visits on July 22, 2007, February 17, 2009 and February 23, 2009 were reasonable and necessary to cure or relieve the effects of her industrial injury. Claimant credibly testified that she has suffered chronic pain, swelling and weakness in her right ankle. She specifically remarked that on July 22, 2007 she suffered a right thigh strain and sacrum contusion when she stepped into an open space on the deck of her home. Claimant commented that an electrician had removed the rear deck steps when working on her residence. Upon realizing that the steps had been moved Claimant attempted to stop walking but her right ankle gave out. She then fell into the area where the steps had been located. On February 17, 2009 and February 23, 2009 Claimant visited McKee Medical Center because of cellulitis in her right leg. Claimant credibly commented that physicians advised her that she suffered from cellulitis because of chronic right ankle swelling and decreased circulation in the area. Claimant has thus established that her emergency room visits on July 22, 2007, February 17, 2009 and February 23, 2009 were reasonable, necessary and related to her August 24, 2004 industrial injury.

11. Claimant has presented substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of her industrial injury or prevent further deterioration of her condition. She credibly testified that as a result of her industrial injury she has suffered chronic pain, swelling and weakness in her right ankle. Claimant explained that her right ankle folds underneath her foot after walking for a few steps. She remarked that her right ankle condition has required her to make numerous emergency room visits. The medical records support Claimant's testimony and reveal that she was evaluated at emergency rooms on numerous occasions between 2004 and 2009 for right ankle symptoms. Claimant thus requires medical maintenance treatment for her right ankle condition. She is entitled to a general award of future medical benefits subject to Employer's right to contest compensability, reasonableness and necessity.

CONCLUSIONS OF LAW

1. 1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

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. As found, Claimant has demonstrated by a preponderance of the evidence that her emergency room visits on July 22, 2007, February 17, 2009 and February 23, 2009 were reasonable and necessary to cure or relieve the effects of her industrial injury. Claimant credibly testified that she has suffered chronic pain, swelling and weakness in her right ankle. She specifically remarked that on July 22, 2007 she suffered a right thigh strain and sacrum contusion when she stepped into an open space on the deck of her home. Claimant commented that an electrician had removed the rear deck steps when working on her residence. Upon realizing that the steps had been moved Claimant attempted to stop walking but her right ankle gave out. She then fell into the area where the steps had been located. On February 17, 2009 and February 23, 2009 Claimant visited McKee Medical Center because of cellulitis in her right leg. Claimant credibly commented that physicians advised her that she suffered from cellulitis because of chronic right ankle swelling and decreased circulation in the area. Claimant has thus established that her emergency room visits on July 22, 2007, February 17, 2009 and February 23, 2009 were reasonable, necessary and related to her August 24, 2004 industrial injury.

Grover Medical Benefits

6. To prove entitlement to medical maintenance benefits, a claimant must present substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of the industrial injury or prevent further deterioration of her condition. *Grover v. Industrial Comm'n.,* 759 P.2d 705, 710-13 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609, 611 (Colo. App. 1995). Once a claimant establishes the probable need for future medical treatment she "is entitled to a general award of future medical benefits, subject to the employer's right to contest compensability, reasonableness, or necessity." *Hanna v. Print Expediters, Inc.*, 77 P.3d 863, 866 (Colo. App. 2003); *see Karathanasis v. Chilis Grill & Bar,* W.C. No. 4-461-989 (ICAP, Aug. 8, 2003). Whether a claimant has presented substantial evidence justifying an award of *Grover* medical benefits is one of fact for determination by the Judge. *Holly Nursing Care Center v. Industrial Claim Appeals Office,* 919 P.2d 701, 704 (Colo. App. 1999).

7. As found, Claimant has presented substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of her industrial injury or prevent further deterioration of her condition. She credibly testified that as a result of her industrial injury she has suffered chronic pain, swelling and weakness in her right ankle. Claimant explained that her right ankle folds underneath her foot after walking for a few steps. She remarked that her right ankle condition has required her to make numerous emergency room visits. The medical records support Claimant's testimony and reveal that she was evaluated at emergency rooms on numerous occasions between 2004 and 2009 for right ankle symptoms. Claimant thus requires medical maintenance treatment for her right ankle condition. She is entitled to a general award of future medical benefits subject to Employer's

right to contest compensability, reasonableness and necessity.

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 emergency room visits on July 15, 2004, December 25, 2005, December 29, 2005, June 12, 2006, April 16, 2007, July 22, 2007, February 15, 2009, February 17, 2009, February 23, 2009, August 20, 2009 and September 15, 2009.

2. Claimant shall receive medical maintenance benefits that are reasonably necessary to relieve the effects of her industrial injury or prevent further deterioration of her condition.

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

DATED: March 8, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-801-210

ISSUES

1 Did the claimant prove by a preponderance of the evidence that he sustained an injury that was proximately caused by an injury arising out of and in the course of his employment as a truck driver?

2 Did the claimant prove by a preponderance of the evidence that the need for surgery and alleged disability was proximately caused by the alleged injury?

3 Did the claimant prove by a preponderance of the evidence that he is entitled to an award of temporary total disability benefits commencing August 17, 2009?

FINDINGS OF FACT

Prior to being hired by the employer on or about June 9, 2009, the claimant was employed by -

EF-, Inc. as a truck driver. While employed by -EF-, Inc., the claimant sustained a work-related injury on May 5, 2009, when he fractured his ankle and rolled on his left shoulder.

Immediately after being hired by the employer the claimant underwent a three-day orientation that included discussions on safety and the reporting of injuries. During this orientation the employer stressed the importance of reporting work-related injuries immediately. The claimant was provided a 24-hour cell phone number to report an injury.

Generally, the claimant testified that the employer assigned him to drive a truck with a rough suspension, and that ride caused his body to jerk forwards and backwards, especially on roads with uneven surfaces. However, the claimant admitted that the truck he drove was “very new,” and that the truck had a “shock absorbing system built into the seat” and a lumbar back support.

The claimant testified that on July 13, 2009, he was driving the truck near Lincoln, Nebraska when he began to experience left shoulder pain and pain down his arm. The claimant further testified that on July 26, 2009, while at the employer’s base in Greeley, Colorado, he advised a supervisor that the truck produced a rough ride and that he was experiencing shoulder pain down into his arm. According to the claimant he asked whether an adjustment could be made to the truck, but none was made. The claimant recalled that he was dispatched to Utah and then to Phoenix, Arizona. According to the claimant’s testimony he drove over a rough road on the way to Phoenix and experienced a severe increase in his pain. Following this incident the claimant drove on to California.

On or about July 29, 2009, the claimant contacted the employer’s HR director, -FG-, by telephone. He advised Ms. -FG- that he began feeling pain in his shoulder and into his arm that he attributed to “the rough ride on the truck.” However, he also stated he was going to see a doctor that treated him for the May 2009 injury because he believed “this injury is a result of my first injury.”

On July 31, 2009, while in California, the claimant first sought chiropractic treatment from Dr. Shelly Webb, D.C. The claimant advised Dr. Webb that he had severe neck pain radiating down his left arm and shoulder blade. According to the claimant this pain began after he “had a rough ride in his PeterBilt truck which rocked him in his seat violently, whipping is head and neck back and forth.” Dr. Webb noted that, according to the claimant, “his illness began on June 30, 2009.” In her report dated October 30, 2009, Dr. Webb expressed the opinion that the claimant’s “injury” was “sustained most likely as a result of the jarring motion of the truck seat he was in.”

Over the life of this claim the claimant has provided inconsistent histories to various medical providers concerning when he first experienced the symptoms that he now attributes to operation of the truck. As found, the claimant told Dr. Webb “the illness began on June 30, 2009.” The claimant told Dr. Charbonneau “he had the onset of symptoms on July 13, 2009.” He told Dr. Rivas-Gotz that, “after 10 weeks . . . he developed those symptoms in his neck.” Ten weeks after claimant’s hire date would be the end of August 2009. Additionally, the claimant reported to Dr. Zeltwanger that his pain started while “driving a truck with a rough ride at the end of July.” The claimant’s testimony and reports of when and how his symptoms began are inconsistent and not persuasive. To the extent the claimant’s evidence and

testimony suggests his neck and upper extremity injuries occurred on or about July 13, 2009, as a result of driving a truck with a rough suspension and ride, that evidence is not credible or persuasive.

The weight of the medical evidence does not support a finding that claimant's neck and upper extremity conditions are related to the operation of the truck. The claimant's conditions are degenerative in nature as supported by the radiological studies. The claimant did not sustain acute changes or a traumatic injury. The claimant's neck and upper extremity problems were not altered by a work-related incident. To the extent other reports or testimony suggest that claimant's neck and upper extremity conditions are work-related, those reports and testimony are rejected as unpersuasive.

Dr. Michael Rauzzino, M.D., a board-certified neurosurgeon, opined that there is "nothing to suggest, with any degree of medical certainty, that this is a work-related condition." In support of this opinion, Dr. Rauzzino cited claimant's delay in reporting the symptoms and the fact that the MRI study shows chronic changes with no acute disc herniation. He further opined that "bouncing on a bumpy road" is not the type of mechanism of injury sufficient to have caused the need for surgery. Dr. Rauzzino's opinions are credible and persuasive and the ALJ credits the opinions of Dr. Rauzzino that claimant's condition is not work-related and the alleged mechanism of injury is insufficient to have caused the need for surgery.

Dr. Michael Tracy, D.O., reviewed the MRI results and stated that he did not see "any signs of acute changes suggesting an annular tear or acute herniation of discs." Dr. Tracy opined that the "spondylosis and facet arthropathy are most likely responsible" for the claimant's condition and are from a lifetime of accumulation of wear and tear on claimant's neck and "not related to a rough patch of road." Dr. Tracy stated that "[c]ausally, I would not say that the radicular symptoms can be attributed to his truck driving vocation" and that "I reviewed with [claimant] that these neck changes are of chronic nature and therefore not causally related." Dr. Tracy's opinion that claimant's condition is "not related to a rough patch of road" is credible and persuasive and the ALJ credits the opinion of Dr. Tracy that claimant's condition is not work-related. To the extent any other parts of Dr. Tracy's reports could be construed as support for the assertion that claimant's neck and upper extremity conditions are work-related, those aspects of the reports are rejected as unpersuasive.

On October 2, 2009, Dr. Gregory Bedynek, D.O., performed a cervical fusion surgery on the claimant. Dr. Bedynek stated that he had no opinion concerning whether or not claimant's "cervical spine injuries" and need for surgery were caused by "driving over rough roads," and further stated that he "does not address causation related to workmans [sic] comp cases." Dr. Bedynek did not opine whether claimant's condition is work-related; therefore, his opinion is not persuasive.

Dr. Webb's opinion that claimant sustained his injury due to the jarring motion of the truck seat is not persuasive. Dr. Webb saw the claimant on only one occasion and did not view the subsequent MRI results. Dr. Webb's opinion is based significantly on claimant's own report of the mechanism of injury and the ALJ finds claimant's report not credible and persuasive.

Dr. Rivas-Gotz stated in a note dated October 15, 2009 that he could "make no conclusive

statements" concerning the cause of claimant's condition, although he had "some suspicion" that it was related to driving a truck. Dr. Rivas-Gotz was provided a "yes" or "no" questionnaire by claimant's counsel. It appears Dr. Rivas-Gotz initialed the box denying a causal relationship; however, an arrow is drawn to the "yes" box indicating that he believed driving a truck caused claimant's condition. No explanation was provided for Dr. Rivas-Gotz's apparent change of opinion. Dr. Rivas-Gotz's opinion is not persuasive. To the extent other testimony or reports suggest claimant's alleged neck and upper extremity conditions are related to his employment, those reports and testimony are rejected as unpersuasive.

The claimant failed to prove it is more probably true than not that he sustained any neck or upper extremity injuries caused or aggravated by the operation of the truck while working for the employer. As found, the claimant's testimony concerning the onset of his symptoms and their relationship to operation of the truck is inconsistent and not credible and persuasive. Moreover, the weight of the medical evidence establishes that the claimant's symptoms are the product of an ongoing degenerative process unrelated to operation of the truck. The opinion of Dr. Rauzzino that the claimant's symptoms are not related to the operation of the truck is credible and persuasive, and given substantial weight by the ALJ. Dr. Tracy's opinions substantially corroborate those of Dr. Rauzzino. Also, for the reasons stated above, the contrary opinions of Dr. Webb and Dr. Rivas-Gotz are not persuasive.

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. X-ray*, 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

The claimant alleges that he proved by a preponderance of the evidence that the rough suspension of the truck caused movement of his head and neck so as to cause or aggravate a pre-existing spine condition, and that this spinal condition is the cause of his need for surgery and the alleged disability. The ALJ disagrees.

The claimant is required to prove by a preponderance of the evidence that the conditions for which he seeks disability benefits and medical treatment were proximately caused by an injury or occupational disease arising out of and in the course of the employment. § 8-41-301(1)(c), C. R.S. The claimant must prove a causal nexus between the claimed disability and the work-related injury. *Singleton v. Kenya Corp.*, 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office*, 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). However, the mere occurrence of symptoms at work does not require the ALJ to conclude that the duties of employment caused the symptoms, or that the employment aggravated or accelerated any pre-existing condition. Rather, the occurrence of symptoms at work may represent the result of or natural progression of a pre-existing condition that is unrelated to the employment. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1995); *Cotts v. Exempla, Inc.*, W.C. No. 4-606-563 (August 18, 2005). 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 14, the ALJ concludes the claimant failed to prove it is more probably true than not that operation of the truck caused the claimant's condition, or aggravated a pre-existing condition so as to result in the disability and need for treatment. As found, the claimant's testimony relating the onset of the symptoms to the operation of the truck is not credible and persuasive. Moreover, the medical evidence establishes that it is more likely than not that the claimant's symptoms are the result of the natural progression of his degenerative condition, not operation of the truck. The claim for benefits in WC 4-801-210 must be denied and dismissed. In light of this determination the ALJ need not address other issues raised by the parties

ORDER

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

The claim for workers' compensation benefits is WC 4-801-210 is denied and dismissed.

DATED: March 9, 2010

David P. Cain

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-802-152

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she suffered injuries to her right shoulder and neck during the course and scope of her employment with Employer on June 15, 2009.

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

FINDINGS OF FACT

1. Claimant worked as a Client Care Aide for Employer at the Wheatridge Regional Center. On June 15, 2009 Claimant was cleaning an overhead cabinet. She explained that while reaching overhead she felt a "pop" in her right shoulder and experienced pain in her trapezius region that radiated into her neck area. She immediately suffered numbness and tingling in her right forearm and fingers.

2. On June 17, 2009 Claimant visited Concentra Medical Centers for treatment. She was diagnosed with a right shoulder strain. Claimant subsequently received conservative medical treatment.

3. On August 24, 2009 Claimant visited Robert I. Kawasaki, M.D. for a physical medicine consultation. Dr. Kawasaki recounted that Claimant had undergone an MRI of her right shoulder. The MRI was normal. An MRI of Claimant's cervical spine revealed multilevel degenerative changes and a disc herniation at C6-C7. Dr. Kawasaki noted that Claimant's work activities caused a shoulder injury but her workup had not reflected any "significant shoulder pathology." However, he concluded that there was no causal connection between Claimant's cabinet cleaning activities on June 15, 2009 and the disc herniation in her cervical spine.

4. On August 31, 2009 Claimant visited Authorized Treating Physician (ATP) John Burris, M.D. for an evaluation. She reported pain throughout her neck that extended into both arms. Dr. Burris noted that Claimant's description of her symptoms was "nonphysiologic" and did not "follow any known neuroanatomical pathways." He agreed with Dr. Kawasaki that Claimant's overhead cleaning activities could have caused a right shoulder injury but both her right shoulder MRI and examination were completely normal. Dr. Burris also concurred with Dr.

Kawasaki that Claimant's pain complaints originated from her neck and were not causally connected to the June 15, 2009 industrial incident. He thus determined that Claimant had reached Maximum Medical Improvement (MMI) with no restrictions or impairment.

5. On November 20, 2009 Claimant visited William S. Shaw, M.D. for an independent medical evaluation. Dr. Shaw prepared a report and testified at the hearing in this matter. After reviewing the medical records and conducting a physical examination, he explained that Claimant suffers from the unrelated clinical diagnoses of a right shoulder sprain and cervical pathology.

6. In addressing the cause of Claimant's right shoulder symptoms, Dr. Shaw remarked that the localization of Claimant's pain and medical records suggested that Claimant's right AC joint constituted the source of her pain. He thus determined that Claimant suffered a minor sprain of the right AC joint during the course and scope of her employment with Employer on June 15, 2009. However, Dr. Shaw persuasively concluded that Claimant's right AC joint sprain had stabilized and she did not require additional medical treatment. He concurred that Claimant had reached MMI on August 31, 2009.

7. In considering Claimant's cervical pathology, Dr. Shaw determined that Claimant suffers from a chronic condition that occurred over a number of years. After reviewing Claimant's cervical MRI, Dr. Shaw remarked that she suffers from multilevel cervical spondylosis and a disc protrusion. He explained that the degenerative changes in Claimant's cervical spine were "almost certainly not the result of work activities in general or the specific activities performed on June 15, 2009." Dr. Shaw thus concurred with doctors Burris and Kawasaki that Claimant's neck symptoms arose from cervical pathology. He concluded that Claimant's work activities on June 15, 2009 did not cause, aggravate or accelerate her cervical condition.

8. Claimant has established that it is more probably true than not that she injured her right shoulder during the course and scope of her employment with Employer on June 15, 2009. Doctors Kawasaki, Burris and Shaw concluded that Claimant experienced a right shoulder strain on June 15, 2009 but both her right shoulder MRI and examinations did not reflect any significant shoulder pathology. Dr. Burris thus determined that Claimant reached MMI on August 31, 2009 with no restrictions or impairment. Dr. Shaw concurred with Dr. Burris' MMI and impairment determinations. He persuasively concluded that Claimant's right AC joint sprain had stabilized and she did not require additional medical treatment. Accordingly, Claimant is not entitled to additional medical treatment for her right shoulder.

9. Claimant has failed to demonstrate that it is more probably true than not that she suffered a compensable neck injury during the course and scope of her employment with Employer on June 15, 2009. Her employment activities on June 15, 2009 did not aggravate, accelerate, or combine with her degenerative cervical condition to produce a need for medical treatment. An MRI of Claimant's cervical spine revealed multilevel degenerative changes and a disc herniation at C6-C7. Dr. Kawasaki concluded that there was no causal connection between Claimant's cabinet cleaning activities on June 15, 2009 and the disc herniation in her

cervical spine. ATP Dr. Burris concurred with Dr. Kawasaki that Claimant's pain complaints originated from her neck and were not causally connected to the June 15, 2009 industrial incident. Finally, Dr. Shaw persuasively explained that Claimant suffers from a chronic, degenerative cervical condition that occurred over a number of years. After reviewing Claimant's cervical MRI, Dr. Shaw remarked that she suffers from multilevel cervical spondylosis and a disc protrusion. He commented that the degenerative changes in Claimant's cervical spine were "almost certainly not the result of work activities in general or the specific activities performed on June 15, 2009." Dr. Shaw thus concluded that Claimant's work activities on June 15, 2009 did not cause, aggravate or accelerate her cervical 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 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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

Compensability

4. For 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 established by a preponderance of the evidence that she injured her right shoulder during the course and scope of her employment with Employer on June 15, 2009. Doctors Kawasaki, Burris and Shaw concluded that Claimant experienced a right shoulder strain on June 15, 2009 but both her right shoulder MRI and examinations did not reflect any significant shoulder pathology. Dr. Burris thus determined that Claimant reached MMI on August 31, 2009 with no restrictions or impairment. Dr. Shaw concurred with Dr. Burris' MMI and impairment determinations. He persuasively concluded that Claimant's right AC joint sprain had stabilized and she did not require additional medical treatment. Accordingly, Claimant is not entitled to additional medical treatment for her right shoulder.

7. As found, Claimant has failed to demonstrate by a preponderance of the evidence that she suffered a compensable neck injury during the course and scope of her employment with Employer on June 15, 2009. Her employment activities on June 15, 2009 did not aggravate, accelerate, or combine with her degenerative cervical condition to produce a need for medical treatment. An MRI of Claimant's cervical spine revealed multilevel degenerative changes and a disc herniation at C6-C7. Dr. Kawasaki concluded that there was no causal connection between Claimant's cabinet cleaning activities on June 15, 2009 and the disc herniation in her cervical spine. ATP Dr. Burris concurred with Dr. Kawasaki that Claimant's pain complaints originated from her neck and were not causally connected to the June 15, 2009 industrial incident. Finally, Dr. Shaw persuasively explained that Claimant suffers from a chronic, degenerative cervical condition that occurred over a number of years. After reviewing Claimant's cervical MRI, Dr. Shaw remarked that she suffers from multilevel cervical spondylosis and a disc protrusion. He commented that the degenerative changes in Claimant's cervical spine were "almost certainly not the result of work activities in general or the specific activities performed on June 15, 2009." Dr. Shaw thus concluded that Claimant's work activities on June 15, 2009 did not cause, aggravate or accelerate her cervical 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: March 9, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-809-499

ISSUES

Whether Claimant has proven by a preponderance of the evidence that she sustained a compensable injury on November 9, 2009.

Whether Claimant is entitled to an award of medical benefits for the expenses of the treatment provided by Arbor Occupational Medicine and its referrals.

Whether Claimant is entitled to an award of temporary total or temporary partial disability benefits from the period from November 10, 2009 through February 24, 2010.

At hearing, the parties stipulated that if the claim was found compensable, Claimant's Average Weekly Wage would be $343.31.

FINDINGS OF FACT

1. Claimant is employed as a personal care provider by Employer. Claimant provides in home services to disabled individuals or other individuals needing in-home assistance.

2. -GH- was a personal care client of Claimant's beginning in the summer of 2009. Ms. -GH- suffers from cerebral palsy, has uncontrolled grand mal seizures and audio-visual perception difficulties. Ms. -GH- is confined to a wheelchair or motorized scooter because of her inability to bear weight on her ankle from the effects of her seizure disorder. Ms. -GH- weighs between 220 and 230 pounds.

3. On November 9, 2009 Claimant took Ms. -GH- to run errands at a strip mall near Ms. -GH-'s home. Ms. -GH- used her motorized scooter to travel to the strip mall with Claimant walking behind her. The strip mall was located at 6th and streets in Lakewood, CO and Ms. -GH- lived near 14th and streets. Ms. -GH- and Claimant used the city streets to travel to the strip mall and return.

4. On the way back from the strip mall as Ms. -GH- was going up a hill in her

scooter near a church the scooter stopped working. Claimant called for the scooter repair service to come assist and waited about 45 minutes for them to arrive, but the service never came. Because of Ms. -GH-'s seizure disorder Claimant was reluctant to leave Ms. -GH- by the side of the road while Claimant went home to get her truck and return to pick up Ms. -GH-. As a result, Claimant decided to push Ms. -GH- home in the scooter. The scooter weighed 220 pounds. Including the weight of Ms. -GH-, the total weight pushed by Claimant was 440 to 450 pounds.

5. Claimant pushed Ms. -GH- in the scooter by herself from approximately 7th and streets to 12th and streets, part of the way being uphill, with one wheel of the scooter on the pavement and one wheel in the gravel by the side of the road. During this time 2 police officers passed Claimant and Ms. -GH- without stopping to assist. After a while a neighbor, who is also a police cadet, saw Claimant and Ms. -GH- and stopped to assist them. The neighbor pushed Ms. -GH- in the scooter the remainder of the way home, a distance of approximately two city blocks.

6. As Claimant was pushing Ms. -GH- in the scooter she began to feel pain in the lower and mid-thoracic area of her back that felt like a rubber band pulling. Claimant had begun to experience this pain prior to the neighbor arriving to assist and push Ms. -GH- the remainder of the way home in the scooter. Claimant laid down once she and Ms. -GH- arrived back at Ms. -GH-'s residence due to the pain between her shoulder blades. Claimant left her shift with Ms. -GH- early and went home.

7. On November 10, 2009 Claimant sent a message to Ms. -GH- around 7 AM to inform her that she would not be coming to work on that day. Claimant then contacted Employer and reported her injury. Claimant was directed by Employer to seek medical care from Arbor Occupational Medicine.

8. Claimant was evaluated at Arbor Occupational Medicine on November 10, 2009 by Dr. David Kistler, M.D. Dr. Kistler obtained a history from Claimant that she had been pushing a client in a scooter and while doing this pulled her back and began to have pain in the mid to lower thoracic area radiating up into the neck and down into the lumbar area. Claimant denied any slip, fall or direct trauma but was just pushing the scooter. On physical examination Dr. Kistler noted moderate tenderness of the paraspinal musculature of the cervical, thoracic and lumbar spines. Dr. Kistler further noted that Claimant was very slow to transfer and was obviously in discomfort with a moderately antalgic gait. Dr. Kistler's impression was cervical, thoracic and lumbar strains. Dr. Kistler restricted Claimant from working until the condition improved. Dr. Kistler referred Claimant for physical therapy and prescribed medications.

9. At the time of the initial evaluation by Dr. Kistler Claimant admitted that she had been involved in a motor vehicle accident at age 10 from which she continued to get headaches. Claimant also reported her recreational activities as running, rollerblading, playing basketball with the kids and teaching cheerleading. Claimant denied any previous problems or similar pain in the areas she had described to Dr. Kistler.

10. In a Physician's Report of Workers' Compensation Injury dated November 10, 2009 Dr. Kistler opined, and it is found, that the objective findings on examination were consistent with the history and mechanism of injury.

11. Dr. Kistler again evaluated Claimant on November 13, 2009. Dr. Kistler continued Claimant off work and referred her to Marc Cahn, D.C. for six visits of chiropractic treatment.

12. Dr. Kistler again evaluated Claimant on November 18, 2009 and on that date released Claimant to return to work under restrictions of no more than 4 (four) hours per day of work, a sitting job only, and no bending or twisting at the waist. Following this release to return to work Claimant returned to work for Employer doing office work. For the pay period from November 22, 2009 through January 2, 2010, a period of 6 (six) weeks, Claimant earned a total of $801.00 for an average weekly earning of $133.50.

13. At the request of Insurer Claimant was evaluated by Dr. Douglas Scott, M.D. on February 10, 2010. In his written report of that date Dr. Scott opined that he doubted that pushing a wheeled object a distance of 2 ½ blocks would cause an injury to the lumbar spine. Dr. Scott further opined that it was not probable that Claimant developed cervical, thoracic and lumbar strains from pushing the scooter because those types of injuries are more suggestive of a mechanism of forward bending and lifting of a heavy object. Dr. Scott suggested that Claimant's injuries could be attributable to Claimant's wearing of high heels in her concurrent job as a cocktail server.

14. Dr. Scott testified at hearing. Dr. Scott testified that the determination of whether Claimant's injuries occurred from pushing the scooter came down to "who do you believe". Dr. Scott testified that if the Claimant was credible then it was "possible" that her injuries came from pushing the scooter. Dr. Scott declined to testify that it was "probable" because pushing a scooter was not the usual mechanism of injury. Dr. Scott agreed that Claimant's injury occurred between the morning of November 9, 2009 and the morning of November 10, 2009.

15. -GH- gave a statement to an investigator from Insurer on December 10, 2009. As recited in Dr. Scott's report, Ms. -GH- told the investigator that Claimant pushed her in the scooter a distance of 1 to 2 ½ blocks, up a slight hill for ½ block, before a police cadet came to their assistance and pushed the scooter the final 1 to 2 ½ blocks home.

16. At hearing, -GH- testified that Claimant was driving behind her as she was traveling in the scooter. Ms. -GH- testified that the police cadet pushing most of the way and that Claimant pushed the scooter ½ block at most. Ms. -GH- acknowledged that Claimant told her the next day that her back hurt and that she would not be coming to work. Ms. -GH- testified that Claimant had mentioned her back was hurting prior to November 9, 2009 but later in her testimony could not recall if Claimant had complained of neck or thoracic pain prior to November 9, 2009. Ms. -GH- testified that Claimant had told her after November 9, 2009 that

she had injured her back lifting her dog but Ms. -GH- could not recall when Claimant had lifted the dog. The ALJ finds the testimony of Ms. -GH- inconsistent and finds that Ms. -GH- is more likely confused concerning the events of November 9, 2009 and whether Claimant had injured her back by lifting a dog. The ALJ finds that testimony of Ms. -GH- unpersuasive to show that Claimant injured her back other than by pushing Ms. -GH- in the scooter on November 9, 2009.

17. The ALJ finds the testimony of Claimant that she injured herself on November 9, 2009 by pushing a 220-pound scooter with a 220 to 230 pound patient in it approximately five blocks, part of that way uphill, and with one wheel in the gravel at the side of the road to be credible and persuasive. Claimant has proven by a preponderance of the evidence that she sustained a compensable injury on November 9, 2009 arising out of and in the course of her employment with Employer.

18. The ALJ finds the opinions of Dr. Scott to be unpersuasive to show that Claimant did not sustain injury from pushing the scooter containing Ms. -GH- on November 9, 2009.

CONCLUSIONS OF LAW

19. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

20. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

21. 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).

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

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

24. In order to recover benefits a claimant must prove that he sustained a compensable injury. A compensable injury is one which arises out of and in the course of employment. Section 8-41-301(1)(b), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origins in an employee's work-related functions. There is no presumption that an injury which occurs in the course of a worker's employment arises out of the employment. *Finn v. Indus. Comm'n,* 165 Colo. 106, 437 P.2d 542 (1968). 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. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989).

25. Section 8-43-404(5)(a), C.R.S. gives the respondents the right in the first instance to select the 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).

26. Authorization to provide medical treatment refers to a medical provider's legal authority to provide medical treatment to the claimant with the expectation that the provider will be compensated by the insurer for providing treatment. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006); *One Hour Cleaners v. Industrial Claim Appeals Office,* 914 P.2d 501 (Colo. App. 1995). 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).

27. Temporary total disability benefits are payable at sixty-six and two thirds percent of the average weekly wage so long as the disability is total. Section 8-42-105(1), C.R.S. Temporary partial disability benefits are payable at sixty-six and two thirds of the difference between the average weekly wage and the average weekly wage during the continuance of the disability. Section 8-42-106(1), C.R.S. The record here does not include sufficient wage

information for the ALJ to calculate the specific amount of temporary partial disability benefits due Claimant for periods after January 2, 2010.

28. Claimant alleges that she sustained a compensable injury on November 9, 2009. As found, Claimant has sustained her burden of proof by a preponderance of the evidence. The medical reports of Dr. Kistler to whom Claimant was referred by Employer for treatment contain evidence of an injury in that Claimant was seen to have tenderness in the paraspinal musculature and an antalgic gait. Claimant's testimony at hearing is consistent with the histories given to Dr. Kistler and Dr. Scott. Further, Claimant's testimony at hearing is largely consistent with the statement given by -GH- to the investigator, i.e., that Claimant pushed Ms. -GH- in her disabled scooter for some distance, including part of the way uphill, on November 9, 2009.

29. The ALJ is not persuaded by Dr. Scott's opinion that Claimant did not likely injure her back pushing the scooter. Dr. Scott at page 7 of his report suggests that if Claimant had injured her back pushing the scooter this would have been the result of an acute event and Claimant would have stopped pushing the scooter to avoid further injury. This theory fails to take into account the fact that Claimant could not stop pushing the scooter because she had to get Ms. -GH- home, could not simply leave her by the side of the road while she got assistance or went to get her vehicle, and that she had waited for some 45 minutes for assistance that had not arrived. Dr. Scott's opinion that Claimant did not likely injure her back pushing the scooter because that is not the typical or usual mechanism for a back strain or disc injury is likewise unpersuasive. Even Dr. Scott acknowledges that Claimant became injured sometime after the morning of November 9, 2009. Even Dr. Scott admits that if the Claimant is credible it is possible she sustained an injury as she has testified. The fact that the mechanism of injury is not the usual or customary method of injury is not persuasive to show that an injury did not occur. The ALJ is likewise not persuaded by Dr. Scott's suggestion that Claimant injured her back wearing high heels in a job as a cocktail server.

30. Respondents' remaining arguments against compensability rest upon the testimony of -GH-. As found, Ms. -GH-'s testimony is inconsistent and not persuasive. At hearing, Ms. -GH-'s testimony was that Claimant injured her back lifting a dog. No mention of an injury as the result of lifting a dog was described in the portions of the statement given by Mr. -GH- to the investigator as recited in Dr. Scott's report. At hearing, Ms. -GH- testified that Claimant barely pushed at all yet in her statement she stated that Claimant pushed her at least 1 to 2 ½ blocks, and ½ block uphill. Ms. -GH- suffers from a number of serious medical conditions that clearly could affect her memory and perception of events. Ms. -GH- even admitted at hearing that she had audio-visual perception difficulties. The ALJ is not persuaded by -GH-'s testimony that Claimant injured her back lifting a dog and not by pushing Ms. -GH- in her scooter on November 9, 2009.

31. Claimant is entitled to temporary total disability benefits for the period from November 10 through November 21, 2009. The wage records from Employer reflect that Claimant returned to work beginning with the pay period beginning November 22, 2009 after

being released to return to work with restrictions by Dr. Kistler. Thereafter, Claimant is entitled to temporary partial disability benefits through February 24, 2010.

32. Claimant sought medical care from Arbor Occupational Medicine, Dr. Kistler, at the direction of Employer. Dr. Kistler and Arbor Occupational Medicine are therefore authorized treating physicians. Dr. Kistler referred Claimant for chiropractic treatment with Marc Cahn, D.C. and chiropractor Cahn is therefore also an authorized treating provider.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation and medical benefits for an injury on November 9, 2009 is compensable and is granted.

2. Insurer shall pay Claimant's medical expenses for treatment by Arbor Occupational Medicine, and its referrals, according to the Official Medical Fee Schedule of the Division of Workers' Compensation.

3. Insurer shall pay Claimant temporary total disability benefits at the weekly rate of $228.87 for the period from November 10 to and including November 21, 2009.

4. Insurer shall pay Claimant temporary partial disability benefits at the weekly rate of $139.87 for the period from November 22, 2009 through and including January 2, 2010. Thereafter, Insurer shall pay Claimant temporary partial disability benefits in accordance with Section 8-42-106 (1), C.R.S. for the period from January 3, 2010 to and including February 24, 2010.

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: March 9, 2010

Ted A. Krumreich

Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-787-301

ISSUES PRESENTED

1 Whether Claimant's workers' claim for compensation time-barred by the statute of limitations found at § 8-43-103(2), C.R.S.; and

2 Whether Claimant's current low back complaints and need for additional medical treatment after being placed at maximum medical improvement (MMI) on February 3, 2004, was authorized, reasonably necessary, and related to Claimant's injury on December 30, 2003.

PROCEDURAL

At the close of Claimant's presentation of his case-in-chief, Respondents moved to dismiss Claimant's claim for worker's compensation pursuant to Rule 41(b)(1) of the Colorado Rules of Civil Procedure (C.R.C.P.). Based on the evidence submitted by the parties (including pleadings, medical records, and Employer's documents), and after considering Claimant's testimony, reviewing case law submitted by Respondent, hearing the oral arguments of both parties, and reviewing the Colorado Workers' Compensation Statute from 2003, the Judge granted Respondents' motion to dismiss. Accordingly, a determination of the remaining issue is unnecessary.

FINDINGS OF FACT

1. In 2003, Claimant worked as a Structural Trade II/Painter for the Employer.

2. On December 30, 2003, Claimant experienced a work-related low back injury while lifting a five-gallon bucket of paint. He immediately stopped what he was doing and reported the injury to his supervisor. He and his supervisor filled out an injury report.

3. After filling out an injury report, Employer sent Claimant for medical care with Concentra where he saw Rosalinda Pineiro, M.D. Dr. Pineiro issued work restrictions.

4. Employer was able to provide modified duty to accommodate Claimant's work restrictions. As a result, Claimant missed fewer than three calendar days and fewer than three shifts due to his December 30, 2003, low back injury.

5. Employer reported the incident to Insurer, which is a third party administrator, on an Employer's First Report of Injury form.

6. Because Claimant did not allege any lost time, and because Employer was able to accommodate Claimant's restrictions, Insurer was not required to report the injury to the Division of Workers' Compensation.

7. Claimant underwent conservative treatment which included physical therapy and prescription medications. Claimant received treatment for approximately one month. Dr. Pineiro determined that Claimant had reached MMI and released Claimant to return to full duty work on February 3, 2004. Claimant then returned to his regular job duties without restrictions.

8. Insurer closed the claim file in March 2004 when there were no further pending issues. No additional payments were made.

9. No indemnity benefits or other compensation was ever paid to Claimant with respect to his December 30, 2003, injury.

10. Claimant obtained additional treatment for his low back condition outside of the workers' compensation system in 2006. Claimant received a series of injections from his personal physician, and noted improvement of his condition after the last injection. Claimant attributed the need for treatment to the injury on December 30, 2003. Respondents did not authorize this treatment.

11. Claimant never requested that his 2003 claim be reopened, and never requested additional treatment from Employer or from the Insurer. Claimant never challenged the “no impairment” rating assigned by the authorized treating physician at the point of maximum medical improvement.

12. There was no persuasive or credible evidence that Employer would have believed or could have reasonably inferred that Claimant’s injury did or could have resulted in permanent physical impairment especially given Claimant’s limited round of treatment and release to full duty with no permanent impairment.

13. On March 11, 2009, Claimant filed a Worker’s Claim for Compensation seeking worker’s compensation benefits as a result of the low back injury on December 30, 2003. There was no credible or persuasive evidence or testimony offered as to why this delay was reasonable.

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 litigation. Section 8-40-102(1), C.R.S. A Claimant in a Workers’ Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 197 Colo. 306, 593 P.2d 792 (1979); *People v. M.A.*,104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers’ Compensation cases are not interpreted liberally in favor of either the rights of the injured worker or the rights of the Employer. Section 8-43-201, C.R.S.

2. The ALJ’s factual findings concern only evidence that is dispositive of the issues

involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, *inter alia*, 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. *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d.

4. Pursuant to § 8-43-103(2), C.RS., a claim "shall be barred unless, within two years after the injury or after death resulting therefrom, a notice claiming compensation is filed with the division."

5. The statute of limitation period in § 8-43-103(2), C.R.S., "commences when the claimant, as a reasonable person, should recognize the nature, seriousness, and probably compensable character of the injury." *Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). As found, Claimant was immediately aware of the injury when it occurred, immediately stopped working, reported the injury to Employer, filled out an injury report, and received medical care over the following month with the authorized treating physician until he was released at maximum medical improvement with no impairment and no restrictions. Claimant recognized the nature, seriousness, and compensable character of the December 30, 2003, injury immediately after it occurred.

6. The statute of limitations for filing a claim does not apply if compensation has been paid to the Claimant. However, the term "compensation" does not include payment of medical expenses for medical, hospital, or surgical treatment. Section 8-43-103(2), C.R.S. Although Respondents paid for Claimant's medical care with the authorized treating physician, no compensation was ever paid to Claimant as a result of this injury.

7. The statute of limitations may be extended to three years if "a reasonable excuse exists for the failure to file such notice claiming compensation and if the Employer's rights have not been prejudiced thereby." *Id.* Even if Claimant had presented a reasonable excuse for his delay, the existence of such excuse only extends the statute of limitations to three years, making the deadline December 30, 2006. Claimant did not file his claim for compensation until March 11, 2009, over five years after the injury occurred.

8. In all cases in which the Employer has been given notice of an injury and fails, neglects, or refuses to report said injury to the division as required by the provisions of said articles, this statute of limitations shall not begin to run against the claim of the injured employee or said employee's dependents in the event of death until the required report has been filed with the division." *Id.*

9. An employer is deemed to have "notice" of an injury when the employer has "some

knowledge of 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." *Jones v. Adolph Coors Co.*, 689 P.2d 681, 684 (Colo. App. 1984). Employer timely completed an Employer's First Report when Claimant initially reported the injury and, therefore, had notice of Claimant's injury.

10. Although Employer was given notice of an injury, there was no obligation to report the injury to the Division which would have tolled the statute of limitations. Section 8-43-101(1), C. R.S., requires an employer provide notice to the Division within ten days of notice of "all injuries that result in fatality to, or permanent physical impairment of, or lost time from work for the injured employee in excess of three shifts or calendar days and the contraction by an employee of an occupational disease that has been listed by the director by rule." Claimant did not miss more than three shifts or more than three calendar days of work due to his December 30, 2003, injury. Further, there is no persuasive or credible evidence to suggest that Claimant's injury resulted in permanent physical impairment. In addition, § 8-43-101(2), C.R.S., explicitly exempts an employer from reporting "no lost time" claims and lack of permanent physical impairment cases to the Division.

11. Under C.R.C.P. Rule 41(b)(1), a "defendant may move for dismissal of an action or of any claim against him. After the plaintiff, in an action tried by the court without a jury, has completed the presentation of his evidence, the defendant, without waiving the right to offer evidence in the event the motion is not granted, may move for a dismissal on the ground that upon the facts and the law the plaintiff has shown no right to relief." This dismissal operates as an adjudication on the merits and has been applied and relied on in workers' compensation proceedings. *Patrick v. Berkey Properties, Inc.*, W.C.No. 4-458-126 (Jan. 15, 2003).

12. In deciding whether to grant a motion to dismiss, the court is not required to view the evidence in the light most favorable to the plaintiff. *Rowe v. Bowers*, 417 P.2d 503 (1966); *Blea v. Deluxe/ Current, Inc.*, W.C. No. 3-940-062 (June 18, 1997) (applying these principles to workers' compensation proceedings). The test is whether judgment for the respondent is justified on the claimant's evidence. *American Nat'l Bank v. First Nat'l Bank*, 476 P.2d 304 (1970); *Bruce v. Moffat Cty. Youth Care Center*, W.C. No. 4-311-203 (Mar. 23, 1998). Based on the evidence and testimony presented, Claimant failed to establish how his Worker's Claim for Compensation filed on March 11, 2009, for an injury that occurred on December 30, 2003, meets the statutory requirements set forth at § 8-43-101, C.R.S. As a result, Respondents' motion to dismiss pursuant to C.R.C.P. Rule 41(b)(1) is granted.

13. Because Claimant's claim for worker's compensation is hereby denied and dismissed for failing to timely file the claim, the remaining issues are moot and will not be addressed.

ORDER

It is therefore ordered that:

1. Claimant's claim for benefits under the Workers' Compensation Act of Colorado for

Claim No. 4-787-301 (DOI December 30, 2003) is denied and dismissed.

2. The remaining issues need not be addressed.

DATED: March 9, 2010

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-784-053

ISSUE(S)

The following issues were raised for consideration at hearing: (1) whether Claimant suffered a compensable injury; (2) whether Claimant is entitled to medical benefits; (3) whether Claimant is entitled to indemnity benefits; (4) whether Claimant is unable to earn wages and therefore is entitled to permanent total disability benefits; (6) whether Claimant overcame the opinion of the Division Independent Medical Examiner; and (6) whether penalties should be awarded against Respondents.

FINDINGS OF FACT

1. On March 31, 2008, Claimant suffered an injury to his left foot and ankle.

2. On February 13, 2009, Respondents filed a final admission of liability based on Dr. Cedillo's opinion that Claimant was at maximum medical improvement (MMI) on July 8, 2008. Claimant subsequently objected to the final admission and requested a Division Independent Medical Examination (DIME).

3. On August 13, 2009, Respondents filed a second final admission based on the DIME physician's opinion that Claimant was at MMI on July 8, 2008, and had a 13% lower extremity impairment rating. The final admission of liability admitted for permanent partial disability benefits based on the 13% lower extremity impairment rating. The admission further denied liability for any medical benefits after MMI. It also specifically stated that all benefits and/or penalties not admitted for in the admission were specifically denied. This would include indemnity benefits and permanent total disability benefits.

4. Along with the final admission, Claimant was sent a blank objection to the final admission

form to fill out if he chose to object to the admission. The objection form specifically stated: "If you disagree with the Final Admission, WITHIN 30 CALENDAR DAYS of the date of the Final Admission you must complete the attached objection form or write a letter to the Division of Workers' Compensation…stating your objection…If a Division Independent Medical Examination has already determined MMI and/or Whole Person Impairment, you must request a hearing on any disputed issues. Otherwise, your claim will be closed as to issues admitted in the Final Admission of Liability."

5. Claimant filed his objection to the final admission on September 2, 2009. On his objection form, Claimant checked the box next to the section stating that he would mail or deliver an application for hearing form on disputed issues to the Office of Administrative Courts within thirty calendar days of the date of the final admission.

6. Claimant did not, however, file his application for hearing until September 21, 2009, or thirty-nine days after the final admission was filed. On his application, Claimant endorsed the issues of compensability, medical benefits, indemnity benefits, permanent total disability benefits, penalties for "improperly breaking down shoring doings [sic] a demolition operation – 3/31/08," and MMI.

7. Claimant's application for hearing was not timely filed. Therefore, the Judge is without jurisdiction to consider the claim.

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. *See, City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); Section 8-41-301(1), 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. X-ray*, 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. Section 8-43-203(2)(b)(II), C.R.S., provides, in relevant part, that a claim "will be automatically closed as to the issues admitted in the final admission if the Claimant does not, within thirty days after the date of the final admission, contest the final admission in writing and request a hearing on any disputed issues that are ripe for hearing." Once a claim has been closed, it may only be reopened pursuant to Section 8-43-303, C.R.S. *Peregoy v. Indus. Claim Appeals Off.,* 87 P.3d 261, 263 (Colo. App. 2004); s*ee,* Section 8-43-203(2)(d), C.R.S. If a claimant fails to object to a final admission, they are deemed by law to agree with the benefits

addressed in the final admission. *Dalco Industries, Inc. v. Garcia*, 867 P.2d 156 (Colo. App. 1993).

3. Under the Workers' Compensation Act, a judge's authority is strictly statutory. *See Roddam v. Rocky Mountain Recycling,* W.C. No. 4-367-003 (ICAO Jan. 24, 2005). Once a claim is closed pursuant to Section 8-43-203(2)(b)(II), C.R.S., no further benefits may be granted unless the closed issues are reopened pursuant to Section 8-43-303, C.R.S. Claimant did not endorse the issue of reopening. As a result, the statute prohibits further litigation once the issues are closed.

3. While Claimant timely filed his objection to the August 13, 2009, final admission of liability, he failed to timely file an application for hearing on any disputed issues that were ripe for hearing. As such, Claimant's claim is closed pursuant to Section 8-43-203(2)(b)(II), C.R.S. *See, Ballesteros v. Westaff, Inc.,* W.C. No. 4-475-838 (ICAO Nov. 24, 2008).

4. Jurisdictional challenges may be raised at any point in the proceedings. *See Roddam v. Rocky Mountain Recycling,* supra. Provisions for objecting to and contesting a final admission are treated as jurisdictional. *Town of Ignacio v. Indus. Claim Appeals Off., 70 P.3d 513, 515 (Colo. App. 2002); Dalco Industries, Inc. v. Garcia, supra*. Respondents raised the issue of subject matter jurisdiction at hearing. This Judge finds that because Claimant's claim is closed as the result of Claimant's untimely application for hearing, this Judge is without jurisdiction to grant any of the additional benefits sought by Claimant.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents' motion to dismiss Claimant's claims is granted.

B. Claimant's claims for compensability, medical benefits, indemnity benefits, permanent total disability benefits, and penalties are hereby denied and dismissed.

DATED: March 9, 2010

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-769-633

ISSUE

The issue presented for consideration is whether Claimant is entitled to medical benefits. Specifically, the issue raised is whether a one-level fusion surgery is a reasonable and necessary medical benefit.

FINDINGS OF FACT

1. Claimant sustained a compensable lumbar injury on September 24, 2007. She came under the care of Perry L. Haney, M.D. who performed bilateral facet injections in October of 2007.

2. In March, April and May of 2008, Dr. Haney performed a series of three bilateral epidural injections. After these were completed, Claimant's pain remained on a scale of seven out of ten. Therefore, Dr. Haney performed a discogram in June of 2008.

3. A second opinion was obtained with a neurosurgeon, Hans Coester, M.D., in October of 2008. At that time, Claimant was complaining of both lower and upper back pain with tingling, numbness, and weakness in bilateral arms and bilateral legs. Dr. Coester indicated there was no "role for operative intervention in her cervical or lumbar spine." However, he recommended repeating the cervical and lumbar MRI scan as well as performing nerve conduction studies.

4. Additional diagnostic studies were performed after the evaluation with Dr. Coester including consultation and EMG with Samuel Y. Chan, M.D. At the time of his examination, Claimant reported to Dr. Chan very diffuse pain from her intrascapular area to the lumbar spine area. She complained of pain into the bilateral soles of her feet and numbness and tingling in her hands. Dr. Chan performed electromyographic studies over bilateral upper as well as lower extremities. These studies were within normal limits. Dr. Chan noted "her clinical examination is very diffuse without any focality. One is unclear exactly what the pain generator is."

5. After the diagnostic studies were completed, Dr. Coester issued a supplemental report in which he indicated that Claimant appeared to have two level degenerative disc disease but that the chance of her "getting durable improvement from a fusion operation is less than 50%." He also felt that there were significant risks. Dr. Coester indicated that he did not have any particular clinical experience with a percutaneous disc decompression followed by annuloplasty, which was the surgery being recommended by Dr. Haney, but that he was "skeptical" that this would give her greater than 40% chance of improvement.

6. Dr. Haney did proceed with the percutaneous disc decompression followed by annuloplasty, which was performed on May 19, 2009. However, by August of 2009 Claimant had no improvement in her symptom complex and therefore Dr. Haney referred her to another neurosurgeon, Dr. Chad Prusmack, M.D., for an evaluation.

7. Dr. Prusmack saw Claimant on one occasion on September 16, 2009. He expressed concerns about a cyst shown on the films. He stated that his recommendation, given the cyst and Claimant's back pain with positive discogram, would be to first evaluate the cyst and then "consider a left-sided L4-5 and L5-S1 decompression and fusion of those levels." A subsequent MRI was performed and Dr. Prusmack issued a note simply indicating that he had reviewed the MRI, which did not show any enhancement abnormally or tumor and that he would "go forth with the surgery as planned." A request was made for authorization of a two level fusion.

8. Respondents requested a second surgical opinion with Brian Reiss, M.D. who evaluated Claimant on October 21, 2009. At that time, Claimant was complaining of pain in her neck, arms, upper back, buttock, thighs, knees, and feet. After evaluating Claimant and reviewing the diagnostic studies and records, Dr. Reiss opined that, due to the fairly diffuse nature of Claimant's symptomatology and lack of any significant nerve compression or evidence of instability, he did not believe that surgical intervention was appropriate. At the time that he issued his written report, Dr. Reiss was of the impression that Dr. Prusmack was recommending a two level fusion. Dr. Reiss did not feel that a two level fusion was reasonable and necessary medical care.

9. The deposition of Chad Prusmack, M.D. was taken on January 11, 2010. At that time, Dr. Prusmack indicated that, although he had never issued a written report changing his opinion, his oral opinion was that Claimant required a one level fusion at the L4-5 level. Dr. Prusmack indicated that he agreed with Dr. Reiss that there was no significant nerve compression, but that, based on the discogram, Claimant had an annular tear. He also indicated that his motor examination showed a left extensor hallucis longus, which was four minus out of five and plantar flexion four plus out of five, which was an objective sign of weakness. Based on these findings he was recommending surgery.

10. Dr. Reiss's testimony was taken on January 27, 2010. At that time he confirmed that, at the time of his examination, Claimant had diffuse symptoms, which included problems in the bilateral upper extremities and bilateral lower extremities. Dr. Reiss described his examination as follows:

> Any touch on her lower back, she was hypersensitive to any touch. Everything was tender and sore and caused her pain and it was widespread and diffuse in all over her lower back and buttock and SI areas and greater trochanteric areas, etc. So it was very diffuse. Now, in her favor, things such as sham rotation and cervical compression did not reproduce her pain, but she was hypersensitive, and she really would not move hardly at all. Sitting her down, her reflexes, there was slight abnormalities there. But her sitting straight leg raising was totally negative to 90 degrees. In other words, while sitting at the table, I could lift her leg

> up all the way to 90 degrees without any complaint of pain…so all in all the impression from that is that there was a pain complaint and non-physiologic factors out of proportion to what we were seeing on the rest of her exam either from observing her or from looking at her MRI. (Depo. Tr. pp. 6 – 7)

11. In regards to the discogram, Dr. Reiss credibly testified that under the *American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Revised)* (AMA Guides), if a discogram is going to be performed the pain needs to be produced at a relatively low pressure. In addition, the AMA Guides recommend that it be a blind test without the treating physician performing the discogram. In this case, the discogram was positive at high pressure and was also performed by Dr. Haney. Therefore, Dr. Reiss did not believe that the discogram was very reliable. In addition, Dr. Reiss had concerns about the diffuse pain complaints, which was also noted by Dr. Coester and Dr. Chan.

12. Dr. Reiss was concerned about the diffuseness of Claimant's pain as he did not feel that her complaints could be related to an L4-5 disc. Dr. Reiss indicated that a L4-5 disc was not going to cause hand numbness, upper back pain, pain in the feet and knee pain. Therefore, any surgery at that level was not going to help those types of pain symptoms because they could not be physiologically linked with her diagnosis. Therefore, the presentation of diffuse pain was a negative indicator in terms of surgery. Dr. Reiss stated:

> So the more negative factors that you have, the less likely you should venture in to do surgery on somebody because the likelihood of them getting better starts from a low level and goes down from there. So the diffuse pain is a very strong negative indicator for surgery for back pain. (Depo. Tr. p. 17).

13. Dr. Reiss also disagreed with the objective finding mentioned by Dr. Prusmack in his report and deposition. Dr. Reiss found no significance to the findings as to the hallucis longus and plantar flexion. Dr. Reiss explained that those nerve roots were not related to the fourth lumbar nerve, which is the area that Dr. Prusmack was proposing surgery. There was no correlation between the apparent physical findings and the nerve that was going to be operated on. (Depo. Tr. pp. 21 – 22).

14. Dr. Reiss opined that the one-level fusion, which Dr. Prusmack recommended in his deposition was not reasonable and necessary medical care as it was highly unlikely to resolve Claimant's pain or to make her more functional. The ALJ finds the deposition testimony of Dr. Reiss to be more credible and persuasive than the deposition testimony of Dr. Prusmack.

CONCLUSIONS OF LAW

1. Claimant shoulders the burden of proving by a preponderance of the evidence that her injury arose in 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 true than not. *Page v. X-ray*, 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 or in favor of the rights of respondents. Section 8-43-201, C.R.S.

2. To sustain a finding in Claimant's favor, Claimant must do more than put the mind of the trier of fact in a state of equilibrium. If the evidence presented weighs evenly on both sides, the finder of fact must resolve the question against the party having the burden of proof. *People v. Taylor*, 618 P.2d 1127 (Colo. 1980). *See also, Charnes v. Robinson*, 772 P.2d 62 (Colo. 1989).

3. It is found and concluded that Claimant failed to establish by a preponderance of the evidence that a one or two level fusion surgery is a reasonable and necessary medical benefit. Dr. Brian Reiss's deposition testimony was found to be more credible and persuasive than the deposition testimony of Dr. Chad Prusmack. Significant factors that support the conclusion that Claimant failed to sustain her burden of proof are, as follows: 1. Claimant has complaints of diffuse pain; 2. Claimant, on examination, has non-physiologic factors, which are out of proportion to what is seen on the rest of Claimant's examination, either from the physician's observations of her or from the MRI; and 3. the authorized treating physician performed a discogram on Claimant at high pressure and the results are therefore unreliable.

ORDER

IT IS THEREFORE ORDERED THAT:

1. Claimant's request for surgery is denied.

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

DATED: March 10, 2010

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-752-086

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to counsel for the Claimant , giving Respondents' counsel 3 working days after receipt thereof to file electronic objections as to form. The proposed decision was filed, electronically, on March 4, 2010. On March 5, 2010, Respondents indicated that they had no objections to the proposed decision as to form. After a consideration of the proposed decision, the ALJ has modified it and hereby issues the following decision.

ISSUE

The sole issue to be determined by this decision concerns whether the Respondents overcame the Division-sponsored Independent Medical Evaluation (DIME) physician's opinion (John S. Hughes, M.D.) on maximum medical improvement (MMI) by clear and convincing evidence.

PRELIMINARY MATTER

At the close of Respondents' case in chief, Claimant moved for a judgment in the nature of a directive verdict and the ALJ granted the motion.

FINDINGS OF FACT

1. The parties stipulated at the beginning of the hearing, and the ALJ finds, that because the Claimant is not at MMI, temporary total disability (TTD) benefits should be reinstated as of June 12, 2009, however, the Respondents are entitled to an offset for unemployment (UI) benefits and previously paid permanent partial disability (PPD) benefits. The parties also stipulated that medical care would remain with Franklin Shih, M.D., and his referred providers, and the ALJ so finds.

2. On February 20, 2008, Claimant sustained an admitted industrial injury to his right upper extremity (RUE) while working as an employee of the Employer in Denver, Colorado, when he dogs attacked him as he was attempting to connect a water hose at a customer's residence for a cleaning operation. As the Claimant was running from the dogs, he was chased over a fence, where he struck his right arm, and as he climbed over the fence, he caught his arm causing his right arm to jerk and dislocate his shoulder.

3. The Claimant received medical treatment from multiple medical providers and his medical care was eventually transferred to authorized treating physician (ATP), Franklin Shih, M.D. Dr. Shih first evaluated the Claimant on October 7, 2008, and eventually referred the Claimant out for surgery to Carl Motz, M.D., who performed arthroscopic exploration of the Claimant's shoulder and found two loose bodies.

4. During the period of time commencing with Dr. Shih's taking over Claimant's medical care, until Dr. Shih placed the Claimant at MMI on June 12, 2009, the Claimant consistently complained of numbness in the ulnar fingers of his right hand. Dr. Shih, however, was of the opinion that the finger numbness was not causally related to the Claimant's industrial injury of February 20, 2008.

5. On August 11, 2009, the Claimant requested a DIME to review Dr. Shih's June 12, 2009, MMI placement and causation opinions, when Claimant filed an Application for a DIME.

6. In the DIME Application, the Claimant requested the DIME physician to, "[a]ddress

numbness and tingling in right hand, treatment of pain. . . [w]hen Client lifts right arm, shoulder pops, finger goes numb."

7. John S. Hughes, M.D., was selected by the State to perform the DIME and the examination occurred on September 25, 2009. Subsequently, Dr. Hughes issued a DIME report finding the Claimant not at MMI for the right ulnar nerve setting forth that:

> [Claimant] presents with an interesting and complex medical history. He describes a traction mechanism injury that occurred when he went over the fence and caught his arm, leading to shoulder dislocation. The emergency department notes document a much more simple injury of a contusion of the shoulder on a fence post. It seems unlikely that a simple contusion would have led to glenohumeral dislocation, and it seems more likely to me that [Claimant] forcefully abducted and externally rotated his arm and then sustained a traction force in the course of escaping from the residential back yard.
>
> If this is true, it would explain a gradual development of entrapment neuropathy of the ulnar nerve. Emergence of symptoms was around five months post injury, and this seems reasonable, given the particular mechanism of injury. In the absence of an alternative medical explanation for entrapment neuropathy of the ulnar nerve, **it is my opinion that this condition is injury-related. It is also my opinion that [Claimant] is not at maximum medical improvement and that he does require the additional measures for evaluation and treatment of his right ulnar nerve injury recommended by Dr. Shih** (emphasis supplied)**.**

8. At hearing, Dr. Shih testified that he did not agree with Dr. Hughes' conclusion that the cause of the Claimant's ulnar nerve entrapment was the injury suffered on February 20, 2008. Dr. Shih, however, did agree with all doctors in the claim, that is, Dr. Hughes and Sean Griggs, M.D., that the Claimant has ulnar nerve entrapment also known as cubital tunnel syndrome and that surgery has been recommended to address that condition. Dr. Shih further testified, however, that different doctors can reach different medical opinions and that such opinions are not necessarily wrong or medically incorrect. The ALJ finds that Dr. Shih maintains a simple difference of opinion with Dr. Hughes that does not rise to the level of making it highly probable, unmistakable and free from serious and substantial doubt that Dr. Hughes' opinion in this regard is wrong.

9. Respondents have failed to prove, by clear and convincing evidence, that Dr. Hughes' DIME opinion that Claimant is not at MMI is erroneous.

CONCLUSIONS OF LAW

The DIME

a. A DIME's findings concerning medical impairment and MMI are binding unless overcome by clear and convincing evidence. Section 8-42-107(8)(b)(III), C.R.S. (2009); *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186, 189 (Colo. App. 2002); *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App. 1995). As found, Dr. Hughes' finding that Claimant is not at MMI has **not** been overcome by clear and convincing evidence.

Burden of Proof on Overcoming DIME

b. The party seeking to overcome a DIME physician's opinions bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office***,** 5 P.3d 385 (Colo. App. 2000). It is well established that the DIME physician's determination of MMI is binding unless overcome by "clear and convincing evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P2d 411 (Colo. App. 1995); Section 8-42-107(b)-(c), C.R. S. (2009). Also, a DIME physician's conclusion that an injured worker's medical problems were components of the injured worker's overall impairment constitutes a part of the diagnostic assessment that comprises the DIME process and , as such the conclusion must be given presumptive effect and can only be overcome by clear and convincing evidence. *Qual-Med, Inc. v. Indus. Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). "Clear and convincing evidence" is evidence, which is stronger than preponderance, is unmistakable, makes a fact or facts highly probable or the converse, and is free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert, supra.* In other words, a DIME physician's finding may not be overcome unless the evidence establishes that it is "highly probable" that the DIME physician's opinion is incorrect. *Postelwait v. Midwest Barricade,* 905 P.2d 21 (Colo. App. 1995). The question of whether the DIME physician has placed a claimant at MMI or not, and whether that determination has been overcome is a factual determination for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, supra. As found, Respondents have failed to demonstrates that it is highly probable that the DIME's conclusions are incorrect. In the absence of such clear and convincing evidence, the DIME's findings herein are binding.

Judgment in the Nature of a Directed Verdict

c. Colo. Rules of Civil Procedure, Rule 41(b)(1), provides that, after a plaintiff in a civil action *tried without a jury* has completed the presentation of his evidence, the defendant may move for a dismissal on the grounds that the plaintiff has failed to present a prima facie case for relief. In determining whether to grant a motion to dismiss or for directed verdict, the court is not required to view the evidence in the light most favorable to the plaintiff, as argued by a claimant. *Rowe v. Bowers*, 160 Colo. 379, 417 P.2d 503 (Colo. 1966)*; Blea v. Deluxe/Current, Inc.*, W.C. No. 3-940-062 [Industrial Claim Appeals Office (ICAO), June 18, 1997] (applying these principles to workers' compensation proceedings). Neither is the court required to

"indulge in every reasonable inference that can be legitimately drawn from the evidence" in favor of the Claimant. Rather, the test is whether judgment for the Claimant is justified on the Respondents' evidence. *See Amer. National Bank v. First National Bank*, 28 Colo. App. 486, 476 P.2d 304 (Colo. App. 1970); *Bruce v. Moffat County Youth Care Center*, W. C. No. 4-311-203 (ICAO, March 23, 1998). The question of whether the Claimant carried this burden was one of fact for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, *supra* As found, Respondents failed to carry their burden of proof as of the time they rested their case-in-chief.

Unemployment Insurance Benefit Offset

d. § 8-42-103 (1) (f), C.R.S. (2009), provides for a 100% UI offset against workers' compensation benefits. As stipulated and found, Respondents are entitled to a UI offset for UI benefits previously paid to the Claimant during TTD.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Respondents have failed to overcome the finding of the Division Independent Medical Examiner by clear and convincing evidence.

B. The Respondents shall resume temporary total disability benefits as of June 12, 2009, and continue payment until terminated pursuant to law.

C. The Respondents are entitled to an offset against temporary total disability benefits owed for unemployment benefits and previously paid permanent partial disability benefits paid in this matter.

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

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

DATED this_____day of March 2010.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-767-680

ISSUE

The issue for determination at hearing was whether Claimant established by preponderance of the evidence that the emergency treatment he received on May 22 and 23, 2009, is reasonable, necessary and related to his admitted injury.

FINDINGS OF FACT

1. Claimant is a credible witness and his testimony is both persuasive and consistent with the medical records in the case.

2. Claimant suffered an admitted work injury on August 1, 2008, when, as a lineman's apprentice installing underground and overhead power lines for Employer, he fell thirty feet from a power poll to the ground and landed on his back. Claimant suffered an injury to his spine and his head. As a result, Claimant suffered a traumatic brain injury.

3. From August 2008 to May 22, 2009, as a result of the August 1, 2008 injury, Claimant experienced severe headaches and insomnia, as well as other symptoms. His medical care providers cautioned Claimant that as an individual with a brain injury he should be concerned about fevers, vomiting, or any sign of blood clotting. As noted by the authorized treating physician, Dr. David Reinhardt, in his report of August 28, 2008, Claimant suffered a vertebral body interior fracture requiring him to continue to wear a clamshell brace. By that date, Claimant was already suffering ongoing headaches accompanied by blurred vision and disequilibrium.

4. On or about May 20, 2009, Claimant experienced chest pain, shortness of breath, and vomiting. On the evening of May 21, 2009, Claimant awakened gasping for breath. He vomited and inhaled the vomit into his lungs.

5. On May 22, 2009, Claimant's chest pain worsened. At 10:14 p.m., he went to the emergency room at Swedish Medical Center where he ran a fever between 100 and 103 degrees. Claimant feared that his medical condition, as a result of his work injury of August 1, 2008, was worsening.

6. Claimant has established by a preponderance of the evidence that his May 22, 2009, visit to Swedish Medical Center emergency room was related to the work injury. Claimant's unresolved symptoms from his work injury, and his resulting concern for his health, caused him

to seek emergency treatment at Swedish Medical Center on the evening of May 22, 2009.

7. Respondents relied on the expert testimony of Dr. William Shaw who opined that Claimant's need for treatment on May 22, 2009, was unrelated to his occupational injury. Dr. Shaw did not dispute necessity. When asked by Claimant's counsel whether it was reasonable for Claimant to seek emergency medical care for his medical condition on May 22, 2009, in light of the advice Claimant had from his physician, Dr. Shaw was equivocal in his response.

8. Although Dr. Shaw opined that the treatment Claimant received on May 22, 2009, was not related to this workers' compensation injury, his opinion is not convincing, given the constellation of factors, detailed above, which resulted in Claimant's decision to seek emergency medical care on May 22, 2009.

9. Specifically, the medical records establish that when Claimant sought treatment at Swedish Medical Center on the evening of May 22, 2009, he was complaining of chest pain, which started two days earlier and was worsening. The pain was sharp and was located in his central chest area. Claimant was also suffering fatigue, difficulty breathing, nausea and vomiting, and tinnitus. Claimant was in pain and in moderate distress. Upon admission, the Swedish records show that Claimant had been having problems with fevers and vomiting for several months prior to his admission following his admitted work related fall.

10. On May 22, 2009, Claimant was not at maximum medical improvement and was still receiving active medical care for his injury; as his medical condition remained unstable.

11. When Claimant was released from Swedish Medical Center, he was diagnosed with atypical chest pain, accompanied by numerous symptoms, which had persisted since his injury.

12. It is found that Claimant is entitled to medical benefits to cure and relieve him of the effects of the industrial injury. The emergency care Claimant received on May 22 and 23, 2009, was reasonable, necessary and related to his injury. As such, Respondents are liable for an emergency room visit on May 22 and 23, 2009, and expenses related to this emergency room visit.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits and compensability by a preponderance of the evidence. 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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979).

2. The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

3. The Findings of Fact only concern evidence dispositive of the issues involved. Not every piece of evidence, which would lead to a conflicting conclusion is included. Evidence contrary to the findings was rejected as not persuasive. *Magnetic Engineering, Incorporated v. ICAO*, 5 P.3d 385 (Colo. App. 2000); *Boyet v. Wal-Mart Stores, Incorporated*, WC 4-460-359 (ICAO 8/28/01).

4. The respondents are liable for medical treatment, which is reasonably necessary to cure and relieve the effects of the industrial injury. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997); *Country Squire Kennels v. Tarshis*, 899 P.2d 362 (Colo. App. 1995); Section 8-42-101 (1)(a), C.R.S. These benefits include emergency care, which is compensable until the emergency ends. *Simms v. ICAO*, 797 P.2d 777 (Colo. App. 1990).

5. Where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove a casual relationship between a work-related injury and the condition for which benefits or compensation are sought. *Snyder v. Industrial Claim Appeals Office*, 942 P .2d 1337 (Colo. App. 1997).

6. The ALJ concludes that Claimant has shown that it is more probably true than not that his emergency room treatment on May 22 and 23, 2009, was triggered by his concern over worsening medical symptoms resulting from the injuries that he sustained in his admitted work related injury of August 1, 2008. Although Respondents argue that Claimant's emergency care was not directly related to his injury, Claimant sought emergency room care for worsening symptoms, which his authorized treaters had cautioned him to address.

7. It was the pain and symptoms that Claimant was experiencing which triggered his visit to the emergency room on May 22, 2009. Claimant's visit to the emergency room arose directly from his need to take steps to ensure that his work related condition did not worsen. He acted reasonably in seeking medical attention given the severity of his injury and the symptoms he was then experiencing.

8. The treatment rendered at Swedish Medical Center was reasonable, necessary and related to his injury. Twenty-twenty hindsight might have informed Claimant that the emergency room visit would end without debilitating consequences. However, without hindsight, it is concluded that Claimant's action in seeking emergency room treatment was reasonable, necessary and related to the work injury of August 1, 2008, and is therefore compensable.

ORDER

It is therefore ordered that:

1. Respondents are liable for the medical care Claimant received at Swedish Medical Center emergency room on May 22 and 23, 2009, and expenses related to this emergency room visit. This treatment is deemed reasonable, necessary and related to Claimant's August 1, 2008, work injury.

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

DATED: _March 10, 2010

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-634-964

ISSUES

Whether the determination by the DIME physician that Claimant has reached maximum medical improvement is sufficient to terminate Claimant's temporary total disability benefits, prior to the DIME report being approved by the division of workers' compensation, pursuant to WCRP 6-4.

FINDINGS OF FACT

1. By Certificate of Service dated August 31, 2009, Respondents herein filed a Petition to Modify, Terminate, or Suspend Compensation.

2. Pursuant to WCRP 6-4(A), Respondents cited the statutory basis for the petition as being section 8-42-105. Respondents cited WCRP 6-4(A)(1) as the rule upon which they rely.

> Claimant suffered a work related injury to his back on June 6, 2006, and an aggravation of the underlying injury on February 22, 2007. On September 28, 2008, Dr. Watson conducted a Division sponsored IME and concluded that the Claimant had reached MMI on November 15, 2006. His report however failed to consider the effects of the February 22, 2007 aggravation.
>
> As a result of this omission, Dr. Watson was deposed and a hearing was scheduled. At deposition Dr. Watson clarified that Claimant, subsequent to the aggravation, reached MMI on August 3, 2007. A hearing in this matter was held on June 25, 2009 and Dr. Watson was ordered to produce a new DIME report based on the

> stipulation that Claimant suffered an injury on June 6, 2006, and a subsequent aggravation of that June 6, 2006 injury on February 22, 2007.
>
> Despite Dr. Watson's assertion that MMI was reached August 3, 2007, temporary disability benefits continue to be paid. As a result, overpayment has occurred. *See* C.R.S. § 8-42-105 (providing that benefits "shall continue until . . . [t]he employee reaches maximum medical improvement"). To prevent, further overpayment, Respondent seeks to terminate or suspend the payment of temporary disability benefits consistent with Dr. Watson's finding that MMI has been established.

3. The evidence presented supports the facts as alleged and the ALJ finds these facts as having been established.

4. Additionally, the testimony of M Y, Senior Claims Case Manager for the Respondent-Insurer, establishes that, as of the date of hearing, no FAL has been filed. Ms Y has received a copy of the final DIME report indicating an MMI date of August 7, 2007.

5. The Division, as of the time of the hearing, had not yet approved the DIME report.

CONCLUSIONS OF LAW

1. WCRP 6-4 (A) provides,

> When an insurer seeks to suspend, modify or terminate temporary disability benefits pursuant to a provision of the Act and Rules 6-1, 6-2, 6-3, 6-5, 6-6, 6-7 or 6-9 are not applicable, the insurer may file a petition to suspend, modify or terminate temporary disability benefits on a form prescribed by the Division. The petition shall indicate the type, amount and time period of compensation for which the petition has been filed and shall set forth the facts and law upon which the petition relies.

2. The Rule indicates that it is to be used when the insurer seeks to "suspend, modify or terminate temporary disability benefits *pursuant to a provision of the Act*." (Emphasis added.)

3. Thus, the ALJ's authority extends no further than applying the provisions of the Act and the Rule does not confer equitable powers to the ALJ.

4. The only provision of the Act cited by Respondents is section 8-42-105, C.R.S. (2009). Respondents argue that because the unapproved report of the DIME doctor indicates a date of MMI, then it is entitled to terminate Claimant's temporary benefits.

5. Since the DIME report has not been approved, it would be premature for the ALJ to find as fact that the Claimant has reached MMI as a result of the as yet unapproved DIME report, and thus terminate temporary benefits.

ORDER

It is therefore ordered that:

Respondents' request to terminate Claimant's temporary benefits is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATE: March 11, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

SUPPLEMENTAL ORDER

Hearings in this matter where held on August 13 and August 19, 2009. A Findings of Fact, Conclusions of Law, and Order was issued on September 15, 2009. Claimant filed a Petition to Review. A partial transcript has been prepared, and briefs submitted. It is determined there is significant confusion on what issues are to be determined. A Supplemental Order is appropriate. Section 8-43-301(5), C.R.S.

1. The Findings of Fact, Conclusions of Law, and Order is incorporated herein by reference.

2. "Relatedness of Right Shoulder Condition":

An authorized treating physician placed Claimant at maximum medical improvement and rated Claimant's impairment on August 10, 2006. Claimant requested a Division independent medical examination (DIME). Dr. McCranie, the DIME physician, placed Claimant at MMI on August 10, 2006. Claimant filed an Application for Hearing and Notice to Set on February 7, 2007. As issues, Claimant marked "Compensability (of Right Shoulder)"; "Medical Benefits" and "Reasonably necessary": and, under "Other Issues to be heard at the hearing" noted "Claimant is trying to overcome the January 4, 2006 DIME opinion of Dr. Kathy McCranie, M.D.; Claimant is seeking to establish compensability of the right shoulder." The Application was set for hearing, but no hearing was ever held.

The claim was determined to be compensable before the Application was filed on February 7, 2007. Therefore "compensability" was not an issue to be decided at any hearing held on the February 7, 2007, Application. However, it is reasonably clear from the fact that Claimant marked the issues of "Medical Benefits" and "Reasonably necessary" that Claimant was seeking additional medical benefits "as may reasonably be needed at the time of the injury … to cure and relieve the employee from the effects of the injury." Section 8-42-101(1)(a), C.R.S. Claimant's comment under "Other issues" makes it clear that Claimant was seeking medical

benefits for her right shoulder.

Claimant has not waived her opportunity to seek medical benefits for her right shoulder, and is not barred by Section 8-43-203(2)(b)(II), C.R.S. from seeking those benefits.

It was determined in the Findings of Fact and Conclusions of Law that "This November 2, 2005, accident did not result in any aggravation to her pre-existing right shoulder condition." Treatment of the Claimant's right shoulder condition is not reasonably needed to cure or relieve Claimant from the effects of the November 2, 2005, compensable injury. Claimant's request for medical benefits for treatment to her right shoulder is denied.

3. Waiver of the issue of conversion to whole person:

The DIME physician rated Claimant's impairment of her left shoulder at seven percent of the upper extremity "which equals a 4 percent impairment of the whole person." Insurer filed a Final Admission of Liability on January 29, 2007, admitting for a Scheduled Impairment of 7%. Under Whole Person Impairment Insurer stated "-0-". Claimant seeks a conversion of that left shoulder impairment to a whole person impairment, which would result in an increase of her permanent partial disability benefits.

Claimant did not indicate that permanent partial disability benefits were an issue on the February 7, 2007, Application for Hearing. Her comments under "Other issues to be heard" give no indication that permanent partial disability benefits or conversion of the left shoulder scheduled impairment to a whole person impairment was to be an issue. Consideration of this permanent partial disability issue is barred by Section 8-43-203(2)(b)(II), C.R.S. Claimant has also waived consideration of this issue by not proceeding to a hearing until August 2009, some two and one-half years after objecting to the Final Admission of Liability.

4. This Supplemental Order denies a medical benefit and denies an increase in permanent disability benefits and is subject to a Petition to Review. Section 8-43-303(2), C.R.S. A brief in support must be filed with any Petition to Review of this Supplemental Order. See Section 8-43-303(6), C.R.S., for the time limitations for filing the Petition to Review and for the briefs in support of and in opposition to any Petition to Review to be filed.

DATED: *March 11, 2010*

Bruce C. Friend
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-778-710

1. On May 21, 2009 Authorized Treating Physician (ATP) Brian Thompson, M.D. issued a report noting that Claimant had reached Maximum Medical Improvement (MMI) for a right shoulder injury. He specifically remarked that Claimant's condition had stabilized after physical therapy.

2. On August 19, 2009 Pre-Hearing Administrative Law Judge (PALJ) Fitzgerald issued an Order holding the Division Independent Medical Examination (DIME) process in abeyance pending a determination of whether Claimant had reached MMI.

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

4. An ATP's opinion regarding a claimant's physical ability to return to work is dispositive unless the opinion is subject to conflicting inferences. *In Re Purser*, W.C. No. 4-643-942 (ICAP, Apr. 4, 2007). When an ATP's opinion is subject to conflicting interpretations, the determination of whether a claimant has been medically released to regular employment is a question of fact for the ALJ. *Id.*; see *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002) (reasoning that an ALJ may resolve ambiguities in an ATP's finding of MMI without requiring the completion of a DIME). Because an ATP's determination of whether a claimant has reached MMI is a question of fact, an ALJ has discretion to resolve conflicts in the physician's report. *In Re Purser*, W.C. No. 4-643-942 (ICAP, Apr. 4, 2007); *see Blue Mesa Forest v. Lopez*, 928 P.2d 831 (Colo. App. 1996) (determining that when the ATP issues conflicting opinions concerning MMI, the ALJ must resolve the conflict).

5. Based on ATP Dr. Thompson's report, Claimant reached MMI on May 21, 2009.

ORDER

1. Claimant reached MMI on May 21, 2009.

2. PALJ Fitzgerald's August 19, 2009 Order holding the DIME process in abeyance is lifted.

DATED: March 15, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. UR 2009-07

ISSUES

Claimant appeals from the Director's Order-Utilization Review dated November 6, 2009 that ordered a change of provided be made. Claimant argues that the Director's Order ordering a change of provider is overcome by clear and convincing evidence on the basis that the Utilization Review panel members found, by a majority, that the care provided by Provider was reasonable and necessary.

FINDINGS OF FACT

Based upon a review of the record, the ALJ finds as fact:

1. The Director of the Division of Workers' Compensation issued a Director's Order-Utilization Review on November 6, 2009 following a request for Utilization Review by Respondents of the care provided by Provider to Claimant. The Director ordered that a change of provider be made.

2. The Director's Order contained a Certificate of Mailing certifying that it was mailed to counsel for Claimant, the Provider under review, Claimant and Respondents' counsel on November 6, 2009. The Certificate of Mailing certified that attached to and mailed with the Order was a one-page item entitled "Appeal Procedures".

3. The "Appeals Procedures" attached to and mailed with the Director's Order on November 6, 2009 advised the parties that if the Director's Order specified that a change of provider be made any party may appeal to an ALJ for review of the Director's Order. The document further specifically advised the parties that any appeal must be submitted to the Division of Workers' Compensation, 633 17th St., 4th Floor, Denver, CO 80202, Attn: UR Coordinator, within (40) forty calendar days from the date of the certificate of mailing of the Director's Order. The "Appeal Procedures" specifically referenced Section 8-43-501(5)(c), C.R.S.

4. Counsel for Claimant signed an Application for Appeal from Director's Order – Utilization Review on December 16, 2009 on behalf of Claimant. The Application for Appeal contained a certification that it was mailed to: Division of Workers' Compensation, 633 17th St., 4th Floor, Denver, CO 80202, Attn: UR Coordinator on December 16, 2009.

5. The Application for Appeal signed by counsel for Claimant was received by the

Utilization Review office of the Division of Workers' Compensation on December 23, 2009.

6. December 23, 2009 is more than (40) forty calendar days from the date of the certificate of mailing of the Director's Order – Utilization Review.

7. Claimant's Application for Appeal of the Director's Order – Utilization Review was not timely filed under Section 8-43-501(5)(c), C.R.S.

CONCLUSIONS OF LAW

8. Under Section 8-43-501(1), C.R.S. any party, including the health care provider, may appeal to an administrative law judge for review of an order specifying that no change occur or that a change of provider be made with respect to a case.

9. W.C.R.P. 10-9 provides that Utilization Review appeals shall be filed with the Medical Utilization Review coordinator within the timeframes set forth in the appeal procedures.

10. Under Section 8-43-501(5)(c), C.R.S., any appeal filed pursuant to subsection (5) of Section 8-43-501 must be filed within forty days from the date of the certificate of mailing of the Director's order.

11. The forty-day time limit for appeal of a medical utilization review ("M-U-R") order is a jurisdictional requirement that cannot be waived or eliminated by consent or avoided by estoppel. An ALJ lacks jurisdiction to consider an appeal of an M-U-R order that is filed more than forty days after the certificate of mailing of the M-U-R order. *Cramer v. Indus. Claim Appeals Office,* 885 P.2d 318 (Colo. App. 1994).

12. To be "filed" an appeal must be actually received at the place where it is to be filed and is not filed until actually received. *Rice v. Indus. Claim Appeals Office,* 937 P.2d 893, (Colo. App. 1997). The timely filing requirement extends to and requires that an appeal be filed with the proper administrative or judicial forum. *Buschmann v. Gallegos Masonry, Inc.,* 805 P.2d 1193 (Colo. App. 1991). Absent a specific statutory provision deeming an appeal filed on the date it is mailed the mailing of an appeal does not suffice to effect filing of the appeal with the administrative forum. See, *Wal-Mart Stores v. Indus. Claim Appeals Office,* 24 P.3d 1, (Colo. App. 2000).

13. Unlike the provisions of Section 8-43-301(2), C.R.S. that specifically provides that a Petition to Review an ALJ's Order is deemed filed upon the date of mailing, Section 8-43-501(5)(c), C.R.S. does not contain a provision deeming an Application for Appeal of an M-U-R order filed upon mailing. The ALJ may not read non-existent terms into the plain language of the statute, nor imply a "mailing window". *Digital Equipment Corp. v. Indus. Claim Appeals Office,* 894 P.2d 54 (Colo. App. 1995). Thus, in absence of a specific statutory provision deeming the Application for Appeal to be filed with the Medical Utilization Review coordinator upon mailing the Application for Appeal is not filed until actually received by the Utilization Review coordinator. As found, the appeal here was not received by the Utilization Review

coordinator until December 23, 2009, more than forty days after the certificate of mailing of the Director's M-U-R Order in this matter. The Application for Appeal was therefore not timely filed under Section 8-43-501(5)(c), C.R.S. and the ALJ lacks jurisdiction to consider the appeal.

ORDER

It is therefore ordered that:

Claimant's Application for Appeal from the Director's Order - Utilization Review dated November 6, 2009 is dismissed, with prejudice.

The Director's Order – Utilization Review dated November 6, 2009 is affirmed.

All matters not determined herein are reserved for future determination.

DATED: March 15, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-725-906

ISSUE

Whether Respondents have produced clear and convincing evidence to overcome Dr. Bisgard's DIME opinion that Claimant's cervical condition was causally related to his job duties for Employer and he has not reached Maximum Medical Improvement (MMI) for the condition.

FINDINGS OF FACT

1. Claimant was employed as a maintenance worker for Employer from 1997 through May 22, 2007. His job activities involved maintaining Employer's buildings, grounds and vehicles. Claimant's duties required extensive lifting, pushing, pulling, carrying and reaching.

2. Claimant testified that he began experiencing right shoulder and neck symptoms in approximately 1998. He noticed general aches and pains that he attributed to his work activities. Claimant described lifting water bottles off of a large rack, dropping them on his shoulder and placing them on a cart to deliver them to water dispensers throughout Employer's building. He commented that the racks had two upper shelves each containing approximately

12 water bottles. The water bottles were five gallons in size and were stacked approximately six to seven feet high. Claimant stated that he performed the task twice each week and moved 15 to 20 water bottles each time.

3. Claimant noted that his symptoms worsened over time. The symptoms included aching in the right shoulder from the base of the neck, pulsating pain down his right arm, numbness in his fingers and loss of grip strength. Claimant did not initially report his concerns to Employer because he suspected that he was experiencing normal aches and pains.

4. Claimant testified that he fell on ice at work in January 2007. He noted that he suffered from neck pain for a couple of months. However, he did not file a Workers' Compensation claim because he expected the pain to subside.

5. On May 22, 2007 Claimant reported his right shoulder, arm, hand and back symptoms to Employer. On June 5, 2007 he completed an Employee Occurrence report in which he attributed his symptoms to lifting five gallon Deep Rock Water Bottles from overhead racks and distributing them throughout Employer's facility. In a hand-written statement to Insurer Claimant specifically reported that he had been lifting 15 to 25 bottles of Deep Rock Water twice each week from a rack that was above shoulder level. He noted that the activity placed stress on his shoulders and back. Claimant explained that, although he could not specify a date of injury, the repetitive nature of lifting water bottles and engaging in other work activities caused his shoulder and back pain.

6. After an initial referral to Big Thompson Medical Group, Claimant obtained medical treatment from Authorized Treating Physician (ATP) Dr. Reents. Claimant reported his right shoulder symptoms and Dr. Reents considered impingement syndrome or rotator cuff tendonitis. He also ordered an MRI of Claimant's right shoulder.

7. On July 3, 2007 Claimant visited Dr. Reents for an examination. Dr. Reents reviewed Claimant's right shoulder MRI and noted that it reflected a mild tendinopathy and partial thickness tear of the superspinatus, fraying of the labrum and tendinopathy of the subscapularis. He determined that physical therapy, time and anti-inflammatory medications would adequately address Claimant's symptoms. Dr. Reents referred Claimant to orthopedic surgeon Dale Martin, M.D. for a right shoulder evaluation.

8. On September 14, 2007 Claimant visited Dr. Martin for a right shoulder evaluation. Dr. Martin administered a right shoulder injection. Although the injection initially alleviated Claimant's right shoulder pain, he experienced a progressive return of symptoms. Dr. Martin recommended right shoulder surgery but Claimant was unable to undergo the surgery because of an unrelated lung condition.

9. Claimant subsequently returned to Dr. Reents with continued right shoulder symptoms. Dr. Reents maintained that Claimant was suffering from right shoulder impingement. On December 28, 2007 Dr. Reents concluded that Claimant had reached MMI and assigned a 16% right upper extremity impairment rating.

10. Claimant challenged Dr. Reents' MMI determination and sought a DIME. However, prior to the DIME Claimant underwent an independent medical examination with Dr. Hughes on March 27, 2008. Dr. Hughes determined that Claimant suffered from a right shoulder strain/sprain with tendonopathy and a labral tear, progressive right shoulder adhesive capsulitis and a cervical sprain. Dr. Hughes maintained that Claimant had suffered an occupational disease as a result of forceful and repetitive heavy lifting while performing his job duties for Employer. He stated that Claimant's right shoulder condition had worsened and required additional treatment. Dr. Hughes also recommended a cervical spine MRI, right upper extremity EMG and nerve conduction study. Dr. Hughes concluded that Claimant had not reached MMI.

11. On June 5, 2008 Claimant visited Dr. Roth for an independent medical examination. Dr. Roth considered Claimant's medical records, employment activities, symptoms and physical examinations. He concluded that Claimant suffered from degenerative rotator cuff disease that was not uncommon in an individual of 47 years old. Dr. Roth noted that, in the absence of a specific traumatic event, Claimant's right shoulder condition was not work-related. Dr. Roth also determined that Claimant's work activities did not cause his cervical spine symptoms.

12. On June 16, 2008 Claimant underwent a DIME with Dr. Bisgard. She determined that Claimant's right shoulder and neck symptoms were caused by his employment activities for Employer. Dr. Bisgard remarked that Claimant had not reached MMI and recommended conservative medical treatment for each condition.

13. Claimant subsequently returned to ATP Dr. Reents for medical treatment. Despite Dr. Bisgard's DIME report, Dr. Reents maintained that Claimant's employment activities did not cause his cervical spine condition. However, he also disagreed with Dr. Roth that Claimant's right shoulder rotator cuff injury was not work-related. Dr. Reents thus provided medical treatment and prescribed physical therapy for Claimant's right shoulder symptoms. He again placed Claimant at MMI on July 1, 2009.

14. On August 18, 2009 Claimant returned to Dr. Bisgard for a second DIME. She concluded that Claimant had reached MMI for his right shoulder condition and assigned a 10% right upper extremity impairment rating. However, Dr. Bisgard maintained that Claimant had not reached MMI for his cervical spine condition. She recommended evaluation by an anesthesiologist for consideration of facet blocks, medical branch blocks and a rhizotomy.

15. Respondents disagreed with Dr. Bisgard's determinations regarding the cause of Claimant's cervical spine condition and his failure to reach MMI. Respondents thus sought a hearing to overcome her DIME opinion.

16. Dr. Reents testified at the hearing in this matter and concluded his testimony through an evidentiary deposition. He explained that repetitively lifting Deep Rock Water

Bottles was consistent with Claimant's right shoulder injury. However, Dr. Reents concluded that Claimant's cervical spine condition was not related to his work activities for Employer. He stated that Claimant did not mention cervical spine symptoms during treatment. Dr. Reents also remarked that Claimant suffered from degenerative cervical spine disease as reflected on an MRI.

17. Dr. Bisgard testified through an evidentiary deposition in this matter. Dr. Bisgard reiterated that Claimant suffered an occupational disease to his cervical spine as a result of his employment activities for Employer. She explained that Claimant did very heavy work that caused wear and tear on his shoulder and caused his underlying degenerative neck condition to become symptomatic. Even in the absence of Claimant's January 2007 slip and fall Dr. Bisgard determined that Claimant would have developed his neck and shoulder symptoms. She specifically explained:

> He is looking up. He's installing ceiling fans. He is in sustained flexion. He is doing lifting. And he is maneuvering heavy tables -- six - to eight-foot tables. He's stacking chairs. And it's just wear and tear. Had it not been -- let's look at it this way.
>
> Had it not been for the work that he does, would he be symptomatic at this time, if he was still jet skiing, water skiing, and doing impact activities on his neck? Maybe.
>
> But I can't tell you that he would have had these symptoms had he not been involved in this kind of heavy work.

18. Dr. Bisgard emphasized that Claimant's 10 years of heavy work for Employer caused his underlying degenerative spine condition to become symptomatic. She stated:

> Well, for 10 years he has been engaged in this -- I don't know if it would actually qualify for heavy -- but moderate to heavy work. Anyway, in any case, it was very physical work that he was engaged in.
>
> He already had degenerative disc disease in the cervical spine. And it just lends itself to the perfect storm of a bad neck with heavy work, and ultimately, a slip and fall, that kind of, well, all the pieces came together. And he became very symptomatic and needed treatment.

19. Dr. Bisgard commented that Claimant engaged in repetitive heavy lifting activities for Employer. She concluded that, in the absence of his work activities he would not have experienced neck symptoms. Dr. Bisgard also emphasized the force required to perform Claimant's job duties. She commented:

> Well, the forces. It shows that frequently he was having to lift 50 pounds,

> occasionally 100 pounds. That is a significant amount. I mean, how much he was carrying, pushing, pulling, reaching overhead. . . .
>
> So those are all forces that are important for putting together why he may have these symptoms as a result of his work exposure.
>
> If he was sitting at a desk, and he was a desk jockey, I would say that I have no explanation for his symptoms, based on his work. But this is a guy who is in a moderately heavy job and has been doing the job for awhile.
>
> I believe, based on a reasonable degree of medical probability and certainty, that I can explain his symptoms, based on his work activities.

20. Dr. Roth testified through an evidentiary deposition in this matter. After explaining medical causation, Dr. Roth concluded that Dr. Bisgard's conclusions were erroneous. He specifically determined that Claimant's cervical condition was not related to his employment for Employer and he had reached MMI. Dr. Roth noted that Dr. Bisgard's opinion was based on inaccurate information pertaining to a January 2007 incident when Claimant's slipped and fell on ice. He remarked that, because Claimant did not mention neck symptoms to medical providers until April 2007, the January 2007 slip and fall could not have caused his cervical condition.

21. Dr. Roth explained that Claimant suffers from degenerative changes in his cervical spine that were not caused by his work activities for Employer. He commented that Claimant's degenerative cervical spine changes would progress and become symptomatic regardless of work activities. Dr. Roth remarked "the concept of wear and tear, it's an old wife's tale. There is not truth in any body part that has an effect or accelerates degeneration, other than in the knees, and only knees of obese people . . . it does not matter what [Claimant] did." He explained that the medical literature did not support a causal connection between Claimant's job duties and cervical spine condition. Dr. Roth specifically commented that Claimant's handling of Deep Rock Water Bottles and other lifting duties did not contribute to the degeneration of his cervical spine. Moreover, Claimant's MRI scan did not reveal any work-related injury or pathology. Dr. Roth thus summarized that Claimant's degenerative cervical spine condition was not impacted by his job duties.

22. Dr. Hughes testified through an evidentiary deposition in this matter. He agreed with Dr. Bisgard's conclusions that Claimant's right shoulder and cervical conditions were caused by his job duties for Employer. Dr. Hughes also agreed that Claimant had not reached MMI for his cervical condition and that he required the medical treatment recommended by Dr. Bisgard.

23. Based on Claimant's MRI results, Dr. Hughes noted that Claimant suffers from degenerative changes to his cervical spine. He specifically stated that Claimant "is susceptible to cervical spine injury to a greater degree than someone without these degenerative changes." Dr. Hughes agreed with Dr. Bisgard that Claimant's January 2007 slip and fall may

have started a cascade of symptoms that combined with his job duties to cause his cervical spine condition. However, even discounting the fall, Dr. Hughes concluded that Claimant's job duties were sufficient to cause his cervical spine symptoms.

24. Dr. Hughes addressed Dr. Roth's opinion that Claimant's job duties did not cause or aggravate his cervical spine condition. He noted that the series of scientific studies referenced by Dr. Roth to support his opinion were related to the lumbar instead of cervical spine. Nevertheless, he remarked that the studies concluded that physical loading increased lumbar annular ligament tears. Dr. Hughes commented that the studies thus supported his opinion that heavy lifting can accelerate degenerative disc disease. He explained:

> In my opinion, an individual with a weakened cervical spine due to degenerative disease is uniquely susceptible to injury by repetitive and forceful material-handling activities on or away from work.
>
> This could be a sports-related injury. He could be a Jet Ski champion and injure himself that way, but I have no evidence that he's a Jet Ski champion. Rather it appears that he was handling Deep Rock water bottles.
>
> Well, overhead work would increase the postural stress and posterior elements of the cervical spine. . . . In my opinion, [Claimant] was uniquely susceptible to injuring those structures in the cervical spine.

25. Respondents have failed to produce clear and convincing evidence to overcome Dr. Bisgard's DIME opinion that Claimant's occupational cervical condition was causally connected to his job duties for Employer and that he has not reached MMI for the condition. Claimant credibly maintained that he suffered occupational diseases to his right shoulder and cervical spine because of his work duties for Employer. He specifically attributed his symptoms to lifting five gallon Deep Rock Water Bottles from overhead racks and distributing them throughout Employer's facility. Claimant explained that he lifted 15 to 25 bottles of Deep Rock Water twice each week from racks that were above shoulder level. The activity placed stress on his shoulders and back. DIME physician Dr. Bisgard persuasively explained that Claimant suffered an occupational disease to his cervical spine as a result of his employment activities for Employer. She explained that Claimant did very heavy work that caused wear and tear on his right shoulder and caused his underlying degenerative neck condition to become symptomatic. She concluded that Claimant had reached MMI for his right shoulder condition and assigned a 10% right upper extremity impairment rating. However, Dr. Bisgard maintained that Claimant had not reached MMI for his cervical spine condition. She recommended evaluation by an anesthesiologist for consideration of facet blocks, medical branch blocks and a rhizotomy.

26. In contrast, doctors Reents and Roth concluded that Claimant's employment activities did not cause or aggravate his degenerative spine condition. Dr. Roth initially noted that Dr. Bisgard's opinion was based on inaccurate information pertaining to a January 2007

incident when Claimant's slipped and fell on ice. However, he emphasized that Claimant's degenerative cervical spine condition would progress and become symptomatic regardless of work activities. He explained that the medical literature did not support a causal connection between Claimant's job duties and cervical spine condition. Dr. Roth specifically commented that Claimant's handling of Deep Rock Water Bottles and other lifting duties did not contribute to the degeneration of his cervical spine.

27. Dr. Hughes addressed Dr. Roth's opinion that Claimant's job duties did not cause or aggravate his cervical spine condition. He agreed with Dr. Bisgard that Claimant's January 2007 slip and fall may have started a cascade of symptoms that combined with his job duties to cause his cervical spine condition. However, even discounting the fall, Dr. Hughes concluded that Claimant's job duties were sufficient to cause his cervical spine condition. He noted that the series of scientific studies referenced by Dr. Roth to support his opinion were related to the lumbar instead of cervical spine. Nevertheless, he remarked that the studies concluded that physical loading increased lumbar annular ligament tears. Dr. Hughes noted that the studies supported his opinion that heavy lifting can accelerate degenerative disc disease. His opinion thus persuasively considered the interaction between Claimant's degenerative cervical spine condition and employment activities. Dr. Hughes' conclusions therefore support Dr. Bisgard's DIME determination regarding the cause of Claimant's cervical spine condition. In contrast, Dr. Roth's opinion merely constitutes a difference of medical opinion. Respondents have thus failed to produce clear and convincing evidence to overcome Dr. Bisgard's DIME opinions that Claimant's cervical condition was caused by his work activities for Employer and that he has not reached MMI for the condition.

CONCLUSIONS OF LAW

1. 1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

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

4. 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 claimant is required to prove by a preponderance of the evidence that the alleged occupational disease was directly or proximately caused by the employment or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251, 252 (Colo. App. 1999). Moreover, §8-40-201(14), C.R.S. imposes proof requirements in addition to those required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819, 824 (Colo. 1993). A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.*

6. In ascertaining the DIME physician's opinion, the ALJ should consider all of the DIME physician's written and oral testimony. *Lambert & Sons, Inc. v. Industrial Claim Appeals Office,* 984 P.2d 656, 659 (Colo. App. 1998). A DIME physician's determination regarding MMI and permanent impairment consists of her initial report and any subsequent opinions. *In Re Dazzio,* W.C. No. 4-660-149 (ICAP, June 30, 2008); *see Andrade v. Industrial Claim Appeals Office,* 121 P.3d 328 (Colo. App. 2005).

7. 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).

8. As found, Respondents have failed to produce clear and convincing evidence to overcome Dr. Bisgard's DIME opinion that Claimant's occupational cervical condition was causally connected to his job duties for Employer and that he has not reached MMI for the condition. Claimant credibly maintained that he suffered occupational diseases to his right shoulder and cervical spine because of his work duties for Employer. He specifically attributed his symptoms to lifting five gallon Deep Rock Water Bottles from overhead racks and distributing them throughout Employer's facility. Claimant explained that he lifted 15 to 25 bottles of Deep Rock Water twice each week from racks that were above shoulder level. The activity placed stress on his shoulders and back. DIME physician Dr. Bisgard persuasively explained that Claimant suffered an occupational disease to his cervical spine as a result of his employment activities for Employer. She explained that Claimant did very heavy work that caused wear and tear on his right shoulder and caused his underlying degenerative neck condition to become symptomatic. She concluded that Claimant had reached MMI for his right shoulder condition and assigned a 10% right upper extremity impairment rating. However, Dr. Bisgard maintained that Claimant had not reached MMI for his cervical spine condition. She recommended evaluation by an anesthesiologist for consideration of facet blocks, medical branch blocks and a rhizotomy.

9. As found, in contrast, doctors Reents and Roth concluded that Claimant's employment activities did not cause or aggravate his degenerative spine condition. Dr. Roth initially noted that Dr. Bisgard's opinion was based on inaccurate information pertaining to a January 2007 incident when Claimant's slipped and fell on ice. However, he emphasized that Claimant's degenerative cervical spine condition would progress and become symptomatic regardless of work activities. He explained that the medical literature did not support a causal connection between Claimant's job duties and cervical spine condition. Dr. Roth specifically commented that Claimant's handling of Deep Rock Water Bottles and other lifting duties did not contribute to the degeneration of his cervical spine.

10. As found, Dr. Hughes addressed Dr. Roth's opinion that Claimant's job duties did not cause or aggravate his cervical spine condition. He agreed with Dr. Bisgard that Claimant's January 2007 slip and fall may have started a cascade of symptoms that combined with his job duties to cause his cervical spine condition. However, even discounting the fall, Dr. Hughes concluded that Claimant's job duties were sufficient to cause his cervical spine condition. He noted that the series of scientific studies referenced by Dr. Roth to support his opinion were related to the lumbar instead of cervical spine. Nevertheless, he remarked that the studies concluded that physical loading increased lumbar annular ligament tears. Dr. Hughes noted that the studies supported his opinion that heavy lifting can accelerate degenerative disc disease. His opinion thus persuasively considered the interaction between Claimant's degenerative cervical spine condition and employment activities. Dr. Hughes' conclusions therefore support Dr. Bisgard's DIME determination regarding the cause of

Claimant's cervical spine condition. In contrast, Dr. Roth's opinion merely constitutes a difference of medical opinion. Respondents have thus failed to produce clear and convincing evidence to overcome Dr. Bisgard's DIME opinions that Claimant's cervical condition was caused by his work activities for Employer and that he has not reached MMI for the condition.

ORDER

1. Respondents have failed to produce clear and convincing evidence to overcome Dr. Bisgard's DIME opinion that Claimant's job duties for Employer caused his occupational cervical spine condition.

2. Claimant has reached MMI for his right shoulder condition. However, Respondents have not produced clear and convincing evidence to overcome Dr. Bisgard's DIME opinion that Claimant has not reached MMI for his cervical spine condition. He is thus entitled to the reasonable and necessary medical treatment recommended by Dr. Bisgard that is designed to cure or relieve the effects of his occupational cervical spine condition.

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

DATED: March 15, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-789-550

ISSUES

The issues for determination are compensability, medical benefits, and temporary disability benefits. The parties stipulated to an average weekly wage of $758.90.

FINDINGS OF FACT

1. Claimant worked for Employer for approximately sixteen years. In January 2008, Claimant was transferred to the records section. Her job duties included retrieving, scanning, coding, and filing documents from the building department. The coding work required her to use a keyboard to enter data into approximately ten to twelve fields for each permit. Some of the fields were self-populating.

2. In early 2009, the Employer instituted a three-week rotation system under which the clerical staff, including Claimant, would perform differing tasks. Under the rotation system, the “B” duties required the most keyboard work, while the “A” and “C” duties included more general clerical functions.

3. Claimant first complained of symptoms on March 4, 2009. She was referred to COSH the same day and saw Dr. Buseman. Her symptoms included pain in her neck and forearms that radiated down into her hands. She was diffusely tender to palpation in the right arm, forearm, elbow, and hand. The left upper extremity was diffusely tender as well. Dr. Buseman diagnosed bilateral upper extremity myofascial pain and questioned whether the diagnosis was work-related.

4. Claimant returned to COSH on March 18, 2009, and complained of pain in both shoulders and upper extremities that radiated down to the wrists and hands. She reported that sometimes her entire arm went numb. The diagnosis was myofascial pain by history and cervical spine films were ordered.

5. Claimant saw Dr. Mulloy at COSH on March 23, 2009, and reported pain and numbness that went down her arm. She stated that the pain was 10/10 although Dr. Mulloy noted that Claimant was sitting comfortably in a chair and was able to move her arms and neck without difficulty. Dr. Mulloy prescribed an EMG study. Dr. Mulloy stated:

> The description of a slow progression of pain over 12 to 14 months with bilateral numbness and the results of her cervical spine showing her to have degenerative disk disease at C5-6 and C7 with mild foramina narrowing with a 3mm C4 and C5 anterolisthesis possibly more likely being the cause of her underlying pain that any of her work activities.

6. Dr. Blei performed bilateral EMG studies on March 31. 2009. He found electrodiagnostic evidence of “very mild” carpal tunnel syndrome on the right and “borderline” carpal tunnel syndrome on the left. He noted that her primary symptoms did not stem from the carpal tunnel.

7. Dr. Blei performed a second set of EMG studies on July 8, 2009. His findings were the same as on the March 31, 2009, studies. He said that some of her hand symptoms could be due to the carpal tunnel syndrome, however, “this appeared to be rather insignificant and doubtful due to the symmetry.”

8. Claimant saw Dr. Kuehn at COSH on April 13, 2009, and complained of increasing pain in her arms. Dr. Kuehn noted that the medial epicondyles were tender. Dr. Kuehn noted that the EMG studies showed borderline carpal tunnel findings although Dr. Blei, the doctor who performed the EMG, did not believe that carpal tunnel would account for her symptomatology. Work restrictions were imposed.

9. Dr. Kuehn saw Claimant again on April 27, 2009, and discussed additional therapies and medications. Dr. Kuehn found swelling in the DIP joints that was consistent with osteoarthritis. Dr. Kuehn noted that Claimant's symptoms have persisted despite appropriate interventions. She stated:

> I would anticipate that if these symptoms were associated with her ergonomics, that correction of the ergonomics and appropriate intervention for soft tissue injuries would result in gradual improvement in symptoms.

Additional work restrictions were imposed and Claimant was referred to Dr. McCranie for further evaluation.

10. Claimant also saw Mark Testa, D.C., in April and May 2009. On April 22, 2009, he noted that Claimant tolerated myofascial release techniques poorly and wanted to be off from work for three to six months to recover. On May 8, 2009, Dr. Testa noted that his treatment had provided 20% improvement. On May 22, 2009, Dr. Testa noted that Claimant had been off from work for two weeks and still had increased arm pain. He stated it was unclear why she had pain that was out of proportion to the objective findings.

11. Dr. Kathy McCranie saw Claimant on May 1, 2009, and took a detailed history. Claimant's complaints included constant pains in her arms, hands, and fingers with intermittent numbness. At the time of the examination, Claimant was limited to 10 minutes of typing per hour. After examination, Dr. McCranie's diagnoses were bilateral upper extremity pain of unclear etiology, bilateral medial elbow tenderness with possible medial epicondylitis, and borderline to mild carpal tunnel syndrome per medical records. Dr. McCranie suggested that Claimant undergo a cervical MRI.

12. On May 11, 2009, Claimant saw Dr. Kuehn and complained of unremitting bilateral upper extremity pain. Tinnel's sign was negative bilaterally.

13. An ergonomic study performed on June 11, 2009, showed that Claimant's workstation had a keyboard platform with a mouse swivel tray, a footrest, and a trackball. The report noted that Claimant spent most of her day typing.

14. Claimant continued with a variety of therapies and medications but did not have any significant benefit. On June 16, 2009, Dr. Kuehn wrote:

> I have reviewed all of her records for this condition. Most soft tissue conditions respond to the treatment that she has been offered. Her work site evaluation does not indicate any significant ergonomic hazards as defined by the treatment Guidelines. At this point, it is difficult to say within a reasonable degree of medical probability that her condition is

related to her job tasks based on my review.

15. Dr. McCranie saw Claimant on June 26, 2009, and repeated Dr. Kuehn's statements regarding the work site evaluation. Dr. McCranie noted that Claimant had been off work since June 4, 2009, and still reported persistent symptomatology.

16. Claimant saw her primary care physician, Dr. Scott Blitz, on July 21, 2009. Her primary complaints at the time included nausea, vomiting, abdominal pain, and back pain. Claimant returned to Dr. Blitz on July 31, 2009, regarding her complaints of arm pain and he referred her to Dr. Pitzer.

17. Dr. Pitzer saw Claimant on August 18, 2009. She complained of pain in her arms, hands, and right shoulder. Dr. Pitzer did not have any medical records concerning prior treatment of the upper extremities. He performed electrodiagnostic studies that showed "mild but definite CTS on the right and a borderline study on the left but likely CTS is present given amplitude drop and EMG."

18. Unlike the complaints of general numbness that Claimant had made earlier, her examination showed a focal deficit in the right median distribution. In contrast to the earlier complaints of unremitting muscle pains in her upper extremities, Dr. Pitzer's examination showed that these were not the primary problems.

19. Claimant returned to Dr. Pitzer on August 31, 2009 and received a right median nerve block. Dr. Pitzer stated that the carpal tunnel syndrome was likely work-related.

20. On September 9, 2009, Dr. Pitzer stated that Claimant has bilateral carpal tunnel syndrome that was work-related since she did not have any significant co-morbid factors.

21. Dr. Clinkscales performed the right carpal tunnel release. Dr. Pitzer stated on January 4, 2010, that both her hand pains and her generalized arm pains had improved.

22. Dr. Watson testified that Claimant has several risk factors that are associated with carpal tunnel syndrome. These include her age, being female, her weight, and her post-menopausal status. Dr. Watson explained how being overweight can cause compression of the median nerve and create carpal tunnel symptoms. The opinions of Dr. Watson are credible and persuasive.

CONCLUSIONS OF LAW

A claimant has the burden to prove by a preponderance of evidence that her claimed injuries arose out of and in the course of her employment. Section 8-41-301(1)(c), C.R.S.; *Madden v. Mountain West Fabricators,* 977 P.2d 861 (Colo. 1999); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo.App. 2000). Proof by a preponderance of the evidence

requires the proponent to establish that the existence of a "contested fact is more probable than its nonexistence." *Page v. X-ray*, 197 Colo. 306, 592 P.2d 792, 800 (1979).

Claimant has failed to establish by a preponderance of the evidence that her bilateral myofascial pain is work-related.

Dr. Watson's opinion that Claimant's work did not cause her carpal tunnel syndrome is consistent with the Carpal Tunnel Syndrome Medical Treatment Guidelines. Dr. Watson cited additional medical studies that show a lack of a causal link to keyboard usage and carpal tunnel syndrome. He further noted that the ergonomic study performed on June 11, 2009, also showed that Claimant's wrists were held in a relatively neutral position that did not place undue pressure on the median nerve. Dr. Watson also explained that Claimant has risk factors commonly associated with carpal tunnel syndrome including her age, sex, weight, and post-menopausal status. The opinions of Dr. Watson are credible and persuasive. Claimant has failed to establish by a preponderance of the evidence that her carpal tunnel syndrome is the result of her employment.

ORDER

It is therefore ordered that the claim is denied and dismissed.

DATED: *March 15, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-633-188

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she is entitled to reopen her worker's compensation claim based on a change in condition pursuant to §8-43-303(1), C.R.S.

2. Whether Claimant has demonstrated by a preponderance of the evidence that she is entitled to receive medical benefits that are reasonable and necessary to cure or relieve the effects of her industrial injury.

FINDINGS OF FACT

1. Claimant worked for Employer as a cashier. On December 29, 2003 she

suffered an admitted industrial injury to her lower back during the course and scope of her employment. Claimant had been lifting a heavy box of unassembled furniture in order to locate the barcode and scan the item.

2. Employer directed Claimant to Occupational Health Services for medical treatment. On January 9, 2004 she visited Authorized Treating Physician (ATP) Donna Brogmus, M.D. for an evaluation. Dr. Brogmus determined that Claimant had suffered a "lumbar strain without radicular symptoms." She assigned Claimant work restrictions that included no lifting, carrying, pushing or pulling in excess of five pounds. The restrictions prohibited squatting or bending and directed Claimant to perform primarily seated work.

3. Claimant subsequently returned to modified duty for Employer as a customer greeter.

4. Over the next several months Claimant received conservative medical treatment for her industrial injury. Treatment included chiropractic care, massage therapy and physical therapy.

5. On March 10, 2004 Claimant underwent an MRI of her lumbar spine. The MRI revealed moderate diffuse disc bulging at L3-4 and mild to moderate disc bulging at L4-5. The disc bulging was asymmetric to the left. There was an abnormal signal associated with the left posterolateral aspect of the L4-5 disc compatible with a radial tear. The radiologist's impression included "neural encroachment at L3-4 and L4-5 and that "the radial tear involving the L4-5 disk is acute in nature." The remaining MRI findings were chronic.

6. Claimant was subsequently referred to doctors Scott Hompland, M.D. and Robert Benz, M.D. for evaluations. The doctors recommended trigger point and facet joint injections. However, Claimant refused the injections because of concerns about her long-term health. She thus continued to receive conservative treatment through Dr. Brogmus.

7. On October 21, 2004 Dr. Brogmus determined that Claimant had reached Maximum Medical Improvement (MMI). She assigned Claimant an 11% whole person impairment rating based on range of motion loss and the lower back injury. Dr. Brogmus also recommended medical maintenance medications for a six-month period. She assigned Claimant permanent work restrictions that included no lifting, carrying, pushing or pulling in excess of 25 pounds. Dr. Brogmus also precluded repetitive bending and stooping.

8. On November 24, 2004 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Brogmus' MMI and impairment determinations. Because Claimant did not challenge the FAL, her claim closed by operation of law.

9. After completing six months of medical maintenance care Claimant obtained treatment from personal physician Fiona Wilson, M.D. Dr. Wilson prescribed medications that Claimant had been taking for her industrial injuries. Dr. Wilson's records do not reflect that Claimant suffered increased or worsened back pain between April 4, 2005 and August 6, 2008.

10. On April 7, 2006 Claimant left her employment with Employer for reasons unrelated to her industrial injury.

11. On August 6, 2008 Claimant contacted Dr. Wilson's office and stated that she had "reinjured her back yesterday and would like some pain pills." On August 7, 2008 Claimant visited Dr. Wilson for an evaluation. Claimant reported that she suffered pain in her right lower back that radiated down her right leg. She also experienced some numbness and tingling in the hip area. Claimant explained that on August 6, 2008 she had been throwing a blanket on a bed when she experienced sudden, severe pain in the right hip and leg. Her right leg was not functioning and she was unable to move for 10 minutes.

12. On August 12, 2008 Claimant returned to Dr. Wilson for an evaluation. She reported continued severe back and right leg pain. Claimant also remarked that she was unable to walk more than a few steps at a time. Dr. Wilson commented:

> Suspect she has disc bulge at L4-5 with right sided radiculopathy – cannot be sure without an MRI. Pt needs to check into her old workman's comp paperwork to see if she can re-open the case as she had 5 years to do this and she is within the window – advised doing this asap – in mean-time recommend ongoing pain meds and acupuncture as an option.

13. On September 24, 2008 Claimant again visited Dr. Wilson for an examination. Although Claimant's condition had improved, she was still experiencing significant pain. Dr. Wilson remarked:

> Seeing specialist and hopefully will be able to reopen her WC case. In meantime is doing somewhat better in that she is able to walk with 6-8 ultracet per day – very expensive for her to afford – recommend trial ultram and tylenol – hopefully will need less of each in numbers. Will provide her with 2 weeks of pain pills and if care not assumed by WC will need f/u here.

14. On November 11, 2008 Claimant underwent an evaluation with E. Jeffrey Donner, M.D. Claimant reported that her industrial injury involved an "aching sensation in the lower back with sharp pain in her buttocks and aching down her legs associated with numbness." Claimant remarked that her pain levels at the time of MMI were 6-7/10. She explained that her pain markedly worsened in August 2008 while throwing a comforter onto her bed. As a result of the incident Claimant experienced severe pain in her back that radiated to her hips. She rated her pain as 10/10 on the pain scale. Claimant reported that her pain had slowly improved since August 2008 and was again at a level of 7/10. Dr. Donner concluded that Claimant had suffered a worsening of her work-related back injury after she was placed at MMI on October 21, 2004. He recommended a repeat lumbar MRI before making additional treatment recommendations and stated that Claimant's prognosis was "guarded due to the intense chronic nature of her pain, which has markedly worsened."

15. On April 16, 2009 Claimant underwent an independent medical examination with Allison Fall, M.D. Claimant reported that after reaching MMI her low back, left leg and hips continued to hurt. Claimant noted that "now it is pretty much the same thing." Claimant commented that in August 2008 she was fluffing a comforter and throwing it over the bed when she experienced increased pain and fell on top of the bed. Claimant noted that she was in a wheelchair for one month because she was unable to walk.

16. After reviewing Claimant's medical records and conducting a physical examination, Dr. Fall explained that on December 29, 2003 Claimant "suffered a lumbar strain with underlying degenerative disc disease, spondylosis, and stenosis with a possible acute radial tear on the left at L4-5." Dr. Fall concluded that Claimant's current symptoms were:

> [C]onsistent with her chronic complaints without any objective indication of worsening. However, the acute complaints as noted in the medical records by Dr. Wilson following the incident in August 2008 are consistent with acute muscular strain versus facetogenic pain versus acute disc herniation in August 2008. The incident and symptoms at that time would not be work-related, but it appears those acute symptoms have resolved. Currently, she is not reporting any right leg symptoms and does not recall that she had any right leg symptoms.

Dr. Fall summarized that Claimant likely suffered an acute new injury on August 6, 2008 but her symptoms had resolved.

17. Dr. Fall testified at the hearing in this matter. She commented that at the time Claimant reached MMI she suffered left-sided back symptoms. However, Dr. Fall noted that Claimant's symptoms after August 6, 2008 were suggestive of an acute right-sided disc herniation at L4-5. Claimant's symptoms were also consistent with an acute muscular strain or facet pain. Dr. Fall explained that an individual of Claimant's age, history of smoking and multilevel degenerative disc disease would be at increased risk for an injury to the low back regardless of a prior back injury. She commented that Claimant's non-work related degenerative disc disease would be expected to progress regardless of whether Claimant had suffered the December 29, 2003 accident. Dr. Fall noted that, as of April 16, 2009, Claimant's symptoms on the right and the left had returned to baseline.

18. Claimant testified at the hearing in this matter. She stated that, following her release from medical care on October 21, 2004, her lumbar and left leg radicular symptoms have never resolved. Her pain has gradually worsened over the years and has radiated into her lower left leg. Claimant also noted that she is prepared to undergo any of the treatment options previously recommenced, including injections, in order to relieve her symptoms.

19. Claimant has failed to establish that it is more probably true than not that she suffered a change in the condition of her compensable injury or a change in her physical or mental condition that can be causally connected to the original compensable injury. Dr. Fall commented that at the time Claimant reached MMI she suffered left-sided back symptoms.

However, Dr. Fall noted that Claimant's symptoms after August 6, 2008 were suggestive of an acute right-sided disc herniation at L4-5. Claimant's symptoms were also consistent with an acute muscular strain or facet pain. Dr. Fall summarized that Claimant likely suffered an acute new injury on August 6, 2008 but the new injury had resolved. In contrast, Dr. Donner concluded that Claimant had a worsening of her work-related back injury after she was placed at MMI on October 21, 2004. However, Dr. Donner noted that Claimant's pain markedly worsened in August 2008 while throwing a comforter onto her bed but her symptoms returned to the same level they had been when she reached MMI.

20. Claimant testified that, following her release from medical care on October 21, 2004, her lumbar and left leg radicular symptoms never resolved. Moreover, she noted that her pain has gradually worsened over the years and has radiated into her lower left leg. However, Dr. Wilson's notes reflect that Claimant did not suffer ongoing, worsening pain or a decline in function between October 21, 2004 and the comforter-throwing incident on August 6, 2008. The medical records thus reflect that Claimant's symptoms remained stable until the August 6, 2008 incident. Claimant has thus failed to demonstrate that she experienced a worsening of her work-related condition that required medical treatment. Instead, Claimant suffered a new injury on August 6, 2008 that constituted an efficient intervening cause for her back symptoms.

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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. Section 8-43-303(1), C.R.S. provides that a worker's compensation award may be reopened based on a change in condition. In seeking to reopen a claim the claimant shoulders the burden of proving her condition has changed and that she is entitled to benefits by a preponderance of the evidence. *Osborne v. Industrial Commission*, 725 P.2d 63, 65 (Colo. App. 1986). A change in condition refers either to a change in the condition of the original compensable injury or to a change in a claimant's physical or mental condition that is causally connected to the original injury. *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082, 1084 (Colo. App. 2002). A "change in condition" pertains to changes that occur after a claim is closed. *In Re Caraveo,* W.C. No. 4-358-465 (ICAP, Oct. 25, 2006). The determination of whether a claimant has sustained her burden of proof to reopen a claim is one of fact for the ALJ. *In re Nguyen,* W.C. No. 4-543-945 (ICAP, July 19, 2004).

5. If an industrial injury leaves the body in a weakened condition and the weakened condition proximately causes a new injury, the new injury is a compensable consequence of the original industrial injury. *In Re Lang,* W.C. No. 4-450-747 (ICAP, May 16, 2005). However, the existence of a weakened condition is insufficient to establish causation if the new injury is the result of an efficient intervening cause. *Owens v. Industrial Claim Appeals Office,* 49 P.3d 1187, 1188 (Colo. App. 2002); *In Re Lang,* W.C. No. 4-450-747 (ICAP, May 16, 2005). The new injury is not compensable "merely because the later accident might or would not have happened if the employee had retained all his former powers." *In Re Chavez,* W.C. No. 4-499-370 (ICAP, Jan. 23, 2004). The determination of whether an injury resulted from an efficient intervening cause is a question of fact for the ALJ. *Id.*

6. As found, Claimant has failed to establish by a preponderance of the evidence that she suffered a change in the condition of her compensable injury or a change in her physical or mental condition that can be causally connected to the original compensable injury. Dr. Fall commented that at the time Claimant reached MMI she suffered left-sided back symptoms. However, Dr. Fall noted that Claimant's symptoms after August 6, 2008 were suggestive of an acute right-sided disc herniation at L4-5. Claimant's symptoms were also consistent with an acute muscular strain or facet pain. Dr. Fall summarized that Claimant likely suffered an acute new injury on August 6, 2008 but the new injury had resolved. In contrast, Dr. Donner concluded that Claimant had a worsening of her work-related back injury after she was placed at MMI on October 21, 2004. However, Dr. Donner noted that Claimant's pain markedly worsened in August 2008 while throwing a comforter onto her bed but her symptoms returned to the same level they had been when she reached MMI.

7. Claimant testified that, following her release from medical care on October 21, 2004, her lumbar and left leg radicular symptoms never resolved. Moreover, she noted that her pain has gradually worsened over the years and has radiated into her lower left leg. However, Dr. Wilson's notes reflect that Claimant did not suffer ongoing, worsening pain or a decline in function between October 21, 2004 and the comforter-throwing incident on August 6, 2008. The medical records thus reflect that Claimant's symptoms remained stable until the August 6, 2008 incident. Claimant has thus failed to demonstrate that she experienced a worsening of her work-related condition that required medical treatment. Instead, Claimant suffered a new

injury on August 6, 2008 that constituted an efficient intervening cause for her back symptoms.

ORDER

1. Claimant's request to reopen her Workers' Compensation claim is denied and dismissed.

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

DATED: March 17, 2010.

Peter J. Cannici
Administrative Law Judge

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

ISSUES

Is Insurer liable for surgery recommended by Dr. Villavicencio?

a. Is the recommended surgery reasonable and necessary and related to the work-related injury?

b. Is the recommended back surgery maintenance care?

c. Since reaching maximum medical improvement in May 2007, has Claimant's condition worsened as the result of compensable injuries such that he is no longer at MMI and surgery is reasonably needed to cure and relieve him from the effects of this compensable injury?

Should Insurer should be assessed penalties for violation of Rule 16-10 for failing to respond to request for prior authorization for a low back surgery that was to be scheduled in January 2009?

Whether Dr. Villavicencio's recommended surgery should be deemed authorized because of Respondent's failure to comply with Rule 16-10, WCRP, is not an issue for this hearing.

FINDINGS OF FACT

1. Claimant sustained a compensable injury to his low back on February 2, 2004.

2. Claimant saw Dr. Wong on March 29, 2004. Claimant reported low back pain as high as 10 out of 10. Dr. Wong reviewed a March 2, 2004, MRI that showed desiccated discs at lumbar levels with a small to medium size disc herniation at the L3-4 level on the right. The MRI also showed lesser stenosis at the L4-5 level with a small disc bulge. Dr. Wong did not consider Claimant a good candidate for fusion surgery because Claimant's degenerative changes were multi-level.

3. Claimant was seen by Dr. Larry Tice, a neurosurgeon, on April 12, 2007. Dr. Tice reviewed the various MRIs that had been performed to Claimant's low back from March 2, 2004 through December 14, 2006. MRIs indicate that, if anything, Claimant's levels of degeneration had improved. Dr. Tice noted that, although the March 2, 2004 MRI showed a disc herniation at the L3-4 level, that disc herniation had actually resolved. Dr. Tice agreed with Dr. Wong that there were significant hazards involving a fusion with the level of degeneration in the adjacent segments. Claimant returned to see Dr. Tice on July 25, 2007. Dr. Tice stated that he did not think that there was any urgent surgical treatment for Claimant.

4. Claimant saw Dr. Cliff Gronseth, an authorized treating physician, on December 22, 2006. Claimant complained of back pain and right leg pain. He described his pain intensity as being an 8 out of 10. Claimant returned to see Dr. Gronseth on May 17, 2007. Dr. Gronseth noted that Claimant was "about the same." Claimant stated that he continued to have a 7 out of 10 intensity, achy pain across the lumbar sacral spine, radiating slightly to the right. Dr. Gronseth placed Claimant at maximum medical improvement as of May 17, 2007.

5. Dr. Jeffery Wunder saw Claimant on January 21, 2008. Claimant reported that his low back pain was localized to the mid-low back area and that his pain did not radiate. Claimant stated that the greatest pain that he had over the past month was a 10 out of 10. His lowest pain level was a 5 out of 10, and his current pain level was an 8 out of 10. Claimant told Dr. Wunder that he was taking both Oxycontin and Oxycodone for pain relief. Dr. Wunder stated that Claimant had reached maximum medical improvement for his low back condition. Dr. Wunder stated that Claimant would not be a very good surgical candidate.

6. Claimant saw Dr. Villavicencio on August 22, 2008. Claimant reported that his pain level was an 8 out of 10. Claimant's pain included low back pain and numbness in the right anterior lateral thigh. Claimant's pain medication continued to be Oxycontin and Oxycodone.

7. Claimant returned to see Dr. Villavicencio on January 6, 2009. Dr. Villavicencio stated that Claimant had two treatment options. Claimant could continue with conservative care, including physical therapy, anti-inflammatories, water therapy, and consideration of other core strengthening exercises. Or Claimant could consider surgical intervention. Dr. Villavicencio recommended a fusion at the L4-5 and L5-S1 levels. Claimant elected to proceed with the surgery. Dr. Villavicencio provided Claimant with appropriate pre-surgical paperwork. Dr.

Villavicencio's January 6, 2009, report was sent to Dr. Jennifer Kempers at Yampa Valley Medical Associates. There is no evidence that Dr. Villavicencio sent a copy of his January 6, 2009 report to Insurer.

8. Dr. Villavicencio saw Claimant again on September 29, 2009. Claimant's pain complaints remained at a 7-8 out of 10. Claimant continued to take Oxycontin and Oxycodone for his pain management. Dr. Villavicencio again indicated that Claimant had two options in terms of additional treatment. The first option would be for him to continue on a course of conservative care. The second option would be for him to consider surgical intervention. Dr. Villavicencio recommended a fusion at the L4-5 and L5-S1 levels. Dr. Villavicencio's report indicates that Claimant wished to proceed with surgical intervention. Claimant was provided with appropriate pre-surgical paperwork. Dr. Villavicencio's report reflects that copies of the report were sent to Dr. Jennifer Kempers and Dr. Gregory Arends. There is no indication in Dr. Villavicencio's report that Dr. Villavicencio's office sent the report to Insurer.

9. Dr. James Ogsbury evaluated Claimant on January 6, 2010. Dr. Ogsbury reviewed extensive medical records for the treatment that Claimant had received for his low back. Claimant reported basically taking the same medications that he had been taking since reaching maximum medical improvement in May 2007. Dr. Ogsbury reviewed an MRI that was performed on September 5, 2008. Dr. Ogsbury noted that, at the L5-S1 level, there was small disc protrusion centrally and slightly to the right, which could compress the right S1 nerve root. At the L4-5 level, Dr. Ogsbury noted a minor disc protrusion centrally and to the right. The L3-L4 level looked more normal, although the L2-L3 level showed a significant disc narrowing with degenerative change.

10. In a report dated January 27, 2010, Dr. Ogsbury addressed whether Claimant's subjective complaints had worsened since the date of his injury. Dr. Ogsbury was of the opinion that Claimant's description of pain, primarily low back pain and some pain in the right lateral thigh to the knee, seemed identical. Although Dr. Ogsbury noted that, since the date of his injury, the severity of Claimant's low back pain seemed to have increased, since May 2007 Claimant's pain complaints in these areas have remained substantially stable at a scale of 7-8 over 10. Dr. Ogsbury stated that, from an objective and diagnostic standpoint, Claimant's condition has not worsened since his injury date. Dr. Ogsbury noted that Claimant's neurological examinations remained normal with the exception of some degree of decreased sensation of the right lateral thigh. Similarly, the MRI described by Dr. Jones in the 2004 MRI indicated a disc protrusion at L3-4 centrally and to the right with degenerative changes at L4-5. Dr. Ogsbury noted that the MRI that he reviewed from 2008 indicated degenerative changes at all levels with a small disc protrusion at L5-S1, but a more normal L3-4, different, but no worse, in terms of the level of degenerative changes.

11. Dr. Ogsbury, in his January 6, 2010 report, stated that the fusion surgery recommended by Dr. Villavicencio should be discouraged. As part of his evaluation, Dr. Ogsbury asked Claimant what kind of pain relief he wished to receive as a result of the surgery, and Claimant stated that

he wished to receive at least 60% pain improvement. Dr. Ogsbury stated that Claimant only had a 33% chance of obtaining a successful result. Dr. Ogsbury also stated that there was also a 33% chance that Claimant's condition following surgery could actually worsen. Dr. Ogsbury went on to state that to attempt a surgery where the risk of failure is greater than the risk of success, and that the risk of complication is as high as the chance of receiving any kind of benefit, was not an appropriate choice.

12. Dr. Ogsbury, in his January 27, 2010 report, responded to follow-up questions posed to him by Respondents' counsel. Dr. Ogsbury stated it was unlikely that Claimant would experience any kind of objective worsening in his low back condition in the future. Given the fact that Claimant's current pain complaints are 8 out of 10, Dr. Ogsbury stated that there was very little room for worsening of that pain. In addition, there was no reason to think that, if Claimant did not have surgery, he would develop a significant neurologic abnormality, given that there has not been a neurologic abnormality demonstrated during the long time that he has been treated for this injury.

13. Dr. Ogsbury also stated that he had concerns about relying on a discogram for purposes of diagnosing the pain generators for the purpose of performing low back surgery. In Dr. Ogsbury's experience, he has seen very few normal discograms. Indeed, almost all discography performed in the context of degenerative disc disease is abnormal at some level. In Dr. Ogsbury's entire career, he can only recall three discograms during discography described as normal. Therefore, if the simple presence of an abnormal level is taken to be indicative of a surgical indicator, discography would lead to surgery in almost all cases.

14. Dr. Ogsbury explained his statement that Claimant's chances of failure significantly outweigh the chances of success, and his risks of actually worsening over time would be as high as the risk of improvement. Dr. Ogsbury stated that, based on the Frizzle study, Claimant's chance of having a successful result would only be approximately 33%. Conversely, the chance of Claimant failing to improve would be twice the chance of having any kind of significant improvement (the chance of failing to improve following surgery would be 67%). Furthermore, because of the relative high rate of complications associated with a surgical fusion, it was Dr. Ogsbury's opinion that the chances of worsening over time (either from a complication, from progression of the symptoms because of the drastic changes to the mechanics of the spine because of the operation, or just because of the perception of worsening when there is no improvement) are probably as high as the chances of significant and prolonged improvement with a fusion. Dr. Ogsbury explained that Claimant is not in a situation where the worse that could possibly happen to Claimant following low back surgery is that he would not experience any improvement in his low back condition. Rather, Dr. Ogsbury stated:

> As noted above, in my experience, the chances that [Claimant] could actually worsen from any of the above factors is probably very close or equal to the chances of improvement. All of us have seen many patients who wish they had not had that

> first operation, particularly after multiple further operations that have failed to rescue the situation back to the status that was present before the first surgery. I have always told my patients that when they fail to improve [following surgery] they actually worsen, given that now there is a scar tissue around the nerves and a lessening of the normal body movement in the segments that are fused, leading to excessive movement and excessive degeneration in the segments that are just adjacent to the fused segment (the so called adjacent segment syndrome).

Dr. Wong and Dr. Tice believe that there was a significant hazard involving a fusion with adjacent segment degeneration.

15. Dr. Ogsbury stated that, if Claimant was his patient, he simply could not ethically be part of any treatment plan, either as a surgeon, or as an advisor, for a patient who insists on proceeding with an operation that stood a better chance of hurting him rather than helping him. Dr. Ogsbury stated that he could not be part of a treatment team which proceeds in the manner that does not produce at least a reasonable chance of improvement (one that he generally felt is at least 50% or better).

16. The statements and opinions of Dr. Ogsbury are credible and persuasive.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Claimant shoulders the burden of proving by a preponderance of the evidence that he is entitled to certain medical benefits. 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. X-ray,* 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. Claimant must to prove by a preponderance of the evidence that the fusion surgery recommended by Dr. Villavicencio (1) constitutes maintenance care or (2) since reaching maximum medical improvement in May 2007, his condition has worsened as a result of the compensable injury such that he is no longer at maximum medical improvement.
4. Claimant has failed to prove by a preponderance of the evidence that the fusion surgery recommended by Dr. Villavicencio constitutes maintenance care. Dr. Gronseth stated that Claimant obtained maximum medical improvement as of May 17, 2007, unless Claimant decided to pursue fusion surgery. Dr. Gronseth is of the opinion that fusion surgery would not be considered maintenance care. Claimant has failed to prove by a preponderance of the

evidence that the fusion surgery recommended by Dr. Villavicencio would be considered maintenance care.

5. Claimant has not proven by a preponderance of the evidence that, since reaching maximum medical improvement in May 2007, his condition has worsened such that he is no longer at maximum medical improvement. Claimant's own reports of pain to the physicians that he has seen since May 2007 do not support a worsening of condition. Claimant saw Dr. Gronseth on May 17, 2007, and reported continuing to have 7 out of 10 low back pain. Although Claimant described pain levels ranging from 5-10 out of 10 to Dr. Wunder, he stated that his pain at that current time was 8 out of 10. Claimant, as early as March 29, 2004, reported to Dr. Wong that his pain levels ranged up to 10 out of 10. Claimant most recently saw Dr. Villavicencio on September 29, 2009, Claimant continued to report that his pain levels were 7 to 8 out of 10. Claimant's level of pain has not increased since reaching maximum medical improvement in May 2007.

6. Claimant's medication use has not changed since he was placed at maximum medical improvement in May 2007. In May 2007, Claimant was taking Oxycontin and Oxycodone for pain relief. Claimant continues to take Oxycontin and Oxycodone for pain relief.

7. Claimant has not shown any objective or diagnostic worsening of his condition since reaching maximum medical improvement in May 2007. Dr. Ogsbury rendered the opinion that, from an objective standpoint, Claimant has not shown any worsening since the date of his injury. Dr. Ogsbury also reviewed the various MRIs that have been performed, both before and after maximum medical improvement, and did not state that there was any significant change in the pathology identified in those MRIs.

8. The fact that Dr. Villavicencio is now recommending surgery is not an indication that his condition has worsened. Prior to Claimant reaching maximum medical improvement, various surgeons had already rendered the opinion that Claimant was a potential surgical candidate, including a candidate for low back fusion.

9. Claimant has neither proven by a preponderance of the evidence that his fusion surgery should be considered maintenance care, or that since reaching maximum medical improvement in May 2007, his condition has worsened so that he is no longer at maximum medical improvement.

10. Claimant has not proven by a preponderance of the evidence that the surgery recommended by Dr. Villavicencio is reasonable and necessary. Dr. Cho and Dr. Villavicencio have recommended low back surgery. However, five other physicians, including three surgeons (Drs. Tice, Wong and Ogsbury), have rendered the opinion that Claimant is not a good surgical candidate.

11. Dr. Ogsbury provided the only opinion as to the relative risks of Claimant improving, worsening, or staying the same. Dr. Ogsbury concludes that Claimant only has a 33% chance of a successful result following surgery and a 67% chance that he will either have no improvement, or that his condition will actually worsen. The evidence that four other physicians all discourage Claimant from having surgery corroborates Dr. Ogsbury's assessment in terms of risk. Claimant has just as much chance of having a worsening of condition following the surgery, rather than having any kind of successful result.

12. Given Claimant's pain levels of an 8 out of 10, and the length of time that Claimant's clinical

and diagnostic condition has remained stable, Dr. Ogsbury opined that there is much of a likelihood that Claimant's condition will worsen if he does not have surgery. If Claimant does not have surgery, it is very unlikely that his condition will worsen. If Claimant does have surgery, there is only a 33% chance that the surgery will be successful. If Claimant does have surgery, there is a 67% chance that Claimant will either not experience any improvement, or that his condition will actually worsen. If Claimant does have surgery, there is a 33% chance that Claimant's low back condition will actually worsen.

13. Claimant has not proven by a preponderance of the evidence that the surgery recommended by Dr. Villavicencio is reasonable and necessary.

14. Imposition of penalties under Section 8-43-304(1), C.R.S. requires a two-step analysis. See *In re Hailemichael*, W.C. No. 4-382-985 (ICAO, 11/17/04). The judge must first determine whether the disputed conduct violated a provision of the act or the rule. *Alison v. Industrial Claim Appeals Office*, 919 P.2d 623 (Colo. App. 1995). The parties seeking imposition of the penalty must establish by a preponderance of the evidence that another party has violated a rule, statute, or Order. *Pioneers Hospital v. Industrial Claim Appeals Office*, 114 P.3d 97 (Colo. App. 2005). Penalties may only be imposed if the judge concludes that the violation was objectively unreasonable. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 907 P.2d 676 (Colo. App. 1995).

15. In ascertaining an appropriate penalty, the ALJ may consider a "wide variety of factors." *Adakai v. St. Mary Corwin Hospital*, W.C. No. 4-619-954 (ICAO, 5/5/06). However, any penalty assessed should not be excessive in the sense that it is "grossly disproportionate" to the conduct in question. *See id*. When determining the penalty, an ALJ may consider factors including the "degree of reprehensibility" of the violators conduct, the severity between the actual or potential harm suffered by a party and the award of penalties, and the difference between the penalties awarded and the penalties assessed in comparable cases. *Associated Business Products v. Industrial Claim Appeals Office*, 126 P.3d 323 (Colo. App. 2005).

16. Before Insurer is required to comply with Rule 16-10, WCRP, in contesting a request for prior authorization, Dr. Villavicencio, as the provider, is obligated to have sent to Insurer a completed request for prior authorization. *Cross v. Microglide Inc.*, W.C. No. 4-355-764 (ICAO, 2/25/03); *Skelly v. Walmart Stores*, W.C. No. 4-632-887 (ICAO, 7/31/08). Rule 16-9(A), WCRP, provides that the request for prior authorization shall be made by the provider. Before Claimant can allege that Respondent has violated Rule 16-10, Claimant must first prove by a preponderance of the evidence that Dr. Villavicencio himself had requested from Insurer prior authorization for payment of low back surgery. Claimant did not submit any evidence indicating that Dr. Villavicencio sent anything to Insurer, let alone a request for prior authorization.

17. Rule 16-9(E), WCRP, provides:

> 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 providers decision making process to substantiate the need for the requested service or procedure.

18. The only evidence that Claimant submitted at hearing to establish that Dr. Villavicencio provided to Insurer a completed request for prior authorization is the January 6, 2009 report.

Dr. Villavicencio's January 6, 2009 report indicates that it was sent to Dr. Jennifer Kempers and Dr. Gregory Errands. There is no indication on the report that Dr. Villavicencio sent a copy of this report to Insurer. Dr. Villavicencio, in his January 6, 2009 report, outlined different treatment options that Claimant had available to him at that time, including ongoing conservative care or surgical intervention. The January 6, 2009 clinical note from Dr. Villavicencio noted that Claimant had elected to proceed with surgery, and noted that Claimant was then provided pre-surgical paperwork. Nowhere in Dr. Villavicencio's January 6, 2009, report is there any language indicating that he was requesting prior authorization from Respondents to proceed with surgery.

19. In cases similar to this one, the Industrial Claim Appeals Office has upheld the determinations from Administrative Law Judges that similarly drafted clinical notes did not constitute a completed request for prior authorization. *See Farber v. Washington Inventory Service*, W.C. No. 4-615-836 (ICAO 6/11/09); *Skelly v. Walmart Stores Inc., supra*.

20. Dr. Villavicencio's January 6, 2009, report did not constitute a request for prior authorization. Before a clinical note that recommends certain medical treatment can be considered a completed request for prior authorization, Claimant must show by a preponderance of the evidence that: a) there must be some kind of language within the context of the clinical note that makes it clear that the provider in fact is requesting prior authorization for the recommended service; and b) the clinical note must contain medical documentation to explain the medical necessity of the services requested.

21. The January 6, 2009 clinical note from Dr. Villavicencio contains no language suggesting that Dr. Villavicencio's office was requesting prior authorization from Insurer to perform the fusion surgery. Claimant has failed to prove by a preponderance of the evidence that Dr. Villavicencio sent the January 6, 2009, letter to Respondent as required by Rule 16-9(A), WCRP. Claimant has failed to show that Insurer was required to respond pursuant to Rule 16-10, WCRP.

22. Dr. Villavicencio's January 6, 2009, report, did not comply with Rule 16-9(E), WCRP, because it does not contain supporting medical documentation. Similar to the medical reports in the *Skelly* and *Farber* decisions, Dr. Villavicencio's January 6, 2009 clinical note does nothing more than discuss treatment options that Claimant had at the time, in continuing with conservative care as well as the option of surgical intervention, and noting that Claimant had elected to proceed with surgical intervention. Respondent submits that the January 6, 2009 report does not contain the necessary medical documentation required by Rule 16-9(E), WCRP.

23. Claimant has not proven by a preponderance of the evidence that Dr. Villavicencio complied with Rule 16-9, WCRP. Claimant has not submitted any evidence showing that Dr. Villavicencio himself in any way communicated with Insurer requesting prior authorization for payment for low back surgery; Nowhere in Dr. Villavicencio's January 6, 2009 report is there any indication that Dr. Villavicencio was in fact requesting from Insurer prior authorization to perform the low back surgery; and Dr. Villavicencio's January 6, 2009 clinical note does not contain the necessary medical documentation required by Rule 16-9(E) to explain the medical necessity of the recommended surgery.

24. Claimant has also failed to submit evidence as to other key elements in any penalty claim

that he may have against Insurer for violation of Rule 16-10, WCRP. Claimant has submitted no evidence as to when Insurer actually received a copy of Dr. Villavicencio's January 6, 2009 letter. Claimant has submitted no evidence that Insurer did not comply with the requirements of Rule 16-10(B), WCRP. Claimant has failed to prove up a violation of Rule 16-10, WCRP.

ORDER

It is therefore ordered that:

1. Claimant's request that Insurer be liable for the costs of the surgery recommended by Dr. Villavicencio is denied.

2. Claimant's request for a penalty for violation of Rule 16-10, WCRP is denied.

Issues not determined by this and previous orders are reserved for future determination.

DATED: *March 15, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

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

ISSUES

The issues to be determined by this decision are:

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

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

3) whether medical benefits are required.

FINDINGS OF FACT

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

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

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

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

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

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

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

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

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

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

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

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

13. On August 7, 2009, Dr. Finn authored a letter stating he had reviewed the video. Dr. Finn

stated that Claimant appeared to be performing activities and moving his back and right shoulder more than what he was able to obtain in the office by direct measurements, and would have to agree with Dr. Venegas and Dr. Jones that Claimant has no impairment functionally as it related to his back and right shoulder injury.

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

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

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

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

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

CONCLUSIONS OF LAW

1. The DIME physician's findings concerning the date of MMI and the degree of medical impairment are binding on the parties unless overcome by clear and convincing evidence. Sections 8-42-107(8)(b) (III) & (8)(c), C.R.S. 2007. If the DIME physician offers ambiguous or conflicting opinions concerning MMI or impairment, it is for the ALJ to resolve the ambiguity and determine the DIME physician's true opinion as a matter of fact. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000); *U v. North & Air Package Express Services*, W. C. No. 4-492-570 (February 16, 2005), *aff'd, U v. Industrial Claim Appeals Office* (Colo. App. 05CA0491, January 26, 2006) (not selected for publication). In so doing, the ALJ should consider all of the DIME physician's written and oral testimony. *Lambert & Sons, Inc. v. Industrial Claim Appeals Office*, 984 P.2d 656, 659 (Colo. App. 1998). A DIME physician's finding of MMI and permanent impairment consists not only of the initial report, but also any subsequent opinion given by the physician. *See Andrade v. Industrial Claim Appeals Office*, 121 P.3d 328 (Colo. App. 2005)(ALJ properly considered DIME physician's deposition testimony where he withdrew his original opinion of impairment after viewing a surveillance

video); *see also, Jarosinski V. Industrial Claim Appeals Office*, 62 P.3d 1082 (Colo. App. 2002) (noting that DIME physician retracted original permanent impairment rating after viewing videotapes showing the Claimant performing activities inconsistent with the symptoms and disabilities she had reported).

2. In testimony during his deposition Dr. Finn provided his findings, which differed from his original report, that the Claimant was at MMI as of March 4, 2009 and the Claimant has no permanent impairment. The ALJ concludes that this is the DIME physician's true opinion in this matter. Dr. Finn further affirmed the zero percent rating in his deposition when asked by Respondents' counsel. Dr. Finn stated the zero percent rating would take the place of the seventeen percent rating he gave on June 3, 2009, and that his true opinion is that Claimant has no impairment. The burden then shifted to Claimant to overcome that opinion by clear and convincing evidence. Claimant failed to do so.

3. It is the ALJ's province to determine the DIME physician's true opinion as a matter of fact. Once the ALJ determines the DIME physician's opinion concerning impairment, the party seeking to overcome that opinion bears the burden of proof by clear and convincing evidence. *X-ray v. Hudick Excavating, Inc.,* W. C. No. 4-524-162 (November 5, 2004). In *Fera v. Resources One, LLC, D/B/A Terra Firma*, W. C. No. 4-589-175 (May 25, 2005) *aff'd, Resources One, LLC v. Industrial Claim Appeals Office* 148 P.3d 287 (Colo. App. 2006) the panel found that when the ALJ determined the DIME physician's true opinion on MMI, the ALJ did not err in assigning the respondents the burden of proof to overcome by clear and convincing evidence the DIME physician's finding that MMI had not been attained. *See also Viloch v. Opus Northwest*, LLC, W. C. No. 4-514-339 (June 17, 2005); *Gurule v. Western Forge*, W. C. No. 4-351-883 (December 26, 2001). The deposition testimony of the DIME physician is properly considered as part of the DIME physician's overall "finding." *U v. North & Air Package Express Services*, *supra*.

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

5. Sections 8-42-107(8)(b)(III) and (c), C.R.S. provide that the finding of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert,* 914 P.2d 411 (Colo.App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert, supra.* A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Browning Ferris Indus. of Colorado,* W.C. No. 4-350-36 (ICAO March 22, 2000).

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

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

8. Pursuant to section 8-40-102(1), C.R.S., the Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray,* 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S. Claimant failed to prove by a preponderance of the evidence that he is entitled to additional medical benefits. Dr. Jones and Dr. Venegas opined that no further medical care is required for Claimant and the ALJ finds their opinions credible.

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

ORDER

IT IS, THEREFORE, ORDERED THAT:

1. Claimant's impairment rating is zero.

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

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

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

DATE: February 9, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-805-582

ISSUES

The following issues were raised for consideration at hearing: whether Claimant suffered an injury in the course and scope of his employment; whether Claimant is entitled to an order awarding reasonably necessary and authorized medical benefits; and whether Claimant is entitled to an order awarding temporary total disability benefits (TTD).

STIPULATION OF FACT

The parties stipulated that Claimant's average weekly wage would result in the payment of TTD benefits at the statutory maximum rate for this date of injury or $807.24.

FINDINGS OF FACT

1. Claimant is a 54 years old male who resides in Arvada, Colorado . Claimant has been employed by the Employer for 30-years. For 20 years, he has worked as a packaging sterilizer.

2. Claimant has never had a previous injury to either knee at work or outside of work. On July 15, 2009, Claimant was descending a flight of stairs in the course and scope of his employment for the Employer. Claimant was performing his duties as a packaging sterilizer. Claimant was taking the direct route down the stairs to the six can filler room. He missed a step, landed on the step below. He hyper extended his left leg, and the knee gave way from the force of his weight. Claimant's testimony regarding the mechanism of injury on July 15,

2009, was credible and persuasive.

3. Medical records reflecting reports of the injury are consistent with Claimant's testimony.

4. Claimant credibly testified that the steps where he injured himself were steep steel steps. He testified that the steps were steeper than normal steps with treads that are shorter than regular steps. Claimant did not have occasion to climb similar steps outside of work. Claimant was taking these steps as the most direct route to the six can filler room to complete a work task.

5. The injury took place at approximately 1:30 p.m. Claimant suffered immediate pain and, soon after, the site of the injury swelled. Claimant's symptoms did not resolve and he informed his supervisor of the injury following a safety meeting that he attended from 2:00 to 3:00 p.m. on July 15, 2009. Claimant was sent to the on-site Employer's Medical Center. Claimant reported to Dr. Smaldone's office and was seen that day as reflected in Dr. Smaldone's records. Claimant was having pain throughout the knee, including on the left hand side, the right outside, and back.

6. Claimant continued to experience pain and swelling in the knee, including daily swelling which required him to ice the knee every evening. Claimant continued to work after the injury, except for periods of time when he took vacation days. During those times off, he would not spend much time on his feet and the knee was doing better, as reflected in Dr. Smaldone's notes. When Claimant was on vacation, he sat in his Lazyboy at home and was not on his feet. During vacations, the swelling went down, although the pain and swelling never completely went away.

7. A substantial part of Claimant's work duties involved walking during the course of the day, including going up and down stairs. Dr. Smaldone was concerned about a meniscus tear from the beginning and, by July 30, 2009, ordered an MRI of Claimant's left knee. The MRI, which was performed on August 3, 2009, demonstrated a radial tear of the body and the posterior horn of the medical meniscus. On September 3, 2009, Dr. Smaldone specifically noted discomfort along the medial aspect of the knee and referred Claimant to Dr. Mann for an orthopedic exam.

8. Dr. Mann performed his initial examination on September 17, 2009. Dr. Mann's examination of Claimant's knee was more extensive than the examinations done at the Employer's Medical Center. Dr. Mann was provided with the Employer's occupational medicine records. Dr. Mann credibly opined in his deposition that a radial tear is something that is caused by direct compression. In situations involving more torsion, the doctor opined that the tear is more curved. Dr. Mann's history documented a waxing and waning history of symptoms. The August 3, 2009, MRI showed a meniscus tear and was consistent with what Dr. Mann found during the October 2009 surgery.

9. During the surgery, Dr. Mann credibly testified that he saw a meniscal tear near the junction of the posterior and the middle third of the meniscus. He reported that Claimant also had a Baker's Cyst in his knee. Dr. Mann opined that the cyst probably predated the trauma on July 15, 2009, however, the cyst got bigger after the trauma.

10. Dr. Mann offered deposition testimony, which was credible and persuasive. The doctor testified in his deposition that Claimant had an incident involving his knee while mowing the lawn. Dr. Mann was not concerned about the details of the lawn-mowing incident because the incident took place after the MRI of August 3, 2009, was taken. Dr. Mann also testified that the lawn-mowing incident took place after the report of midline symptoms by Claimant on September 3, 2009.

11. Dr. Mann opined that Claimant's history and physical exam was consistent with and supported his opinions. Dr. Mann further opined that the degenerative changes in Claimant's knee were not as severe as the doctor often sees with other patients. Dr. Mann opined that this fact supports his opinion that Claimant's condition was caused by an acute event. Dr. Mann testified that Claimant's good response to the surgery further supported his opinion that Claimant's condition was caused by an acute or an acute on chronic event traceable to the July 15, 2009, date of injury. Dr. Mann opined that the axial loading that occurred during the July 15, 2009, work injury contributed to Claimant's injury, which Dr. Mann observed during the October 2009 surgery.

12. Dr. Mann credibly opined that, to a reasonable degree of medical probability, the incident on July 15, 2009, either caused or significantly aggravated the condition the doctor ultimately performed surgery on in October. This opinion is reflected in Dr. Mann's report dated November 2, 2009.

13. Dr. Fall conceded that Claimant suffered a lateral calf strain in connection with the incident. Her remaining opinions are not as credible or persuasive as those of the attending surgeon in the case, Dr. Mann. Dr. Fall is not an orthopedic surgeon and never examined or spoke with Claimant to take a history. Her opinions are based primarily on Dr. Smaldone's records. Prior to hearing Claimant's testimony at hearing, Dr. Fall did not know that Claimant took vacation time after the incident. Dr. Fall acknowledged that there were no records of any prior knee problems, the MRI took place before the lawn-mowing incident in mid-September 2009, and there is reference to midline symptoms before the lawn mowing.

14. Claimant missed a week of work following the surgery from October 26, to October 30, 2009, and was unable to perform his regular work duties during that time. Claimant was disabled from his usual employment as a result of the work injury.

15. Claimant was not happy with the treatment that he was receiving from Dr. Smaldone and exercised his right to change physicians by completing a notice of one-time change of physician. Prior to the injury, Employer did not designate two doctors for treatment of work-

related injuries. In any event, after the injury Claimant was never provided with a designation, written or otherwise, of two separate providers within 7 business days of the injury. In fact, Claimant was provided with a designation of a second doctor September 29, 2009. Accordingly, the right of selection of an authorized treating physician passed to Claimant.

16. The evidence established that Claimant chose Dr. Yamamoto as the authorized treating physician. The employer's designation, in writing, of a second doctor occurred on September 29, 2009, which was an untimely designation under the Rule.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101 to 8-47-209, C.R.S. (2009) (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 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. X-ray*, 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. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The requirements of proof for civil non-jury cases in the district courts apply in workers' compensation hearings. Section 8-43-210, C.R.S. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that may lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering Inc. v. Industrial Claims Appeals Office*, 5 P.3d 385 (Colo. App 2000).

3. Claimant contends that he suffered an injury in the course and scope of his employment for the employer when he missed a step descending stairs on July 15, 2009. Under the Workers' Compensation Act of Colorado, an employee is entitled to compensation where the injury or death is proximately caused by an injury or occupational disease arising out of and in the course of the employee's employment. Section 8-41-301(1), C.R.S. 2009; *Horodyskyj v. Karanian* 32 P.3d 470 (Colo. 2001). The phrases "arising out of" and "in the course of" are not synonymous and a claimant must prove both requirements. *Younger v. City & County of Denver*, 810 P.2d 647, 649 (Colo. 1991); *In re Question Submitted by U.S. Court of Appeals*, 759 P.2d 17, 20 (Colo. 1988). The latter requirement refers to the time, place, and circumstances under which a work-related injury occurs. *Popovich v. Irlando*, 811 P.2d 379, 381 (Colo. 1991). Thus, an injury occurs "in the course of" employment when it takes place within the time and place limits of the employment relationship and during an activity connected

with the employee's job-related functions. *In re Question Submitted by U.S. Court of Appeals, supra; Deterts v. Times Publ'g Co.*, 38 Colo. App. 48, 51, 552 P.2d 1033, 1036 (1976). The parties do not dispute that the Claimant's injury occurred in the course of his employment.

4. The term “arises out of” refers to the origin or cause of an injury. *Deterts v. Times Publ'g Co., supra*. There must be a causal connection between the injury and the work conditions for the injury to arise out of the employment. *Younger v. City & County of Denver, supra*. An injury “arises out of” employment when it has its origin in an employee's work-related functions and is sufficiently related to those functions to be considered part of the employee's employment contract. *Popovich v. Irlando, supra*.

5. Claimant’s fall in this case was shown by a preponderance of the evidence to be precipitated by the circumstances or conditions of the Claimant's employment and, therefore, the resulting injury is compensable. *Childers v. Swift Transportation*, W. C. No. 4-571-907 (November 8, 2004). Where the claimant's injury is initiated or precipitated by an event or condition “associated with the employment,” the claimant is not required to prove a “special hazard” in order to recover benefits. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *Warm v. Safeway*, W.C. No. 4-465-204 (October 5, 2001). Based on Claimant’s credible and persuasive testimony, medical reports noting the injury, and the deposition testimony of Dr. Mann, it is found and concluded that Claimant suffered a compensable work injury in the course and scope of his employment on July 15, 2009. Claimant suffered a left knee injury when he hyper-extended his left knee while descending stairs in the course and scope of his employment.

6. Here, there is no evidence that Claimant's fall was precipitated by a preexisting condition. To the contrary, the ALJ finds that the injury occurred in the course of Claimant’s employment because he was performing an activity directly related to his employment. Therefore there is no need to show that a special hazard of employment existed.

7. Respondents rely on Y*barra v. Thompson School District*, W.C. 4-767-145, (ICAP, Sept. 25, 2009). Respondents contend that Claimant suffered an “unexplained fall” such as is seen in *Rice v. Dayton Hudson Corp.*, W.C. No. 4-386-678 (July 29, 1999) where the claimant was “unable to provide any explanation for her fall.” To the contrary in this case, the medical evidence and other testimony document how Claimant missed a step and Dr. Mann has provided credible testimony how that incident led to the radial meniscus tear and the need for surgery. Claimant missed the step and that caused all of his weight to shift onto his left leg, which resulted in the injury. Thus, Claimant's injuries resulted from an identifiable accidental event, which occurred during work-related activity. *See Olivas v. Keebler Co.*, W.C. No. 4-418-316 (ICAP, May 3, 2001); *see also Pieper v. City of -Q-wood Village*, W.C. 4-675-476 (ICAP, Jan. 20, 2010).

8. Claimant established by a preponderance of the evidence that he was disabled from his usual employment for a period of one week following his surgery. 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 the 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). Accordingly, it is concluded that Claimant is entitled to TTD benefits at the maximum rate of $807.24 from October 23 through October 30, 2009;

9. Respondents are liable for all reasonable, necessary and related medical treatment. Specifically, Respondents are liable for medical treatment for the July 15, 2009, work injury, including surgery, provided by Dr. Smaldone, Dr. Mann, Dr. Yamamoto, and their referrals.

10. Section 8-43-404(5)(a)(I)(A), C.R.S. provides a detailed procedure for requesting a change of physician after the initial designated physician has been selected. In addition, the Workers' Compensation Rules of Procedure outline the steps to be taken. Rule 8-2 provides that an injured worker may request a one-time change of authorized treating physician. Rule 8-2 (D) provides that if the employer fails to comply with Rule 8-2, the injured worker may select an authorized treating physician. Even when an employer designates an on-site healthcare provider under Rule 8-4, the employer must still provide written designation under Rule 8-2(A)(2) within 7 business days under Rule 8-4(C) or the right to select a doctor passes to the claimant.

11. The ALJ concludes that Employer did not designate two physicians prior to the injury or, as important, provide written designation under Rule 8-2(A)(2) or Rule 8-4(C) within 7 business days of the injury. Under Rule 8-2(D), Claimant was entitled to select an authorized physician. The evidence established that Claimant chose Dr. Yamamoto as the authorized treating physician. Employer's designation, in writing, of a second doctor occurred on September 29, 2009, which was an untimely designation under the Rule. It is specifically found and concluded that Respondents failed to comply with Sections 8-43-404(5)(a)(I)(A), 8-43-404(5)(a)(II)(B), and 8-43-404(5)(a)(III) and related rules and therefore the right of selection of the authorized treating physician passed to Claimant and Dr. Yamamoto is an authorized treating physician. Dr. Yamamoto is an authorized provider from Claimant's selection forward

ORDER

IT IS THEREFORE ORDERED THAT:

1. Claimant has established a compensable left knee injury arising out of and in the course and scope of his employment on July 15, 2009;

2. Respondents are liable for all medical treatment, including the surgery, provided by Dr. Smaldone, Dr. Mann, Dr. Yamamoto and their valid referrals;

3. Dr. Yamamoto is an authorized treating physician;

4. Claimant is entitled to TTD benefits at the maximum rate of $807.24 from October 23 through October 30, 2009;

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

6. All other issues are reserved for later determination.

DATED: _March 15, 2010

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-791-029

ISSUES

The issue determined herein is temporary total disability ("TTD") benefits. The parties stipulated to an average weekly wage of $350.73.

FINDINGS OF FACT

1. In approximately August 2007, claimant began employment for the employer doing welding, fabrication, and drilling. Claimant also hauled off scrap metal.

2. On March 27, 2008, claimant suffered an admitted work injury when he was tying down a load of scrap metal and a binder popped off, striking claimant on the side of his face.

3. The employer transported claimant to Custer County Medical Center. Nurse Practitioner Stark examined claimant and was given a history of a possible loss of consciousness. N.P. Stark noted a curved laceration just lateral to the right eye. Claimant had no complaints and

had no visual problems. N.P. Stark sutured the laceration and instructed claimant to follow up in one week.

4. On March 27, 2008, claimant returned to the employer's premises, but did not perform any additional work for the rest of the day.

5. On March 28, 2008, claimant returned to work at his regular job duties. He sought treatment from Dr. Robert Bliss on that day because he got a foreign body in his left eye. Claimant denied any headache.

6. Claimant continued to work his regular job duties thereafter, including performance of overtime.

7. On May 5, 2008, N.P. Stark removed the sutures lateral to the right eye.

8. Claimant quit his employment at the end of May 2008 because he had a better job offer. While still employed, claimant never returned to the authorized treating providers and never requested that the respondents provide any additional medical treatment. He did not complain to the employer that he suffered headaches or was unable to perform his duties as a welder.

9. Claimant worked as a painter for his brother for about one month. Claimant also hauled off scrap metal on his own and performed odd job repairs. On several occasions, claimant requested that the employer re-hire him, but the employer refused because claimant had quit his employment during a project.

10. On April 1, 2009, claimant returned to Dr. Bliss and reported a history of the gradual onset of headaches for months. Dr. Bliss diagnosed post-traumatic headache and recommended a magnetic resonance image ("MRI") of the brain. The April 14, 2009, MRI was normal.

11. On April 21, 2009, claimant filed his workers' claim for compensation for alleged eye and headache injuries.

12. Claimant was referred to Dr. Herrera, a neurologist. On May 5, 2009, Dr. Herrera examined claimant, who reported a history of persistent throbbing head pain since the work injury. Dr. Herrera diagnosed post-concussive syndrome.

13. On August 5, 2009, Dr. Hall performed an independent medical examination for claimant and diagnosed temporomandibular joint problems causing the headaches as well as post-concussive syndrome causing the headaches and visual problems.

14. On August 18, 2009, Dr. Herrera reexamined claimant, who reported that he no longer suffered much headache.

15. On November 18, 2009, Physician's Assistant Johnson examined claimant, who reported a history of increased headaches, blurred vision, and dizziness for three months. Clamant reported that he sat close to the "teevee" due to his hearing problems.

16. Claimant has failed to prove by a preponderance of the evidence that he was disabled from his regular occupation as a result of the admitted March 27, 2008, work injury. He received a laceration on his right cheek, lateral to his right eye. He received sutures. He returned to regular work the next day and continued to perform that regular duty work until he quit his employment at the end of May 2008 because he had a better job offer. He returned to the Nurse Practitioner for suture removal. He sought no additional medical care and made no complaints of headaches or blurred vision until April 1, 2009, when he provided a history of gradual onset of headaches for several months. He then inconsistently provided a history to the neurologist of persistent throbbing since the work injury. On August 18, 2009, claimant reported that he did not have much headache. Three months later, he informed P.A. Johnson that he had increased headaches, blurred vision, and dizziness for three months. Claimant's testimony is not credible. The testimony of Mr. Pinner and Mr. Puda is credible. Claimant did not report to the employer any ongoing symptoms or problems performing the regular job duties. Claimant had no medical restrictions due to the work injury. Claimant unbelievably insists that he never requested medical care for headaches and visual problems before having to quit his job because he did not think that the physician would be able to help. Claimant was not disabled.

CONCLUSIONS OF LAW

1. As found, claimant failed to prove by a preponderance of the evidence that he was unable to return to the usual job due to the effects of the work injury. Consequently, claimant is not "disabled" within the meaning of section 8-42-105, C.R.S. and is not entitled to TTD benefits. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999); *Hendricks v. Keebler Company*, W. C. No. 4-373-392 (Industrial Claim Appeals Office, June 11, 1999). Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused claimant to leave work, and claimant missed more than three regular working days. 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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979). Because claimant is not entitled to TTD benefits, the affirmative defense that claimant was responsible for his termination of employment is moot.

ORDER

It is therefore ordered that:

1. The insurer shall pay benefits for all admitted periods based upon the stipulated

average weekly wage of $350.73.

2. Claimant's claim for TTD benefits commencing March 27, 2008, is denied and dismissed.

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

DATED: March 16, 2010 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-358-465

ISSUES

The following issues were raised for consideration at hearing:

1. Whether Claimant is entitled to additional temporary total disability benefits (TTD) after October 19, 2002, and continuing;

2. Whether the stipulated average weekly wage (AWW) of $402.46 should be increased by the cost of replacement health insurance;

3. Whether Claimant is entitled to an award of penalties against Respondents for unpaid interest; and

4. Whether Respondents are entitled to an order relieving them of the duty to pay interest to Claimant.

FINDINGS OF FACT

1. Claimant sustained a work injury to her low back on September 17, 1997. An average weekly wage of $300 was admitted by Respondents.

2. Claimant was placed at maximum medical improvement on May 7, 1998. By Final Admission of Liability dated September 3, 1998, Respondents admitted liability for permanent partial disability benefits in the amount of 10% of the whole person.

3. Claimant did not object to the Final Admission of Liability but filed Petitions to Reopen on February 16, 2001, and December 16, 2002.

4. Claimant filed Applications for Hearing on or about May 27, 2004 (*pro se*), October 29, 2004, January 19, 2005 and June 7, 2005. Despite the numerous filings, the Application for Hearing of June 7, 2005, was the first one that went to hearing. The sole issue on this Application for Hearing was Claimant's Petition to Reopen. No benefits were requested.

5. As a result of the Application for Hearing dated June 7, 2005, Claimant's claim was eventually reopened after an order of remand by Industrial Claim Appeals Office. After the Order of Remand, ALJ Henk determined that Claimant sustained an intervening motor vehicle injury to her low back on October 19, 2002. ALJ Henk reopened Claimant's claim for the time period of September 16, 1997, to the date of the motor vehicle injury on October 19, 2002.

6. On May 15, 2007, Claimant filed an Application for Hearing. One of the issues for hearing was temporary total disability benefits from February 17, 2001, to October 1, 2002.

7. As a result of hearing on the request for temporary total disability benefits, on April 15, 2008, ALJ Cannici ordered that temporary total disability benefits be awarded from August 1, 2001, through November 7, 2001. ALJ Cannici reserved for future determination "any issue not resolved in this Order."

8. Upon remand from ICAO, ALJ Cannici entered an order on December 24, 2008, requiring Respondents to pay temporary total disability benefits from August 1, 2001, "until terminated by statute." He once again reserved for future determination any issue not resolved in the order.

9. Because the Application for Hearing had limited the request for temporary total disability benefits to a specific time period, ICAO modified the order of ALJ Cannici and ordered Respondents to pay temporary total disability benefits from August 1, 2001, to October 19, 2002, the date Claimant had the motor vehicle accident.

10. The Final Order from ICAO was issued on June 8, 2009.

11. Respondents timely issued a check to Claimant for the awarded temporary total disability benefits on June 25, 2009. Respondents did not pay interest on the award of temporary total disability benefits.

12. Respondents' did not act unreasonably in failing to pay interest. Since the order of the ALJ reserved all issues other than payment of medical benefits and payment of temporary total disability benefits, it was not unreasonable for Respondents to rely on the reservation in the order of the ALJ and not pay interest.

13. After the ICAO order limiting temporary total disability benefits, Claimant filed an Application for Hearing on the issues of temporary total disability benefits "from 10/19/02 to statute." By Motion to Add, the issue of average weekly wage was added. Claimant subsequently filed an Application for Hearing on the issue of failure to pay interest. These issues were consolidated for hearing.

14. The parties stipulated at hearing that Claimant's average weekly wage on the date of her injury was $402.46. Claimant failed to sustain her burden of proof to establish an increased average weekly wage based on the cost of replacement health insurance.

15. Claimant testified that she did not remember if she had health insurance from her employer. After being shown an application for insurance by her attorney, Claimant then recalled that she did have health insurance. However, Claimant is not credible on this point of testimony more than 12 ½ years post injury.

16. Claimant's earnings statement for the period ending September 15, 1997, the date of her injury, does not show any deduction or indication that she was receiving health care benefits. In fact, Claimant testified that she was on her husband's health insurance policy before the date of the injury and that his policy was for family coverage. Claimant's husband's health insurance paid for her first surgery after her claim closure. The reasonable inference is that Claimant did not have health insurance through her employer since she had it through her husband. Further, an application for health insurance is not evidence of actual health insurance. The application for health insurance is six months prior to her injury and shows that she would have her entire family covered, including her husband by whose health insurance she was covered before and after the injury. There is no evidence documenting actual health insurance issued or payment for family health insurance coverage. Claimant's testimony regarding health insurance benefits is incredible and unpersuasive. Claimant failed to prove by a preponderance of the evidence that she had insurance coverage from her employer.

17. Claimant's claim was closed in 1998. She alleged a worsening of her condition as early as February 16, 2001, when she filed her first Petition to Reopen Claim. Despite filing numerous Applications for Hearing, Claimant did not actually go to hearing on the issue of temporary total disability benefits until September 28, 2007. Because Claimant's contention was that she again became temporarily totally disabled on August 1, 2001, there was no reason why she could not have prosecuted her claim for temporary total disability benefits sooner than 6 ½ years after filing a Petition to Reopen Claim. Of further note is the fact that Claimant specifically went to hearing on the sole issue of Petition to Reopen Claim on October 12, 2005. Claimant's negligence in prosecuting her claim led to the late award of benefits. To award interest on Claimant's award of indemnity benefits would permit Claimant to benefit from her own negligence. Therefore, it is found that Respondents have made a satisfactory showing that they should be relieved of payment of interest on the award of temporary total disability 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. Section 8-42-101 (1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 592.P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App.2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C. R.S.

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 of 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); CJI, Civil, 3:16 (2005).

Temporary Total Disability Benefits

4. The evidence established that Claimant reached maximum medical improvement for her work injury on May 7, 1998. Subsequent to maximum medical improvement, Claimant sustained a worsening of condition. After her work condition worsened, Claimant had a non-work related motor vehicle injury to her low back on October 19, 2002.

5. In ruling on Claimant's Petition to Reopen, ALJ Henk found as a finding of fact:

a. On October 19, 2002, Claimant sustained an intervening injury to her back as a result of a motor vehicle accident. …Claimant has undergone extensive medical treatment for the injuries she sustained in this motor vehicle accident. Claimant's condition and need for treatment since October 19, 2002 to the present are causally related to the October 19, 2002 motor vehicle accident. Claimant's current condition and need for medical treatment are not causally related to the admitted work injury of September 17, 1997.

6. ALJ Henk concluded that Claimant's condition was worse after the filing of the Final Admission of Liability and before the intervening event. However, she specifically found that

Claimant's condition after the motor vehicle accident was causally related to the motor vehicle accident and not to the work injury.

7. Claimant did not appeal the Order of ALJ Henk, which she was required to do if she disagreed with the denial of benefits. The "law of the case" doctrine requires that issues that have been litigated cannot be relitigated in the same proceeding. *Venzuh v. Rouse*, 660 P.2d 1301 (Colo. App. 1982).

8. Respondents are not liable for temporary total disability benefits after the intervening motor vehicle accident. The intervening injury severed the causal connection between Claimant's disability and the work injury of September 17, 2007. The benefits paid for a workers' compensation claim are presumed to be paid for a condition caused by a work injury. *Siefried v. Industrial Commission*, 736 P. 2d 1262 (Colo. App. 1986). When intervening events indicate that a claimant's wage loss results from factors other than the work injury, the causal connection between the injury and the wage loss is severed. *Roe v. Industrial Commission*, 734 P.2d 138 (Colo. App. 1986). Once the causal connection is severed by an intervening event, CRS 8-41-105 does not apply and a limited award of TTD is permissible. *See, Collinge v. Safeway*, WC No. 4-680-590 (ICAO June 1, 2007).

Average Weekly Wage

9. Parties stipulated at hearing that Claimant's average weekly wage on the date of her injury was $402.46. Claimant failed to sustain her burden of proof to establish an increased average weekly wage based on the cost of replacement health insurance.

10. Claimant testified that she did not remember if she had health insurance from her employer. After being shown an application for insurance by her attorney, Claimant then recalled that she did have health insurance. However, Claimant is not credible on this point of testimony more than 12 ½ years post injury.

11. Claimant's earnings statement for the period ending September 15, 1997, the date of her injury, does not show any deduction or indication that she was receiving health care benefits. In fact, Claimant testified that she was on her husband's health insurance policy before the date of the injury and that his policy was for family coverage. Claimant's husband's health insurance paid for her first surgery after her claim closure. The reasonable inference is that Claimant did not have health insurance through her employer since she had it through her husband. Further, an application for health insurance is not evidence of actual health insurance. The application for health insurance is six months prior to her injury and shows that she would have her entire family covered, including her husband by whose health insurance she was covered before and after the injury. There is no evidence documenting actual health insurance issued or payment for family health insurance coverage. Claimant's testimony regarding health insurance benefits is incredible and unpersuasive. Claimant failed to prove by a preponderance of the evidence that she had insurance coverage from her employer.

Penalties

12. The imposition of penalties under Section 8-43-304(1), C.R.S. is a two-step process. First, it must be determined whether a party has violated the Act in some manner, failed to carry out a lawfully enjoined action, or violated an order. If a violation is found, it must then be determined if the violator acted reasonably. *Allison v. Industrial Claim Appeals Office,* 916 P.2d 623 (Colo. App. 1995). CRS 8-43-304 is penal in nature and must be narrowly and strictly construed. *Support, Inc. v. Industrial Claim Appeals Office*, 968 P.2d 174 (Colo. App. 1998).

13. Section 8-43-410, C.R.S. requires payment of interest on the date "fixed by award of the director or the administrative law judge." The order that ALJ Cannici entered on April 15, 2008, ordered a period of temporary total disability benefits and did not address interest. The order specifically reserved "any issues not resolved" for future determination. Likewise, in his order entered upon remand from ICAO on December 24, 2008, ALJ Cannici again did not address interest and reserved any issue not resolved for future determination.

14. Respondents' did not act unreasonably in failing to pay interest. Since the order of the ALJ reserved all issues other than payment of medical benefits and payment of temporary total disability benefits, it was not unreasonable for Respondents to rely on the reservation in the order of the ALJ and not pay interest.

Interest

15. Section 8-43-410, C.R.S. allows for relief from payment of interest upon "application and satisfactory showing to the director or administrative law judge of valid reasons therefore."

16. Claimant's claim was closed in 1998. She alleged a worsening of her condition as early as February 16, 2001, when she filed her first Petition to Reopen Claim. Despite filing numerous Applications for Hearing, Claimant did not actually go to hearing on the issue of temporary total disability benefits until September 28, 2007. Because Claimant's contention was that she again became temporarily totally disabled on August 1, 2001, there was no reason why she could not have prosecuted her claim for temporary total disability benefits sooner than 6 ½ years after filing a Petition to Reopen Claim. Furthermore, Claimant went to hearing on the sole issue of Petition to Reopen Claim on October 12, 2005. Claimant's negligence in prosecuting her claim led to the late award of benefits. It is concluded that it is Claimant's negligence, which led to the late award of indemnity benefits. Therefore, Respondents have made a satisfactory showing that they should be relieved of payment of interest on the award of temporary total disability benefits.

ORDER

1. Claimant's claim for temporary total disability benefits after October 19, 2002 is

denied and dismissed.

2. Claimant's request for an increase in her average weekly wage based on the cost of replacement health insurance is denied and dismissed.

3. Claimant's claim for penalties against Respondents' is denied and dismissed.

4. Respondents' request for relief of payment of interest for temporary total disability benefits awarded is hereby granted. Respondents shall not be liable for payment of interest on the awards of temporary total disability benefits.

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

DATED: March 16, 2010

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-778-829

ISSUES

1 Whether Claimant's permanent impairment related to her left lower extremity resides on the schedule or should be converted to whole person impairment.

2 Whether Claimant has established Employer is liable for payment of a medical bill incurred as a result of an emergency room visit.

3 Whether Claimant should have received temporary total disability (TTD) or temporary partial disability (TPD) benefits when she missed work due to her admitted work-related injury.

4 The parties stipulated that Claimant's average weekly wage (AWW) is $653.85.

5 The parties stipulated that Claimant is entitled to a disfigurement award in the amount of $500.00.

FINDINGS OF FACT

1. On November 20, 2008, Claimant sustained an admitted injury to her low back on November 20, 2008. As a result, Claimant's authorized treating physician imposed work restrictions and Claimant underwent medical treatment.

Permanent Partial Disability

2. Claimant treated with Dr. Robert Kawasaki until he placed her at maximum medical improvement on June 30, 2009. Dr. Kawasaki assigned a permanent impairment of 10 percent whole person for Claimant's spine condition. Dr. Kawasaki assigned a two percent impairment for Claimant's left lower extremity radicular symptoms, which converted to one percent whole person impairment and designated it as a neurologic impairment. In his conclusions, Dr. Kawasaki stated, "Impairment rating, as calculated above, equals 11% whole-person impairment."

3. Employer admitted for 10 percent whole person impairment and the two percent scheduled impairment for Claimant's left lower extremity rather than 11 percent whole person.

4. In his June 30, 2009, report, Dr. Kawasaki noted that Claimant had decreased sensation in the L5 distribution along the lateral calf and over the dorsum of the foot.

5. Claimant described shooting pain, numbness and tingling in her left leg and three toes. She has also has pain in her buttocks and hip area. Claimant occasionally uses a cane when her numbness increases such that she loses control of her foot.

6. Claimant has established that she is entitled to conversion of the left lower extremity impairment rating to a whole person impairment rating. Claimant's functional impairment extends beyond the lower extremity.

Medical Benefits – Emergency Treatment

7. On the night of May 6, 2009, Claimant sought emergency treatment at Healthone North Suburban Medical Center. Claimant was in and out of consciousness so a friend took her to the emergency room.

8. Earlier on May 6, 2009, Claimant went to her family physician, Dr. Nash, due to feelings of depression. Dr. Nash gave Claimant samples of Cymbalta, which she took. Claimant had also taken Vicoden and gabapentin. It was Claimant's understanding that the combination of prescription medications caused an adverse physical reaction which caused her to fade in and out of consciousness.

9. Pursuant to the medical records dated March 10, 2009, Dr. Kawasaki noted that Claimant was taking gabapentin and Robaxin. There is no mention of Vicoden in Dr. Kawasaki's medical records subsequent to February 24, 2009.

10. No persuasive or credible evidence suggests that Claimant had similar types of reactions prior to the introduction of Cymbalta which her personal physician gave to her. Dr. Kawasaki later prescribed Cymbalta, but he did not prescribe it simultaneously with Vicoden.

11. Claimant presented no credible or persuasive evidence that the medications prescribed

by her workers' compensation physicians caused her to have an adverse physical reaction that necessitated emergency room treatment.

12. Claimant received bills from Healthone North Suburban Medical Center for this emergency treatment which she believes is related to her industrial injury. Claimant, however, has failed to establish that the need for treatment at Healthone was causally related to her industrial injury.

Temporary Total and Temporary Partial Disability

13. For the first 90 days an employee misses work due to a disability including a workers' compensation injury, the Employer's policy provides for payment of 80 percent of the employee's wages. These wages are paid to employees through the normal payroll process. The 90th day following Claimant's injury was February 18, 2009.

14. Employer required Claimant and all employees to approve their timecards in a computerized timekeeping system known as Kronos.

15. On February 17, 2009, Claimant's physician restricted her from working until February 21, 2009. Employer used 20 hours of Claimant's sick leave to pay Claimant her full wages for February 17 and 19. Claimant was still within the first 90 days of her injury on February 17, 2009.

16. On February 21, 2009, Claimant worked for four hours per her doctor's restrictions. Employer used 4.45 hours of vacation leave to pay Claimant her full wages.

17. On February 23, 2009, Claimant worked for 15 minutes before her supervisor sent her home because the Employer could not accommodate her restrictions. Employer paid Claimant her full wages by using 9.15 hours of vacation leave.

18. Employer could not accommodate Claimant's restrictions on February 24 and 26, 2009, so her supervisor advised her not to come into work. Employer paid the Claimant her full wages by using 20 hours of vacation leave.

19. The records from the third party administrator, CCMSI, reflect that it issued TTD payments for February 19, 2009, through February 26, 2009, in the amount of $492.25. Accordingly, Claimant has not established further entitlement to TTD for February 19, 21, 23, 24, and 26, 2009.

20. Claimant would be entitled to TTD for February 17, 2009, but for the Employer's policy that provides for payment of 80 percent of a disabled worker's wages during the first 90 days of the disability. Thus, Claimant is entitled to either TTD or payment of her wages at 80 percent for February 17, 2009.

21. On February 27, 2009, Employer sent Claimant to a modified duty job where she

worked for four hours according to her restrictions. Employer paid Claimant her full wages based on 10 hours of vacation leave. The Kronos administrator later credited Claimant for fours of work. Claimant would be entitled to TPD for the remaining six hours.

22. The records from the third party administrator, CCMSI, reflect that it issued TPD payments for February 27, 2009, through March 22, 2009, in the amount of $895.40. Thus, Claimant has not established further entitlement to TPD for February 27, 2009, because Employer has already paid such benefits.

23. Between May 11 and May 21, 2009, Claimant alleges that the Employer used 8.5 hours of sick leave, but that she should have been paid TPD because she missed work for workers' compensation related appointments.

24. On Claimant's paycheck stub for the pay period May 10, 2009, through May 23, 2009, Claimant's pay was deducted 8 hours for "Voluntary Leave Without Pay" and 6.5 hours for "Vacation Used Exception."

25. The Kronos administrator was unable to explain the leave without pay reflected on the pay stub, but believed it may have been a furlough day for all employees.

26. No medical records reflecting Claimant's appointments between May 11 and May 21, 2009, were offered into evidence. Claimant's testimony that Employer used 8.5 hours of sick leave is inconsistent with the payroll records that indicate Claimant's vacation leave bank was charged 6.5 hours. Thus, Claimant has not established entitlement to TPD for 8.5 hours as alleged. There is no credible or persuasive evidence that Claimant missed work due to her work injury between May 11 and 21, 2009.

27. The Kronos administrator for Claimant's work unit received incomplete timecards for Claimant. Employer's policy requires that the administrator attempt to contact the employee or supervisor to inquire about the incomplete timecard. If neither the employee nor the supervisor can be reached, the administrator fills in the incomplete time cards so that the employee will receive full pay for the relevant time period.

28. Claimants submitted incomplete timecards on many of the days discussed herein. The Kronos administrator filled in the missing time by using Claimant's paid sick leave. Once the sick leave was exhausted, the administrator used the vacation leave. The evidence indicates that for some days Claimant received both TTD or TPD and vacation or sick leave pay.

29. Claimant seeks reinstatement of her sick and vacation leave, which is not within the authority of the Judge. According to the Kronos administrator, the Employer can reinstate Claimant's paid time off, but it would require Claimant to reimburse the Employer the pay she already received.

CONCLUSIONS OF LAW

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

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

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

Permanent Partial Disability

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 for whole person ratings. The question of whether the claimant sustained a whole person medical impairment compensable under § 8-42-107(8), C.R.S., is one of fact for determination by the ALJ. In resolving this question, the ALJ must determine the situs of the "functional impairment" and the situs of the functional impairment is not necessarily the location of the injury itself. *Langton v. Rocky Mountain Health Care Corp.* 937 P.2d 883 (Colo. App. 1996); *Stauch v. PSL Swedish Healthcare System,* 917 P.2d 366 (Colo. App. 1996).

5. Claimant has proven by a preponderance of the evidence that the situs of her functional impairment extends beyond her left lower extremity. Claimant's physical functional limitations including occasional use of a cane combined with Dr. Kawasaki's findings and conclusions, establishes that her left lower extremity injury affects the whole person. Consequently, Claimant's left lower extremity impairment is converted to a one percent whole person impairment resulting in a total whole person impairment of 11 percent.

Medical Benefits – Emergency Treatment

6. Respondents are obligated to provide medical benefits to cure or relieve the effects of

the industrial injury. Section 8-42-101(1), C.R.S.; *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). As found, Claimant has failed to establish that the emergency treatment she underwent on May 6, 2009, was related to the effects of the industrial injury. Claimant believed her medications caused an adverse physical reaction that necessitated emergency treatment. There was no credible or persuasive evidence, however, that the medications prescribed by Claimant's workers' compensation physicians caused the adverse reaction. Rather, Claimant did not experience the reaction until she took Cymbalta, which her personal physician gave to her. Accordingly, Employer is not responsible for payment of the emergency room bill.

Temporary Partial and Temporary Total Disability Benefits

7. Claimant has failed to establish *further* entitlement to TTD or TPD benefits for February 19 – 27, 2009, as described above. It is true that Claimant has established that she was entitled to TTD and TPD; however, Employer has already issued such TTD and TPD payments as appropriate. Claimant has established that she is entitled to TTD for the missed time on February 18, 2009, to the extent that Employer has not paid her 80 percent of her regular wages pursuant to its internal policy. Claimant would not be entitled to both TTD and 80 percent of her regular wages for February 18, 2009.

8. Based upon a lack of credible or persuasive evidence, Claimant has not established that she missed work due to her work injury between May 11 and May 21, 2009, for which she should be paid TPD.

9. Claimant also seeks reinstatement of her sick and vacation leave that the Employer used while Claimant missed work due to her industrial injury. The Claimant concedes that the Judge has no authority to order the Employer to reinstate her leave. See *Mihulka v. University of Northern Colorado*, W.C. No. 4-431-682 (March 30, 2001).

ORDER

It is therefore ordered that:

1. Employer shall pay to Claimant permanent partial disability calculated at 11 percent whole person.

2. Employer is not liable for payment of the bills associated with the emergency room treatment Claimant underwent on May 6, 2009.

3. Claimant is not entitled to further TTD or TPD for the dates described above.

4. Employer shall pay disfigurement benefits to Claimant in the amount of $500 as stipulated by the parties.

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

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

DATED: March 17, 2010

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-805-505

ISSUES

Whether the Claimant sustained a compensable injury on September 14, 2009, including a determination of the part(s) of the body injured.

If compensable, whether Claimant is entitled to an award of medical benefits for the treatment provided by Rocky Mountain/Aurora Urgent Care, Dr. Bethany Wallace, D.O. and Dr. David Reinhard, M.D. At hearing the parties agreed that Rocky Mountain/Aurora Urgent Care, Dr. Wallace and Dr. Reinhard should be considered authorized treating physicians.

FINDINGS OF FACT

1. Claimant worked for Employer as a bill collector. Claimant worked for Employer in an office building located at Creek Drive South in Denver, CO. The offices of Employer where Claimant works are located on the third floor of the building.

2. Claimant's normal work hours are from 8:00 AM to 5:00 PM and Claimant leaves work at 5:00 PM.

3. On September 14, 2009 Claimant was leaving work about 5:00 PM. Claimant exited the office suite of Employer and went to the elevators located in a common area of the building to leave work. Claimant uses the elevator on a daily basis to access Employer's offices on the third floor of the building. As Claimant was entering the elevator in a head forward position the elevator doors suddenly closed on Claimant striking her on the sides of her head. The elevator doors did not immediately retract after striking Claimant on the head and held her head for a few seconds. As Claimant was attempting to extract her head from the doors she "wrenched" her neck.

4. -S- is a co-worker of Claimant. On September 14, 2009 she was leaving work

with Claimant and was getting on the elevator with Claimant. Ms. -S- was getting on the elevator at the same time as Claimant and saw the elevator strike Claimant as Claimant got on the elevator ahead of Ms. -S-. After Ms. -S- walked into the elevator after Claimant she noticed that Claimant had a bump on her head.

5. Claimant presented to Rocky Mountain/Aurora Urgent Care on September 14, 2009. Claimant gave a history that she had had elevator doors close on her head between 5:00 PM and 5:15 PM at work. Claimant stated that the doors had hit each side of her head. Claimant complained of a bump on her mid-forehead and neck pain. Claimant was examined by Dr. Dale J. Kliner, M.D. On physical examination Dr. Kliner noted paracervical neck pain. Dr. Kliner diagnosed a closed head injury and cervical neck strain, prescribed medications and referred Claimant to Dr. Bethany Wallace, D.O. for follow up.

6. Dr. Wallace evaluated Claimant on September 17, 2009. Dr. Wallace obtained a history that an elevator door had closed on Claimant's head. Dr. Wallace noted complaints of pain in the front and across the back of Claimant's neck, across the tops of her shoulders and between the shoulder blades, and intermittent headaches. Claimant did not complain of specific right shoulder joint pain at this visit. On physical examination Dr. Wallace noted a raised and ecchymotic area on the forehead, and tightness to palpation of the paracervical and parascapular muscles. Dr. Wallace further noted tight trigger bands in the cervical and thoracic areas. Dr. Wallace diagnosed a scalp/forehead contusion, cervical/thoracic strain and cervicogenic/myofascial headache. Dr. Wallace opined, and it is found, that the findings on physical examination were consistent with the mechanism of injury. Dr. Wallace continued Claimant on medications and referred her to physical therapy.

7. Claimant was initially evaluated by Physical Therapist Patrick R. Ritchen on October 8, 2009 for complaints of pain and stiffness in the upper cervical region. Claimant first complained of specific right shoulder pain on October 22, 2009 at a physical therapy visit with therapist Ritchen.

8. Dr. Wallace evaluated Claimant on November 5, 2009 and noted that Claimant had improved since the initial visit of September 17, 2009. Dr. Wallace noted that Claimant's right shoulder was sore. Dr. Wallace's assessment was cervicogenic headache and cervical thoracic strain.

9. Dr. Wallace evaluated Claimant again on December 15, 2009. Dr. Wallace noted that Claimant had been experiencing an increase in right arm pain, neck pain and had again begun to have headaches. Dr. Wallace referred Claimant for a physical medicine/ rehabilitation consultation with Dr. David Reinhard.

10. Dr. Reinhard initially evaluated Claimant on January 18, 2010. Dr. Reinhard noted complaints of pain in the neck, suprascapular and right shoulder regions as well as distally involving the right upper arm and forearm. On physical examination Dr. Reinhard noted decreased range of motion of the right shoulder with a positive impingement sign and

tenderness over the right AC joint with palpation. Dr. Reinhard noted that a previous cervical MRI had revealed a small left posterolateral disc protrusion at C5-6 and mild canal stenosis at C5-6. Dr. Reinhard referred Claimant for an MRI of the right shoulder.

11. Dr. Reinhard again evaluated Claimant in February 8, 2010 and reviewed the results of the right shoulder MRI. Dr. Reinhard noted that the MRI revealed a near full-thickness right supraspinatus tear. Dr. Reinhard's impression was "nearly full thickness right supraspinatus tear secondary to work injury. Dr. Reinhard did not provide any specific analysis or explanation for his opinion that the right supraspinatus tear was secondary to a work injury.

12. Claimant was evaluated by Dr. Rachel Basse, M.D., a physical medicine and rehabilitation physician, at the request of Respondents on February 2, 2010. Dr. Basse reviewed medical records, took a history from Claimant and performed a physical examination. From her review of the medical records Dr. Basse noted that the emergency room, first medical and physical therapy evaluations were localized to the neck, upper back and headaches. Dr. Basse opined that any traumatic acute shoulder injury would have manifest clinically more immediately. Dr. Basse that in looking at medical causality several factors are considered including temporal relationship, mechanism, diagnosis and ability of the mechanism to cause the diagnosis and the presence of other plausible biological explanations.

13. Following her review of the right shoulder MRI Dr. Basse issued a report dated February 24, 2010. Dr. Basse opined that if the Claimant had suffered a near full-thickness supraspinatus tear on September 14, 2009 she would have had the immediate onset of symptoms. In the opinion of Dr. Basse, the delay in the onset of right shoulder symptoms suggested the MRI findings of a supraspinatus tear were degenerative in nature.

14. At hearing, Dr. Basse testified that in her opinion it was not medically probable that Claimant's rotator cuff/supraspinatus tear occurred at the time of the September 14, 2009 injury. In reaching this opinion at hearing Dr. Basse referred to the causality factors referenced in her report of February 2, 2010, primarily the lack of a temporal relationship between the onset of right shoulder symptoms and the injury of September 14, 2009.

15. At hearing, Dr. Basse testified and opined that the cervical MRI findings do not provide an explanation for Claimant's subjective complaints and the severity of her pain. In the opinion of Dr. Basse, the C5-6 disc protrusion shown on the cervical MRI is typical of the natural aging process.

16. Claimant has proven by a preponderance of the evidence that she sustained a compensable injury arising out of and in the course of her employment on September 14, 2009. The ALJ finds that Claimant sustained injuries consisting of a scalp/forehead contusion, cervical/thoracic strain and cervicogenic/myofascial headache as diagnosed by Dr. Wallace on September 17, 2009.

17. The ALJ finds persuasive the opinions of Dr. Basse that Claimant's right shoulder supraspinatus tear and C5-6 disc protrusion are not causally related to the injury of

September 14, 2009. Claimant has failed to prove by a preponderance of the evidence that the right shoulder rotator cuff tear and the C5-6 disc protrusion were caused or aggravated by the September 14, 2009 injury with Employer.

CONCLUSIONS OF LAW

18. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 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*.

19. 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*.

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

21. In order to recover benefits a claimant must prove that she sustained a compensable injury. A compensable injury is one which arises out of and in the course of employment. Section 8-41-301(1)(b), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origins in an employee's work-related functions. There is no presumption that an injury which occurs in the course of a worker's employment arises out of the employment. *Finn v. Indus. Comm'n,* 165 Colo. 106, 437 P.2d 542 (1968). 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. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989).

22. The claimant was required to prove by a preponderance of the evidence that at the time of the injury she was performing service arising out of and in the course of the employment, and that the injury or occupational disease was proximately caused by the performance of such service. Section 8-41-301(1)(b) & (c), C.R.S. An injury occurs "in the course of" employment where the claimant demonstrates that the injury occurred within the time and place limits of her employment and during an activity that had some connection with her work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The "course of employment"

includes a reasonable interval before and after work for the purpose of engaging in activities which are preparatory to the employment, or reasonably incident to the work. See Industrial Commission v. Hayden Coal Co., 113 Colo. 62, 155 P.2d 158 (1944); Ventura v. Albertson's, Inc., 856 P.2d 35, 38 (Colo. App. 1992). The question of what constitutes a reasonable interval is factual and depends on not only the length of time involved, but also "on the circumstances occasioning the interval and the nature of the employee's activity." 2 Larson's Workers' Compensation Law, § 21.06 [1] [a]. The question of whether the claimant met the burden of proof is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

23. Generally, injuries that occur while a claimant is going to or coming from the place of employment are not considered to have arisen out of and in the course of the employment. *Madden v. Mountain West Fabricators,* 977 P.2d 861 (Colo. 1999). The "going to and coming from" rule applies to injuries which occur off the employer's premises while the claimant is traveling to or from work. However, once the claimant arrives at work and is on the employer's premises, the rule is no longer applicable. See *Roache v. Industrial Commission,* 729 P.2d 991 (Colo. App. 1986); *Perry v. Crawford & Co.*, 677 P.2d 416 (Colo. App. 1983); *Wood v. Wal-Mart Stores,* W.C. No. 4-481-581 (November 30, 2001). The determination of what constitutes the employer’s premises is a question of fact. When the place of employment is a building, it is not necessary that the employer own or lease the place where the injury occurred. It is sufficient if the employer has some kind of right of passage, as in the case of common stairs or elevators. 1 Larson’s Workers’ Compensation Law, § 15.43. An access road contiguous to the employer’s place of business has been found to be a part of the employer’s premises. *Holloway v. City of Aurora,* W.C. No. 4-352-279 (January 27, 1999).

24. The claimant was required to prove by a preponderance of the evidence that the conditions for which she seeks medical treatment were proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(c), C.R.S. The claimant must prove a causal nexus between the claimed disability and the work-related injury. *Singleton v. Kenya Corp.,* 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). However, the mere occurrence of symptoms at work or following an injury at work does not require the ALJ to conclude that the duties of employment caused the symptoms, or that the employment aggravated or accelerated any pre-existing condition. Rather, the occurrence of symptoms at work or following a work injury may represent the result of or natural progression of a pre-existing condition that is unrelated to the employment. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1995); *Cotts v. Exempla, Inc.,* W.C. No. 4-606-563 (August 18, 2005). 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).

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

26. Respondents argue that Claimant's claim should be held not compensable on the basis that it did not occur in the course of Claimant's employment with Employer. Respondents argue that Claimant's injury falls within the "going to and coming from" rule, and further, because Claimant's injury was not from a "special hazard" or "special circumstance" it is not compensable. The ALJ disagrees. Claimant's injury occurred as she was leaving work shortly after the end of her normal workday at 5:00 PM. Claimant's injury occurred when an elevator door closed on Claimant's head. The elevator was located in the common area of the building where Employer's offices were located and was used regularly by Claimant for access to her place of work and, as such, is found and concluded to be part of the Employer's premises. Because Claimant was still on the premises of the Employer at the time the injury occurred, the "going to and coming from" rule does not apply. As the "going to and coming from" rule is not applicable here, the ALJ need not consider whether Claimant's injury came from a "special hazard" or "special circumstance" of the employment. Even though the elevator may have been a ubiquitous condition and not a special hazard of the employment, the ALJ need not consider this as there is no persuasive evidence or argument made by Respondents that Claimant's injury arose from a pre-existing idiopathic condition. Accordingly, the "special hazard" rule is also not applicable. See, *Shelton v. Eckstine Electric Company,* W.C. No. 4-724-391 (May 30, 2008). Claimant was in the course of her employment at the time of the injury as the injury occurred within a reasonable interval after the end of Claimant's workday and at a time when she remained on the Employer's premises in the act of leaving the premises at the end of the workday. As found, Claimant has proven by a preponderance of the evidence that she sustained a compensable injury on September 14, 2009 arising out of and in the course of her employment for Employer.

27. As found, the ALJ is not persuaded that Claimant's C5-6 disc protrusion and right shoulder supraspinatus/rotator cuff tear are causally related to the compensable injury of September 14, 2009. As found, the opinions of Dr. Basse are considered persuasive on these issues. Claimant complained only of head, neck and upper back pain at the initial visit with Dr. Wallace and did not complain of specific right shoulder pain until over one month after the injury. Although Dr. Reinhard opined that Claimant's right shoulder supraspinatus tear was secondary to her work injury Dr. Reinhard did not provide an analysis of causality as did Dr. Basse, and, accordingly the ALJ does not find the opinion of Dr. Reinhard persuasive. Dr. Reinhard noted the MRI findings of the C5-6 disc protrusion but does not offer a persuasive opinion on whether this finding can be more likely than not attributed either by way of direct causation or aggravation to the September 14, 2009 injury. Dr. Basse's opinion, which the ALJ

finds persuasive, was that this finding was consistent with the natural aging process for a person of Claimant's age. Claimant's injuries from the September 14, 2009 are a scalp/ forehead contusion, cervical/thoracic strain and cervicogenic/myofascial headache as diagnosed by Dr. Wallace on September 17, 2009. The ALJ concludes that Claimant's bump on the head likely resulted from the September 14, 2009 incident. Although Claimant principally testified that the elevator doors struck her on the side of her head, Claimant was "dazed" by this incident and thus, it is plausible as argued by Claimant, that Claimant bumped her head in the act of attempting to get her head from between the elevator doors.

28. The parties do not dispute that Rocky Mountain/Aurora Urgent Care, Dr. Wallace and Dr. Reinhard are authorized physicians. Respondents do not specifically dispute that any of the medical care or diagnostic testing performed to date by the authorized physicians was not reasonable or necessary. The ALJ concludes that Insurer should therefore be liable for the medical care provided by the authorized physicians, subject to Respondents' right to contest the reasonableness, necessity or causal relationship of any future treatment.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation and benefits for an injury of September 14, 2009 is granted, with the exception that any and all claims for compensation and benefits for a right shoulder rotator cuff tear and C5-6 disc protrusion are denied and dismissed as those conditions and injuries are not causally related to the compensable September 14, 2009 injury.

2. Insurer shall pay, in accordance with the Official Medical Fee Schedule of the Division of Workers' Compensation, for the treatment provided to date by the authorized physicians Rocky Mountain/Aurora Urgent Care, Dr. Wallace, D.O. and Dr. Reinhard, M.D.

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: March 17, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-633-188

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she is entitled to reopen her worker's compensation claim based on a change in condition pursuant to §8-43-303(1), C.R.S.

2. Whether Claimant has demonstrated by a preponderance of the evidence that she is entitled to receive medical benefits that are reasonable and necessary to cure or relieve the effects of her industrial injury.

FINDINGS OF FACT

1. Claimant worked for Employer as a cashier. On December 29, 2003 she suffered an admitted industrial injury to her lower back during the course and scope of her employment. Claimant had been lifting a heavy box of unassembled furniture in order to locate the barcode and scan the item.

2. Employer directed Claimant to Occupational Health Services for medical treatment. On January 9, 2004 she visited Authorized Treating Physician (ATP) Donna Brogmus, M.D. for an evaluation. Dr. Brogmus determined that Claimant had suffered a "lumbar strain without radicular symptoms." She assigned Claimant work restrictions that included no lifting, carrying, pushing or pulling in excess of five pounds. The restrictions prohibited squatting or bending and directed Claimant to perform primarily seated work.

3. Claimant subsequently returned to modified duty for Employer as a customer greeter.

4. Over the next several months Claimant received conservative medical treatment for her industrial injury. Treatment included chiropractic care, massage therapy and physical therapy.

5. On March 10, 2004 Claimant underwent an MRI of her lumbar spine. The MRI revealed moderate diffuse disc bulging at L3-4 and mild to moderate disc bulging at L4-5. The disc bulging was asymmetric to the left. There was an abnormal signal associated with the left posterolateral aspect of the L4-5 disc compatible with a radial tear. The radiologist's impression included "neural encroachment at L3-4 and L4-5 and that "the radial tear involving the L4-5 disk is acute in nature." The remaining MRI findings were chronic.

6. Claimant was subsequently referred to doctors Scott Hompland, M.D. and Robert Benz, M.D. for evaluations. The doctors recommended trigger point and facet joint injections. However, Claimant refused the injections because of concerns about her long-term health. She thus continued to receive conservative treatment through Dr. Brogmus.

7. On October 21, 2004 Dr. Brogmus determined that Claimant had reached

Maximum Medical Improvement (MMI). She assigned Claimant an 11% whole person impairment rating based on range of motion loss and the lower back injury. Dr. Brogmus also recommended medical maintenance medications for a six-month period. She assigned Claimant permanent work restrictions that included no lifting, carrying, pushing or pulling in excess of 25 pounds. Dr. Brogmus also precluded repetitive bending and stooping.

8. On November 24, 2004 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Brogmus' MMI and impairment determinations. Because Claimant did not challenge the FAL, her claim closed by operation of law.

9. After completing six months of medical maintenance care Claimant obtained treatment from personal physician Fiona Wilson, M.D. Dr. Wilson prescribed medications that Claimant had been taking for her industrial injuries. Dr. Wilson's records do not reflect that Claimant suffered increased or worsened back pain between April 4, 2005 and August 6, 2008.

10. On April 7, 2006 Claimant left her employment with Employer for reasons unrelated to her industrial injury.

11. On August 6, 2008 Claimant contacted Dr. Wilson's office and stated that she had "reinjured her back yesterday and would like some pain pills." On August 7, 2008 Claimant visited Dr. Wilson for an evaluation. Claimant reported that she suffered pain in her right lower back that radiated down her right leg. She also experienced some numbness and tingling in the hip area. Claimant explained that on August 6, 2008 she had been throwing a blanket on a bed when she experienced sudden, severe pain in the right hip and leg. Her right leg was not functioning and she was unable to move for 10 minutes.

12. On August 12, 2008 Claimant returned to Dr. Wilson for an evaluation. She reported continued severe back and right leg pain. Claimant also remarked that she was unable to walk more than a few steps at a time. Dr. Wilson commented:

> Suspect she has disc bulge at L4-5 with right sided radiculopathy – cannot be sure without an MRI. Pt needs to check into her old workman's comp paperwork to see if she can re-open the case as she had 5 years to do this and she is within the window – advised doing this asap – in mean-time recommend ongoing pain meds and acupuncture as an option.

13. On September 24, 2008 Claimant again visited Dr. Wilson for an examination. Although Claimant's condition had improved, she was still experiencing significant pain. Dr. Wilson remarked:

> Seeing specialist and hopefully will be able to reopen her WC case. In meantime is doing somewhat better in that she is able to walk with 6-8 ultracet per day – very expensive for her to afford – recommend trial ultram and tylenol – hopefully will need less of each in numbers. Will provide her with 2 weeks of pain pills and if care not assumed by WC will need f/u here.

14. On November 11, 2008 Claimant underwent an evaluation with E. Jeffrey Donner, M.D. Claimant reported that her industrial injury involved an "aching sensation in the lower back with sharp pain in her buttocks and aching down her legs associated with numbness." Claimant remarked that her pain levels at the time of MMI were 6-7/10. She explained that her pain markedly worsened in August 2008 while throwing a comforter onto her bed. As a result of the incident Claimant experienced severe pain in her back that radiated to her hips. She rated her pain as 10/10 on the pain scale. Claimant reported that her pain had slowly improved since August 2008 and was again at a level of 7/10. Dr. Donner concluded that Claimant had suffered a worsening of her work-related back injury after she was placed at MMI on October 21, 2004. He recommended a repeat lumbar MRI before making additional treatment recommendations and stated that Claimant's prognosis was "guarded due to the intense chronic nature of her pain, which has markedly worsened."

15. On April 16, 2009 Claimant underwent an independent medical examination with Allison Fall, M.D. Claimant reported that after reaching MMI her low back, left leg and hips continued to hurt. Claimant noted that "now it is pretty much the same thing." Claimant commented that in August 2008 she was fluffing a comforter and throwing it over the bed when she experienced increased pain and fell on top of the bed. Claimant noted that she was in a wheelchair for one month because she was unable to walk.

16. After reviewing Claimant's medical records and conducting a physical examination, Dr. Fall explained that on December 29, 2003 Claimant "suffered a lumbar strain with underlying degenerative disc disease, spondylosis, and stenosis with a possible acute radial tear on the left at L4-5." Dr. Fall concluded that Claimant's current symptoms were:

> [C]onsistent with her chronic complaints without any objective indication of worsening. However, the acute complaints as noted in the medical records by Dr. Wilson following the incident in August 2008 are consistent with acute muscular strain versus facetogenic pain versus acute disc herniation in August 2008. The incident and symptoms at that time would not be work-related, but it appears those acute symptoms have resolved. Currently, she is not reporting any right leg symptoms and does not recall that she had any right leg symptoms.

Dr. Fall summarized that Claimant likely suffered an acute new injury on August 6, 2008 but her symptoms had resolved.

17. Dr. Fall testified at the hearing in this matter. She commented that at the time Claimant reached MMI she suffered left-sided back symptoms. However, Dr. Fall noted that Claimant's symptoms after August 6, 2008 were suggestive of an acute right-sided disc herniation at L4-5. Claimant's symptoms were also consistent with an acute muscular strain or facet pain. Dr. Fall explained that an individual of Claimant's age, history of smoking and multilevel degenerative disc disease would be at increased risk for an injury to the low back regardless of a prior back injury. She commented that Claimant's non-work related

degenerative disc disease would be expected to progress regardless of whether Claimant had suffered the December 29, 2003 accident. Dr. Fall noted that, as of April 16, 2009, Claimant's symptoms on the right and the left had returned to baseline.

18. Claimant testified at the hearing in this matter. She stated that, following her release from medical care on October 21, 2004, her lumbar and left leg radicular symptoms have never resolved. Her pain has gradually worsened over the years and has radiated into her lower left leg. Claimant also noted that she is prepared to undergo any of the treatment options previously recommenced, including injections, in order to relieve her symptoms.

19. Claimant has failed to establish that it is more probably true than not that she suffered a change in the condition of her compensable injury or a change in her physical or mental condition that can be causally connected to the original compensable injury. Dr. Fall commented that at the time Claimant reached MMI she suffered left-sided back symptoms. However, Dr. Fall noted that Claimant's symptoms after August 6, 2008 were suggestive of an acute right-sided disc herniation at L4-5. Claimant's symptoms were also consistent with an acute muscular strain or facet pain. Dr. Fall summarized that Claimant likely suffered an acute new injury on August 6, 2008 but the new injury had resolved. In contrast, Dr. Donner concluded that Claimant had a worsening of her work-related back injury after she was placed at MMI on October 21, 2004. However, Dr. Donner noted that Claimant's pain markedly worsened in August 2008 while throwing a comforter onto her bed but her symptoms returned to the same level they had been when she reached MMI.

20. Claimant testified that, following her release from medical care on October 21, 2004, her lumbar and left leg radicular symptoms never resolved. Moreover, she noted that her pain has gradually worsened over the years and has radiated into her lower left leg. However, Dr. Wilson's notes reflect that Claimant did not suffer ongoing, worsening pain or a decline in function between October 21, 2004 and the comforter-throwing incident on August 6, 2008. The medical records thus reflect that Claimant's symptoms remained stable until the August 6, 2008 incident. Claimant has thus failed to demonstrate that she experienced a worsening of her work-related condition that required medical treatment. Instead, Claimant suffered a new injury on August 6, 2008 that constituted an efficient intervening cause for her back symptoms.

CONCLUSIONS OF LAW

1. 1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the

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

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

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

4. Section 8-43-303(1), C.R.S. provides that a worker's compensation award may be reopened based on a change in condition. In seeking to reopen a claim the claimant shoulders the burden of proving her condition has changed and that she is entitled to benefits by a preponderance of the evidence. *Osborne v. Industrial Commission*, 725 P.2d 63, 65 (Colo. App. 1986). A change in condition refers either to a change in the condition of the original compensable injury or to a change in a claimant's physical or mental condition that is causally connected to the original injury. *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082, 1084 (Colo. App. 2002). A "change in condition" pertains to changes that occur after a claim is closed. *In Re Caraveo,* W.C. No. 4-358-465 (ICAP, Oct. 25, 2006). The determination of whether a claimant has sustained her burden of proof to reopen a claim is one of fact for the ALJ. *In re Nguyen,* W.C. No. 4-543-945 (ICAP, July 19, 2004).

5. If an industrial injury leaves the body in a weakened condition and the weakened condition proximately causes a new injury, the new injury is a compensable consequence of the original industrial injury. *In Re Lang,* W.C. No. 4-450-747 (ICAP, May 16, 2005). However, the existence of a weakened condition is insufficient to establish causation if the new injury is the result of an efficient intervening cause. *Owens v. Industrial Claim Appeals Office,* 49 P.3d 1187, 1188 (Colo. App. 2002); *In Re Lang,* W.C. No. 4-450-747 (ICAP, May 16, 2005). The new injury is not compensable "merely because the later accident might or would not have happened if the employee had retained all his former powers." *In Re Chavez,* W.C. No. 4-499-370 (ICAP, Jan. 23, 2004). The determination of whether an injury resulted from an efficient intervening cause is a question of fact for the ALJ. *Id.*

6. As found, Claimant has failed to establish by a preponderance of the evidence that she suffered a change in the condition of her compensable injury or a change in her physical or mental condition that can be causally connected to the original compensable injury. Dr. Fall commented that at the time Claimant reached MMI she suffered left-sided back symptoms. However, Dr. Fall noted that Claimant's symptoms after August 6, 2008 were suggestive of an acute right-sided disc herniation at L4-5. Claimant's symptoms were also consistent with an acute muscular strain or facet pain. Dr. Fall summarized that Claimant likely

suffered an acute new injury on August 6, 2008 but the new injury had resolved. In contrast, Dr. Donner concluded that Claimant had a worsening of her work-related back injury after she was placed at MMI on October 21, 2004. However, Dr. Donner noted that Claimant's pain markedly worsened in August 2008 while throwing a comforter onto her bed but her symptoms returned to the same level they had been when she reached MMI.

7. Claimant testified that, following her release from medical care on October 21, 2004, her lumbar and left leg radicular symptoms never resolved. Moreover, she noted that her pain has gradually worsened over the years and has radiated into her lower left leg. However, Dr. Wilson's notes reflect that Claimant did not suffer ongoing, worsening pain or a decline in function between October 21, 2004 and the comforter-throwing incident on August 6, 2008. The medical records thus reflect that Claimant's symptoms remained stable until the August 6, 2008 incident. Claimant has thus failed to demonstrate that she experienced a worsening of her work-related condition that required medical treatment. Instead, Claimant suffered a new injury on August 6, 2008 that constituted an efficient intervening cause for her back symptoms.

ORDER

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

1. Claimant's request to reopen her Workers' Compensation claim is denied and dismissed.

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

DATED: March 17, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-680-008

CORRECTED FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

AMENDED ISSUES

The issues to be determined by this decision concern whether the Employer is entitled to an offset for an occupational disability retirement pension, despite the fact that Claimant did not apply for or receive a disability retirement pension.

FINDINGS OF FACT

1. Claimant was born on April 30, 1948. She worked as a Police Officer for the Police Department until her straight retirement on August 31, 2008.

2. On March 7, 2006, Claimant was injured while subduing a 6'3", 295 lbs, combative suspect. Respondent admitted liability and provided medical treatment for the Claimant.

3. Following the injury, the Claimant received treatment from a variety of clinicians and therapists including physical therapy, osteopathic manipulation, acupuncture, pilates and injections.

4. The Employer referred the Claimant to Dr. George Schakaraschwili, M.D., in May 2006.

5. By August 2006, Claimant's symptoms were primarily focused in the right scapular region, left lumbosacral region, and the neck. Claimant's MRI (magnetic resonance imaging) showed severe L5-S1 degenerative disc disease and mild disc bulging that abutted the L5 nerve roots.

5. Dr. Schakaraschwili ultimately determined that Claimant had a 29% whole person permanent impairment for specific disorders of and loss of range of motion in the cervical and lumbar spine. The ALJ finds Dr. Schakaraschwili's opinions persuasive, credible and undisputed.

6. On March 13, 2007, Dr. Schakaraschwili determined that the Claimant was at maximum medical improvement (MMI). He did not order a formal Functional Capacity Evaluation (FCE) because he felt it would not adequately measure police requirements. Dr. Schakaraschwili's permanent work limitation recommendation was that Claimant should not lift more than 50 lbs occasionally, and 25lbs on a regular basis. He also restricted the Claimant from frequent twisting or bending for more than 20 minutes an hour or for 1 hour a day. The Claimant cannot do any work as a police officer with these restrictions. Desk or light duty assignments with the police department are of a temporary nature only.

7. On June 1, 2007 Claimant was released to work with permanent restrictions assigned by Dr. Schakaraschwili..

8. William Shaw, M.D., evaluated the Claimant on October 2, 2007. Dr. Shaw concurred with

Dr. Schakaraschwili's assessment but found a final combined impairment of 27% of the whole person. The ALJ finds Dr. Shaw's opinions persuasive, credible and undisputed.

9. Respondent filed a Final Admission of Liability (FAL), dated November 21, 2007, admitting, *inter alia*, for 27% whole person permanent partial disability at a rate of $383.07 per week from March 13, 2007 through February 9, 2011, with an admitted temporary total disability benefit rate of $697.20 per week, based on an average weekly wage (AWW) of $1,186.85. Based on Claimant's admitted AWW, she was entitled to the maximum statutory TTD and PPD rate of $697.20. There is no persuasive evidence of the face of the FAL that Respondent was exacting an offset for Federal Social Security Disability (SSDI) benefits. There is no persuasive evidence that Claimant had ever received such benefits. Based on Respondent's conceded FFPA offset amount of $336.18 per week, Claimant's net PPD benefit would have been $361.02 per week $22.05 per week less than the amount admitted in the FAL and paid to the Claimant. On March 10, 2009, the Director of the Division of Workers' Compensation issued a lump sum order and Respondent received a 4% discount, or $1,295.20, on the lump sum payment of $35, 271.04, over Respondent's objection, which was not appealed. The lump sum order did not allow for a deduction of alleged overpayments.

10. The date that Claimant retired and would have been eligible for the FFPA disability pension was September 1, 2008. From that date to the hearing date, January 13, 2010, equals 499 days. Between September 1, 2008 and January 13, 2010, there was an overpayment of $22.05 per week, or $3.15 per day, in the aggregate amount of $1,571.85, less the $1,295. 04 discount for the approved lump sum payment. Consequently, the net overpayment between September 1, 2008 and January 13, 2010, was $276.81, which Respondent is entitled to recoup this amount. There will continue to be a $22.05 per week overpayment during the remainder of the PPD payout period.

11. Based on Dr. Shaw's report, the ALJ finds that Claimant cannot perform the essential functions of a police officer and would, therefore, to a reasonable degree of probability, be entitled to disability retirement benefits.

12. On June 2, 2008, Respondent wrote to the Claimant and requested that she apply for disability retirement benefits from the Fire and Police Pension Association (FPPA).

13. Claimant retired from her employment with Denver on August 31, 2008. Claimant entered the Deferred Retirement Option Program (DROP) [straight retirement without regard to disability] in 2003. As a condition of DROP, Claimant had a mandatory retirement date of September 1, 2008. Claimant made a determination that it was in her best financial interests to take a straight retirement rather than a disability retirement.

14. On January 26, 2009, Respondent again wrote to the Claimant to request that she apply for the disability retirement pension. Respondent informed Claimant that she had until February 27, 2009 to do so.

15. Respondent made a final request of the Claimant by letter on February 20, 2009.

16. Claimant applied for a lump sum payment of her remaining permanent partial disability benefits (workers' compensation), which was granted in the amount of $35, 271.04, giving Respondent a 4% discount in the amount of $1,295.20. Although Respondent objected to the payment because the offset for a disability pension had not been determined, the Director overruled the objection and the lump sum order was issued March 10, 2009. Respondent received the benefit of the 4% discount. No timely appeal was taken on the Director's lump sum order.

17. Claimant entered the Deferred Retirement Option Program (DROP) [straight retirement without regard to disability] in 2003. As a condition of DROP, Claimant had a mandatory retirement date of September 1, 2008. Claimant's participation in DROP does not affect her eligibility for the disability retirement pension because she entered DROP before her admitted injury and based on a vested retirement.

18. To be eligible for an Occupational Disability Retirement Pension, a finding that a member is no longer able to perform the duties of the job must be made. The Fire and Police Pension Association makes this finding after the member has been examined by three doctors. This finding has not been made by the FPPA.

19. Kevin Lindahl, General Counsel to the Fire and Police Pension Association (FPPA), stated that to be eligible for an occupational disability retirement pension a finding must be made, based on the examination of three doctors, that the member is no longer able to perform the duties of his or her job. Claimant never applied for the disability retirement pension, and thus was not examined by a panel of three doctors and no such finding was made. Respondent, however, has proven, through Claimant's medical records and the testimony of Sgt. Patrick Theriot, that it is reasonably probable that Claimant would be found to be no longer able to perform the duties of her job as a police officer. The ALJ further finds that, based on the analysis of Dr. Schakaraschwili, Dr. Shaw and the testimony or Sgt. Theriot, the Claimant would have been entitled to a disability retirement had she applied, and thus the disability benefits are "payable" to the employee.

20. If the Claimant had applied for the100% Employer financed FPPA disability pension, she would have received $1, 456.80 per month, or $336.18 per week.

21. Respondent has proven, by a preponderance of the evidence, that Claimant is no longer able to perform the duties of a police officer and, therefore, with the benefit of hindsight, she would have been entitled to a disability retirement from the FPPA, which was 100% Employer financed.

AMENDED CONCLUSIONS OF LAW

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). The medical opinions concerning the Claimant's permanent work restrictions are un-contradicted. *See, Annotation, Comment: Credibility of Witness Giving Un-contradicted Testimony as Matter for Court or Jury,* 62 ALR 2d 1179, maintaining that the fact finder is not free to disregard un-contradicted testimony. As found, the opinions of Dr. Scharakaschwili and Dr. Shaw, concerning the Claimant's permanent work restrictions, are persuasive, credible and un-contradicted. The testimony of Sgt. Theriot is persuasive, credible, and it supports a fairly drawn inference and finding that the Claimant would have been awarded a disability pension had she applied.

Burden of Proof

b. The burden of proof is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P. 2d 535 (Colo. App. 1992). In this case, Respondent is asserting entitlement to an offset for a disability pension for which Claimant did not apply. A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. X-ray,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Respondent has sustained its burden.

Obligation to Apply for a Disability Pension

c. An employee must apply for periodic disability benefits upon the request of the insurer

or employer. §8-42-103(1)(d)(II), C.R.S. (2009). As found, the Employer requested that the Claimant apply for such disability benefits on June 2, 2008, January, 27, 2009, and February 20, 2009. Failure to apply after the Employer's request "shall be cause for suspension of benefits." *Id.* The question is if the Employer does not request that Claimant's benefits be suspended, may the Employer receive the offset as if a claimant had been awarded a disability pension.

d. § 8-42-103 (1)(d)(I), C.R.S. (2009), provides that "in cases where it is determined that periodic disability benefits are payable to an employee under the provisions of a pension or disability plan financed in whole or in part by the employer…the aggregate benefits payable for temporary partial disability, permanent partial disability, and permanent total disability to this section shall be reduced, but not below zero, by an amount equal as nearly as practical to such employer pension or disability plan benefits…" For the Employer to collect an offset, it must be determined that disability benefits are "payable" to the Claimant. The term "payable" does not mean that a claimant has actually applied for or obtained an employer disability pension, but rather the question is "whether he or she is entitled to the benefits." *Culver v. Ace Electric*, 952 P.2d 1200, 1204 (Colo. App. 1997). As found, Claimant would have been entitled to disability retirement had she applied, and thus the disability benefits are "payable" to the Claimant within the meaning of the *Culver* opinion.

e. The intent of the offset provision is to prevent employees from receiving double disability benefits both financed by the employer. *See Scriven v. Indus. Comm'n*, 736 P.2d 414 (Colo. App. 1987); *Sparling v. Colo. Dept. Hwys*, 812 P.2d 686 (Colo. App. 1990). The purpose of the statutory offset is not met in this case because Claimant is not seeking to receive duplicative disability benefits. The Employer, however, is entitled to an offset even thought the Claimant did not realize any economic gain. *Ihnen v. Western Forge*, 936 P.2d 634 (Colo. App. 1997). The Court of Appeals recognized that in certain situations people elect to not apply for disability benefits because it is not in their best financial interests. *Id.* at 636. The court, however, concluded that it was not the proper position of the judiciary to create exemptions to clearly written statutes: "It may well be more equitable for the General Assembly to create an exception to the offset statute in circumstances when, as here, the claimant has a valid reason not to accept [a disability pension] or does not benefit from a determination that [a disability pension] is payable. However, it is not the function of this court to rewrite the legislation, as the power to change the present scheme rests with the General Assembly." *Id.* As found, although it is not in the Claimant's best economic interests to apply for the disability pension, the Employer is nonetheless entitled to an offset.

The Offset Calculation

f. The offset calculation is controlled by §8-42-103 (1)(d)(III), C.R.S. (2009), which provides:

> The provisions of this paragraph (d) shall apply to a disability pension paid pursuant to article 30.5 or 31 of title 31, C.R.S.; except that said reduction shall not reduce the

combined weekly disability benefits below a sum equal to one hundred percent of the state average weekly wage as defined in section 8-47-106 and applicable to the year in which the weekly disability benefits are being paid.

As found, if the Claimant had applied for the100% Employer financed FPPA disability pension, she would have received $1, 456.80 per month, or $336.18 per week. Respondent filed a Final Admission of Liability (FAL), dated November 21, 2007, admitting, among other things, for 27% whole person permanent partial disability at a rate of $383.07 per week from March 13, 2007 through February 9, 2011, with an admitted temporary total disability benefit rate of $697.20 per week, based on an average weekly wage (AWW) of $1,186.85. Based on Claimant's admitted AWW, she was entitled to the maximum statutory TTD and PPD rate of $697.20. There is no persuasive evidence of the face of the FAL that Respondent was exacting an offset for Federal Social Security Disability (SSDI) benefits. There is no persuasive evidence that Claimant had ever received such benefits. Based on Respondent's conceded FFPA offset amount of $336.18 per week, Claimant's net PPD benefit would have been $361.02 per week, after the FFPA offset, which is $22.05 per week less than the amount admitted in the FAL and paid to the Claimant. On March 10, 2009, the Director of the Division of Workers' Compensation issued a lump sum order and Respondent received a 4% discount, or $1,295.20, on the lump sum payment of $35, 271.04, over Respondent's objection, which was not appealed. The lump sum order did not allow for a deduction of alleged overpayments. Also as found, the date that Claimant retired and would have been eligible for the FFPA disability pension was September 1, 2008. From that date to the hearing date, January 13, 2010, equals 499 days. Between September 1, 2008 and January 13, 2010, there was an overpayment of $22.05 per week, or $3.15 per day, in the aggregate amount of $1,571.85, less the $1,295. 04 discount for the approved lump sum payment. Consequently, the net overpayment between September 1, 2008 and January 13, 2010, was $276.81, which Respondent is entitled to recoup this amount. There will continue to be a $22.05 per week overpayment during the remainder of the PPD payout period.

Overpayments

g. As found in paragraph f above, the date that Claimant retired and would have been eligible for the FFPA disability pension was September 1, 2008. From that date to the hearing date, January 13, 2010, equals 499 days. Between September 1, 2008 and January 13, 2010, there was an overpayment of $22.05 per week, or $3.15 per day, in the aggregate amount of $1,571.85, less the $1,295. 04 discount for the approved lump sum payment. Consequently, the net overpayment between September 1, 2008 and January 13, 2010, was $276.81, which Respondent is entitled to recoup this amount. There will continue to be a $22.05 per week overpayment during the remainder of the PPD payout period.

AMENDED ORDER

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IT IS, THEREFORE, ORDERED THAT:

A. Claimant is legally entitled to a Fire and Police Pension Association disability retirement pension, thus, periodic disability benefits are legally "payable" to Claimant within the meaning of § 8-42-103(1)(d)(II), C.R.S. (2009).

B. The Employer is entitled to claim an offset for a 100% Employer financed occupational disability retirement pension in the amount of $1,456.80 per month, or $336.18 per week, against PPD benefits, in the net amount of $276.81 for the period from September 1, 2008 through January 13, 2010, both dates inclusive, a total of 499 days. Thereafter, Respondent shall be entitled to reduce the permanent partial disability benefit to $361.02 per week from January 14, 2010 through the remainder of the permanent partial disability payout period.

DATED this_____day of March 2010.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-805-957

ISSUES

The issues for determination are compensability and medical benefits. The parties stipulated to an average weekly wage of $344.24.

FINDINGS OF FACT

1. Claimant testified that she injured her back at work on August 5, 2009, while she was bending over and **pushing** a box that was too heavy to lift.

2. Claimant did not report the injury on August 5, 2009. On August 6, 2009, she told her employer that she was injured when **lifting** a heavy box.

3. Claimant was initially treated at Sky Ridge Medical Center. She told her care providers that that there was an abrupt onset when **standing** after taking a break. She also stated that

the mechanism of injury was **lifting**.

4. Claimant was treated at Concentra. She filled out a form there and stated that the injury occurred when **carrying** boxes.

5. Claimant was examined by Dr. Morfe on January 28, 2010. She described the injury to him as occurring when was **pushing** a box across the floor.

6. English is not Claimant's primary language. The difference histories can be attributed to that and Claimant's lack of precision when describing what happened. It is found that Claimant suffered back pain after pushing a box that was too heavy to lift.

7. A cervical MRI was taken at Sky Ridge Medical Center on August 6, 2009. The MRI showed that Claimant had facet degenerative joint disease. Neither this report nor any later reports attributed Claimant's facet degenerative joint disease to the compensable accident.

8. Mark Winslow, D.O., an authorized treating physician at Concentra, examined Claimant on August 26, 2009. His diagnosis was lumbar strain with no evidence of radiculopathy. He attributed Claimant's condition to her employment. Claimant received physical therapy.

9. Branden Reiter, D.O., an authorized treating physician at Concentra, examined Claimant on December 3, 2009. Claimant stated that she had returned to work regular duty in September and there her condition had worsened. He diagnosed lumbar and cervical strain and elbow tenosynovitis. Claimant was referred to a radiologist. The radiologist commented on December 4, 2009, that Claimant's study showed a normal lumbar and cervical spine. Claimant received additional physical therapy. On December 21, 2009, Dr. Reiter re-examined Claimant. Claimant stated that her symptoms were improving, Dr. Reiter's assessment was cervical and lumbar strain. Dr. Reiter assessment was the same after a follow-up examination on January 5, 2010.

10. Claimant was examined by Erasmus Morfe, D.O. on January 28, 2010. Dr. Morfe is not a treating physician. Dr. Morph's impression was mechanical low back pain without neurological deficit and overlying myofascial pain.

CONCLUSIONS OF LAW

Claimant has established by a preponderance of the evidence that she was injured as a result of an accident at work on August 5, 2009, that occurred when she was bending over and pushing a box that was too heavy to lift. The claim is compensable.

As a result of the compensable accident, Claimant suffered a lumbar strain or mechanical low back pain without neurological deficit. Respondent is liable for medical care from authorized providers that is reasonably needed to cure and relieve Claimant from the effects of her injury. Section 8-42-101(1), C.R.S. Liability is limited to those 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. Respondent is liable for the medical care Claimant receives that is reasonably needed to cure and relieve her from the effects of the compensable injury.

3. Matters not determined by this order are reserved for future determination.

DATED: *March 18, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-772-006

ISSUES

The issues to be decided are whether the Respondents have overcome the Division Independent Medical Examiner's (DIME) opinion concerning the relatedness of Claimant's right hip condition to his work-related injury and if so, whether a total right hip replacement is reasonable and necessary.

FINDINGS OF FACT

1. Claimant was injured in two separate work-related injuries on September 25, 2007 and August 21, 2008 respectively.

2. Claimant was treated under the workers' compensation system and was ultimately placed at maximum medical improvement on May 5, 2009 by Dr. Olson, after Dr. Olson noted that the insurance company denied authorization for hip replacement surgery.

3. Claimant underwent a division independent medical evaluation on September 30, 2009, which was conducted by Dr. Greg Reichhardt.

4. Dr. Reichhardt concluded that Claimant's right hip condition was permanently aggravated by his work-related injury of August 21, 2008 and is therefore work-related. Dr. Reichhardt

opined that Claimant should get a second opinion with a different orthopedic surgeon concerning the need for total hip replacement. If the recommendation is for total hip replacement then Dr. Reichhardt believes that it is reasonable to proceed with such surgery.

5. Dr. Steven Myers, MD saw Claimant after Dr. Finn referred Claimant to him. Dr. Myers saw Claimant on January 2, 2009 for a one-time evaluation. Claimant reported to Dr. Myers that he had hip pain of several months duration.

6. Claimant was seeing Dr. Finn for other work related pains.

7. Claimant had had an MRI arthrogram study completed. A Dr. Bollinger produced the report. The report indicated that the Claimant had degenerative changes in both hips, with joint space loss and joint line osteophytes seen at the humeral head on the right hip.

8. Dr. Myers pointed out that the humerus is in the shoulder, which lead him to believe the report was hastily prepared. He also indicated that the report was rather brief. He was used to seeing reports of two pages for this procedure. As a result, Dr. Myers opined that the report was erroneous in some ways.

9. The report did suggest a labral tear and possibly a cyst. Dr. Myers felt that it was not a convincing report and he had little faith in it.

10. Dr. Myers did not see the actual films of the MRI and acknowledged that he has not been trained in the reading of MRI films but has had training in reading x-rays and CAT scans.

11. Dr. Myers opined that the presence of a labral tear rarely indicates a surgical procedure is necessary.

12. On examination, Claimant had some pain when Dr. Myers flexed his hip and when he rotated his hip, which he opined is typical of a patient with osteoarthritis. Claimant did not have any mechanical symptoms like a click or a snap that is sometimes seen with a torn labrum or a snapping tendon.

13. Dr. Myers' impression was that Claimant had fairly typical findings of a patient with arthritis of the hip.

14. Dr. Myers did review x-rays that were provided to him by the Claimant. These x-rays indicated to Dr. Myers that there was indeed osteoarthritis of the hip, which is not surprising for a 66-year-old man.

15. Dr. Myers explained that osteophytes are bone spurs that form in a joint, any joint, and they are in response to the presence of arthritis in that joint. He opined that the osteophytes take years to form.

16. The finding of the osteophytes confirms Dr. Myers' conclusion of osteoarthritis. He points

out that the osteophytes are one of the four cardinal findings on an x-ray showing osteoarthritis. He continued that joint space narrowing is one, osteophytes is second, bone cysts are the third, and sclerosis, which is a whiteness of the appearance of the bone, is the fourth sign of osteoarthritis as seen on an x-ray.

17. Dr. Myers opined that the Claimant had osteoarthritis of the hip that was not produced by his employment.

18. He further explained, that perhaps the injury made Claimant's symptoms worse but he does not feel that the injury Claimant sustained caused the findings that he saw on the x-ray. He explained that the findings on the x-ray take years to develop and are not produced by an acute injury.

19. Dr. Myers opined that all he, or any orthopedist has to offer under these circumstances, for long-term benefit, is a hip replacement.

20. Dr. Myers also states that he feels the Claimant should put up with the situation for as long as he possibly can. He states that the Claimant, at 66-years-old, is on the relatively young side of patients for a hip replacement and points out that these hip replacements don't last forever. He thinks that these procedures could last 30 years with today's technology but that they like to see patients wait as long as possible to increase the chances that they will only need one hip replacement in their lifetime.

21. Dr. Myers indicated that once a patient starts having pain associated with the osteoarthritis, that the pain symptoms would not normally abate.

22. Dr. Myers indicated that sometimes cortisone injections can offer very short-term relief but that there is nothing to offer the patient other than hip replacement.

23. Genetic disposition is the number one predisposing factor in the development of osteoarthritis. People are born with skeletal structures that over time wear out with use. Secondly, a history of traumatic injury can lead to development of arthritis of a joint. This usually develops over a long period of time.

24. Dr. Myers opined that injury was a factor in the Claimant's case. Based upon the records provided to Dr. Myers and his other evaluations, Claimant did not have hip pain until subsequent to the accident. He believes that the Claimant is being truthful when he states that he did not have hip pain before the injury.

25. He opined that an injury that is superimposed on a joint that has started to show some wear and tear will certainly be interpreted as a post-traumatic injury, even though the degeneration of that joint had started years before.

26. Dr. Myers opined that he thinks that is the case with the Claimant.

27. Dr. Myers pointed out that as we all get older we have some minor aches and we just accept it because we are getting older. He stated that if you are 66-years-old you tend to have some achy joints.

28. If the condition worsens then Dr, Myers opines that the injury probably does have some causal relationship to the worsening of this joint pain.

29. Dr. Myers also opined that weight can be a factor. He believes that carrying extra weight would have an affect on the joints, stating that the knees and the hips probably take the brunt of being overweight.

30. Ultimately, Dr. Myers opined that he believed that the Claimant's injury was an acute worsening of a condition that he already had.

31. Dr. Myers, after having his memory jarred, recalled that the Claimant did have a hip injection that provided 75 percent relief for two weeks. Based upon this Dr. Myers opined that if he had to proportion this out, he would say that Claimant's hip pain is 75 percent due to his arthritis and 25 percent due to the injury.

32. Dr. Myers opined that the Claimant's injury created a higher probability of medical certainty that the injury probably did hasten the Claimant's symptoms.

33. Claimant was seen by Dr. Hall for an independent medical evaluation on January 6, 2010. Dr. Hall reviewed Claimant's medical records including the DIME report. Dr. Hall also examined the Claimant.

34. Dr. Hall opined that he agreed with Dr. Reichhardt's conclusions as stated in the DIME report.

35. On February 5, 2010 Dr. Jeffrey A Wunder conducted an IME of the Claimant at the request of the Respondent-Insurer.

36. Dr. Wunder ultimately opines that Claimant's need for hip replacement surgery is unrelated to his work injury.

37. While Dr. Wunder reviewed the Claimant's medical history, took the Claimant's history, and examined the Claimant, his analysis and conclusions do not establish that the Dr. Reichhardt's conclusions and opinions as stated in DIME report are clearly erroneous. The medical evidence establishes nothing more than a difference of opinion between Dr. Wunder and Dr. Reichhardt. Additionally, Dr. Reichhardt's analysis and conclusions are supported by separate IMEs conducted by Dr. Myers and Dr. Hall, further reinforcing Dr. Reichhardt's conclusions.

38. The Respondents have failed to overcome, by clear and convincing evidence, that Dr. Reichhardt's DIME report, analysis, conclusions, are clearly erroneous with respect to the relatedness of Claimant's right hip condition to his work-related injury and therefore have failed

to establish that Claimant is at MMI for his work-related conditions.

39. Respondents have failed to overcome by a preponderance of the evidence, the DIME physician's opinion that a right total hip replacement is reasonable and necessary, pursuant to the proviso of the Claimant getting a second opinion as outlined in the DIME report.

CONCLUSIONS OF LAW

Sections 8-42-107(8)(b)(III) and (c), C.R.S. (2009), 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 is highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

The 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).

The ALJ finds the DIME physician's opinion on the relatedness of the Claimant's right hip condition to be credible and finds insufficient medical or other evidence to establish by clear and convincing evidence that the DIME physician's opinion was clearly wrong. Claimant has failed to overcome the DIME physician's finding on relatedness of the Claimant's right hip condition and therefore the Claimant is not at MMI.

The ALJ finds the DIME physician's opinion on the treatment of Claimant's right hip condition to be credible and finds insufficient medical or other evidence to establish by a preponderance of the evidence that the DIME physician's opinion should fail. Claimant has failed to overcome the DIME physician's finding on the reasonableness and necessity of the treatment as recommended him.

ORDER

It is therefore ordered that:

1. Respondents shall pay for medical treatment for the Claimant's right hip condition, to cure or relieve him from the effects of the work injury, and thus to bring Claimant to MMI.

2. Respondents shall arrange for a second opinion with an orthopedic surgeon in accordance with the direction of the DIME report.

3. Respondents shall provide Claimant with total right hip replacement surgery, with the proviso that the second opinion supports such surgery, as stated by the DIME report.

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

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

DATE: March 18, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-809-463

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUES

The issues to be determined by this decision concern compensability of injuries sustained in a motor vehicle accident on September 29, 2009, specifically, whether or not the Claimant was in the course and scope of employment at the time of the accident. If compensable, whether the Claimant is entitled to medical benefits.

FINDINGS OF FACT

1. Claimant is an employee and principal corporate shareholder of the Employer, a restaurant located in Thornton, Colorado. Her regular job duties are physically demanding and include cooking and food stocking.

2. Claimant had sustained a preexisting work-related injury when she injured her left hand while working for the Employer on June 30, 2009, which is the subject of W.C. No. 4-796-965 (hereinafter "the prior claim"). Claimant immediately told her initial treating physicians that her injury in the prior claim was work-related.

3. VC was formerly the Pinnacol claim representative assigned to the prior claim. VC testified by telephone that Claimant promptly sought workers' compensation benefits in the prior claim after Claimant was injured on June 30, 2009.

4. The Claimant received and negotiated checks for temporary total disability (TTD) benefits in the prior claim for the period of July 1, 2009 through October 15, 2009. Pinnacol admitted liability for those TTD benefits on the basis that Claimant's June 30, 2009 injury prevented her from performing her regular job duties thereafter.

5. The Claimant periodically visited to oversee things while she received the aforementioned TTD benefits, but she was not paid for those non-physical activities and she denied that she was working during that period.

6. On September 29, 2009, the Claimant was involved in a motor vehicle accident (MVA) that occurred in the southbound lanes of N. Washington Street in Thornton, Colorado. Law enforcement determined that the Claimant was at-fault for the MVA because she rear-ended the vehicle in front of her.

7. According to the Claimant, she was en route to the Employer's restaurant from her personal residence (which is located North of the Employer's location in Thornton) at the time of the MVA. According to the Claimant, the MVA occurred when she dropped her cell phone, which she was previously holding from a conversation she had with her husband during which he asked her to purchase some groceries from a store located at Grant St. in Thornton. The MVA occurred immediately after that conversation ended. The ALJ finds that even though the Claimant was "going to" the restaurant outside the course and scope of her employment, immediately after the cell phone conversation with her husband, the Claimant entered the course and scope of her employment to pick up groceries and deliver them to the restaurant. The ALJ further finds that "picking up groceries" for an employer is within the course and scope of employment. There was no persuasive medical evidence or lay testimony presented to suggest the MVA was simply an exacerbation in the natural progression of her previously admitted work injury. Indeed, the evidence established that the Claimant sustained a new

aggravation and acceleration of her previous injury on September 29, 2009.

8. The locations of the MVA, the store, and the Employer's restaurant are depicted in Respondents' Exhibit "L." Several businesses are located on N. Washington Street within a few miles from the location of the MVA. Several major highways are also located within a short drive from where the MVA occurred, including Interstate Highways 25, 70, and 76. The Claimant explained that she is a "creature of habit" and travels on the roads with which she was already familiar "all the time."

9. On September 29, 2009, the Claimant was treated at St. Anthony Hospital where she reported that the MVA happened when she "fell asleep at the wheel."

10. The Claimant was receiving TTD benefits at the time of the MVA due to her injuries in the prior claim. She was not paid for the activities she allegedly performed on September 29, 2009.

11. The Employer owns a bank account to which the Claimant has access. The Employer uses receipts to track the cash revenue it receives. It receives periodic statements concerning the credit card revenue it receives. The Employer tracks its business expenses for tax purposes.

12. Respondents attempted to introduce the testimony of Adjuster VC concerning a hearsay conversation with Claimant's husband on October 14, 2009. Because the hearsay testimony dfid not fall under any exceptions to the hearsay rule, the ALJ sustained Claimant's objection thereto.

13. On October 16, 2009, Arthur Kuper, D.O., examined the Claimant. Dr. Kuper was already treating the Claimant for the injuries she sustained in the prior claim. After describing the Claimant's MVA-related injuries in the "interval history" section of his report, Dr. Kuper noted that the Claimant was "*not currently working* due to her other injuries." The ALJ infers and finds that this was a generic non-medical observation by Dr. Kuper. Dr. Kuper described the Claimant's MVA as being non-work-related throughout that report and noted that the Claimant was still receiving benefits "under her auto insurance" at that time. The ALJ infers and finds that this was a legal and not a medical observation on the part of Dr. Kuper.

14. The Claimant's automobile insurance carrier at the time of the MVA was Government Employees Insurance Company (hereinafter GEICO). GEICO covered the first $10,000 of the Claimant's MVA-related medical expenses, but stopped making payments on October 29, 2009 after her policy's coverage limits were exhausted. In early November 2009, the Claimant began receiving letters stating that GEICO would not pay for any further medical treatment.

15. On November 11, 2009, GEICO verbally informed the Claimant's husband that her policy's coverage limits were exhausted, before all of her medical bills had been paid.

16. On November 13, 2009, the Claimant filed the herein Workers' Compensation – First Report of Injury. At no time did Respondents inform the Claimant that she could not treat with Dr. Kuper for the MVA incident of September 29, 2009.

17. On November 23, 2009, the Claimant told Dr. Kuper for the first time that she was "shopping for her restaurant" at the time of the MVA. Respondents inherently argue that the timing of events is so suspicious that it renders the Claimant's testimony incredible to the point that Respondents' imply that Claimant conjured up the telephone call from her husband immediately prior to the accident about changing course to go to the store to pick up groceries to bring to the Employer's restaurant. The ALJ finds the Claimant's testimony in this regard credible. As Mark Twain said: "Truth is stranger than fiction. After all, fiction has to make sense." Respondents' argument glosses over the details of Claimant's statements to her doctor, coupled with the doctor's inferences and statements arising out of the fact that the Claimant was already treating for a previously compensable injury. The ALJ finds that it is not improbable that the Claimant failed to appreciate the compensable nature of the MVA shortly after it happened because she was already treating for a compensable injury. It is also not unlikely that she would pursue a new workers' compensation claim when the benefits from her auto insurance had been exhausted. It makes sense that as long as GEICO was paying her medical bills, she would not be that concerned about filing or pursuing a workers' compensation claim for the MVA.

18. The Claimant has proven, by a preponderance of the evidence that she sustained compensable aggravating injuries arising out of the MVA of September 29, 2009, when she stepped out of the mere "going to" work and into the course of employment after the cell phone conversation with her husband whereupon she was changing course to go to the store to pick up groceries for the Employer's restaurant and deliver them to the restaurant. In fact this new event superseded the previous admitted injury. Also, since the Claimant went to Dr. Kuper, the previously authorized workers' compensation medical provider, her treatment arising from the September 29 MVA was authorized. It was also causally related to the MVA and reasonably necessary to cure and relieve the effects of that MVA.

CONCLUSIONS OF LAW

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or

actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions; the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). As found, Respondents inherently argue that the timing of events is so suspicious that it renders the Claimant's testimony incredible to the point that Respondents' imply that Claimant conjured up the telephone call from her husband immediately prior to the accident about changing course to go to Sam's Club to pick up groceries to bring to the Employer's restaurant. As Mark Twain said: "Truth is stranger than fiction. After all, fiction has to make sense." As found, the ALJ accepted the Claimant's testimony in this regard as credible. Respondents' argument glosses over the details of Claimant's statements to her doctor, coupled with the doctor's inferences and statements arising out of the fact that the Claimant was already treating for a previously compensable injury. The ALJ finds that it is not improbable that the Claimant failed to appreciate the compensable nature of the MVA shortly after it happened because she was already treating for a compensable injury. It is also not unlikely that she would pursue a new workers' compensation claim when the benefits from her auto insurance had been exhausted. It makes sense that as long as GEICO was paying her medical bills, she would not be that concerned about filing or pursuing a workers' compensation claim for the MVA.

Stepping Into the Course of Employment On the Way to Work

b. Ordinarily, an employee traveling to work is not within the course and scope of employment. *Madden v. Mountain West Fabricators,* 977 P.2d 861 (Colo. 1999). Travel performed for the sole purpose of facilitating a worker's arrival at work is not covered by the Workers' Compensation Act. *See, e.g., Berger v. Kelly Services, Inc.*, W.C. No. 4-605-086 [Industrial Claim Appeals Office (ICAO), 2005]. *Madden* spells out special circumstances that create exceptions to the "going-to and coming-from" bar on compensability, one of which is when the obligations or conditions of employment create a special zone of danger resulting in the injury. Another is when the travel is part of the service the employee provides for the employer. *See Mineral County v. Industrial Commission,* 649 P.2d 728 (Colo. App. 1982); *Loffland Brothers v. Baca,* 651 P.2d 431 (Colo. App. 1982). As found, the Claimant was about to change course in her journey to work, specifically, to go to Sam's to pick up groceries for the Employer's restaurant, when the September 29, 2009 accident occurred. Thus, she had stepped back into the course and scope of her employment to render a service to the Employer.

Compensability

c. A compensable injury is one that arises out of and in the course of employment. § 8-41-301(1)(b), C.R.S. (2009). 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. § 8-41-301(1)(c), C.R.S. (2009). *See Merriman v. Industrial Commission,* 120 Colo. 400, 210 P.2d 448 (1949); *National Health Laboratories v. Industrial Claim Appeals Office,* 844 P.2d 1259 (Colo. App. 1992); *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). Claims for secondary injuries can be compensable. If the work injury leaves the body in a weakened condition and the weakened condition plays a causative role in a subsequent injury, the additional injury is compensable. *Jarosinski v. Industrial Claim Appeals Office*, 62 P.3d 1082 (Colo. App. 2002). Claimant dropped her phone while she was still recovering from her first injury. But for the injured hand, it is likely that she would not have dropped the phone. As found, the MVA of September 29, 2009 aggravated the Claimant's preexisting, underlying condition. Thus, she sustained a new compensable injury on September 29, 2009, which superseded and supplanted her previous admitted injury of June 30, 2009.

May an Individual Receiving TTD Benefits Sustain a Compensable Injury

d. In *Winters v. Industrial Commission of State of Colorado*, 736 P.2d 1256 (Colo. App. 1986) the Court held that for the self-employed person, monthly withdrawals from company assets do not constitute an ability to earn income as the result of the employee's personal labor. *Winters* was determined to be entitled to temporary disability benefits even though he withdrew monthly amounts from his company's assets for living expenses. As found, the Claimant was essentially doing one task for the benefit of the Employer, *i.e.,* going to pick up groceries, and this task did not negate her status as a temporarily and totally disabled worked, entitled to receive TTD benefits. Nonetheless, the September 29, 2009 injuries superseded the June 30, 2009 injuries. Respondents argue for the ALJ to infer that Claimant was acting as a volunteer for the Employer on the date of the MVA. An unpaid volunteer in the service of a private entity cannot be an employee for purposes of the Act because there is no contract of hire. *Hall v. State Compensation Insurance Fund*, 387 P.2d 899 (Colo. 1963). Militating against this argument is the fact that Claimant was a co-owner/employee of the Employer at the time of the MVA, who was entitled to make a cash draw for herself from the Employer's funds. The ALJ finds that Claimant was **not** a volunteer at the time of the MVA.

Medical Benefits

e. Pursuant to Section 8-43-404 (5) (a) (I) (A), C.R.S. (2009), the employer is required to furnish an injured worker a list of at least two physicians or two corporate medical providers, in the first instance. An employer's right of first selection of a medical provider is triggered when the employer has knowledge of the accompanying facts connecting the injury to the employment. *Jones v. Adolph Coors Co.,* 689 P. 2d 681 (Colo. App. 1984). An employer

must tender medical treatment forthwith on notice of an injury or its right of first selection passes to the injured worker. *Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565 (Colo. App. 1987). As found, the Employer tendered Dr. Kuper for the June 30, 2009 injury; and, Claimant continued to treat with Dr. Kuper after the superseding injury of September 29, 2009. After Respondents became aware of the MVA claim of September 29, at no time did they inform the Claimant that she could not treat with Dr. Kuper. It would be pure sophistry to argue that Claimant should have re-contacted the insurance carrier to ask if she could continue treating with Dr. Kuper after the MVA claim of September 29, 2009. Therefore, Dr. Kuper was authorized to treat the Claimant for the September 29, 2009 MVA claim.

f. 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 is causally related to the aggravation of her underlying condition on September 29, 2009. Also, medical treatment must be reasonably necessary to cure and relieve the effects of the industrial occupational disease. § 8-42-101 (1) (a), C.R.S. (2009). *Morey Mercantile v. Flynt,* 97 Colo. 163, 47 P. 2d 864 (1935); *Sims v. Industrial Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). As found, all of the Claimant's medical care and treatment, as reflected in the evidence, was and is reasonably necessary.

Burden of Proof

g. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. (2009). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. X-ray,* 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, the Claimant has met her burden of proof.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Claimant sustained a new, aggravating compensable injury on September 29, 2009; and, this injury superseded the admitted injury of June 30, 2009

B. Respondents shall pay all of the costs of causally related and reasonably

necessary medical care and treatment resulting from the September 29, 2009 injury, subject to the Division of Workers' Compensation Medical Fee Schedule.

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

DATED this_____day of March 2010.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-747-343

ISSUES

1. Whether the Respondent is required to carry through with a previously approved one-time evaluation of the Claimant, where the Respondent required the approved evaluation be conducted by a doctor that refuses to see the Claimant and the Respondent thereafter refuses to appoint an ATP who is willing to do the evaluation.

2. If so, has the Claimant established the right to select the ATP for the one-time evaluation?

FINDINGS OF FACT

Claimant was injured in a work-related incident while working for the Respondent-Employer.

Claimant was referred for treatment with the Respondent-Employer's workers' compensation medical providers.

Claimant had several authorized treating physicians over the course of her treatment. Her last ATP was Dr. Sacha. Claimant began to see Dr. Sacha in February 2009. Claimant and Dr. Sacha had a contentious relationship. At their last visit Dr. Sacha forbade Claimant from returning to the Concentra facilities.

Claimant was forbidden to return to Dr. Sacha's office and to any Concentra facility. What precipitated the banning of the Claimant was the fact that Claimant brought a tape recorder to her appointment with Dr. Sacha. Dr. Sacha saw the tape recorder, which Claimant had laid in

plain sight on a table, and he told her to turn it off. Claimant responded that she would like to find out about her rights to tape record the treatment session.

Dr. Sacha was then reaching for the tape recorder and commented that the police need to be called. The Claimant was neither combative nor rude with Dr. Sacha.

Dr. Sacha indicated in his notes that the Claimant was illegally taping the exam and that they called the police and that a police call number would be placed in the Claimant's records. There was no police report provided by either party hereunder. Thus, the ALJ has no indication as to how the police handled the matter.

Claimant departed the office and called her attorney and did not wait for the police to respond.

Dr. Sacha did not indicate what law was being violated by the Claimant's taping of the examination.

The ALJ is unaware of what law the Claimant was allegedly violating by tape recording the examination.

The ALJ finds that Dr. Sacha's conduct clearly created an adversarial relationship with the Claimant.

In discussing the preliminary matters at the hearing Respondents' counsel conceded that the Respondents authorized a one-time evaluation for the Claimant subsequent to the DIME conducted in this matter. However, they only authorized the current ATP, Dr. Sacha, to perform the evaluation. Based upon the fact that Claimant was forbidden to see the ATP, she requested to see another physician but that request was denied.

Respondent has failed to establish that the approval for the one-time evaluation should be rescinded.

The ALJ infers that the referral by the Respondent to a Dr. that they know will not see Claimant due to non-medical reasons is in fact a refusal to provide the Claimant with an ATP, and thus a refusal to provide the authorized evaluation.

CONCLUSIONS OF LAW

1. Dr. Sacha did not indicate what law was being violated by the Claimant's taping of the examination.

2. The Colorado Criminal Code, section 18-9-304(1), C.R.S. (2009) states in part,

> Any person not visibly present during a conversation or discussion commits eavesdropping if he:
>
> (a) Knowingly overhears or records such conversation or discussion without the consent of at least one of the principal parties thereto, or attempts to do so.

3. It has been held in Colorado that the consent of one party to a recording is sufficient to support summary judgment, where the issue to be determined was whether or not the conversations were illegally recorded. *Abrahamsen v. Mountain States Tel. & Tel. Co.*, 494 P.2d 1287 (1972).

4. The Claimant's consent was all that was required.

5. The ALJ concludes that Dr. Sacha's conduct created an adversarial relationship with the Claimant.

6. The ALJ concludes that the manner in which the Respondent referred the Claimant was inappropriate at best, since they were aware of the inability of the Claimant to actually be seen.

7. Once Respondents have selected an ATP willing to treat the Claimant, the ATP may make authorized referrals in the ordinary course of care. At that point, Claimant may not independently retain additional physicians without procuring permission from the insurer or the ALJ. If the claimant does so, the treatment provide by such personal physicians is not compensable. Section 8-43-404(7), C.R.S.; *Cf. In re Gale*, W.C. No. 4-606-010 (ICAO, 6/16/2005). Here, the Respondent has failed to provide an ATP willing to treat the Claimant.

8. The ALJ concludes the Respondent has lost the right to determine the ATP for Claimant's one time follow up that the Respondent has approved.

ORDER

It is therefore ordered that:

1. Respondents are ordered to pay for the one-time evaluation they agreed to and the Claimant shall select the ATP for this evaluation.

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

DATE: March 19, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

INTERIM ORDER GRANTING RESPONDENTS' MOTION FOR SUMMARY JUDGMENT, ORDER VACATING HEARING, AND ORDER CONCERNING EX-PARTE COMMUNICATION FROM CLAIMANT

Respondents' Motion for Summary Judgment

1. On February 16, 2010 the Respondents herein filed a Respondents' Motion for Summary Judgment Regarding Unripe Issues and Statute of Limitations.

2. On February 17, 2010 Claimant's attorney, William A. Alexander, Jr., Esq, filed a Motion for Withdrawal of Counsel, averring that the Claimant requested such withdrawal. Claimant was informed through the motion of his right to object to such withdrawal and failed to object within the prescribed time.

3. On March 4, 2010 the Motion for Withdrawal of Counsel was granted. Claimant has been *pro se* since such order as no attorney has filed an appearance on behalf of the Claimant in this matter. Claimant was properly advised in the Motion for Withdrawal of Counsel of his obligations concerning the proceedings.

4. Claimant had twenty days to respond to the Respondents' motion for summary judgment. The twentieth day was March 8, 2010. On March 16, 2010 the Office of Administrative Courts (OAC) received a letter from the Claimant, dated March 10, 2010. The letter is addressed to: "To Whom it Concerns or ALJ." The letter is not entitled a response to the motion for summary judgment but does address the issues. Although it is not timely filed the ALJ will consider this a response to the motion.

5. After fully reviewing the Respondents' motion, and the Claimant's response thereto, the undersigned ALJ GRANTS the Respondents' motion as follows:

6. Claimant's Application for Hearing is hereby stricken.

7. Respondents' request for attorney fees in the amount of $2,025.00 is reasonable and is granted. Claimant shall pay the Respondents' attorney within 30-days of the date of this order.

8. The hearing scheduled for March 23, 2010 is hereby vacated.

Ex-Parte **Communication from Claimant**

1. On March 8, 2010 the OAC received a letter from the Claimant, dated March 2, 2010, indicating that he no longer lives in Colorado and stating that he would appear by phone for the hearing scheduled for March 23, 2010. This letter bears no indication that it was sent to the opposing attorney.

2. On March 16, 2010, as detailed above, the OAC received a letter from the Claimant dated March 10, 2010. This letter, considered a response by the ALJ, bears no indication that it was sent to the opposing attorney.

3. A copy of each of these letters will be provided to Respondents' attorney with this order.

4. Claimant is HEREBY ORDERED to cease from providing the OAC with substantive documentation concerning his case, unless Claimant conforms to the Office of Administrative Courts' Rules of Procedure (OACRP), specifically OACRP Rule 3, *Ex-Parte* Communications, and OACRP Rule 6, Service of Documents.

5. These rules are available on the internet through the OAC website.

6. This interim order, with respect to the Respondents' Motion for Summary Judgment Regarding Unripe Issues and Statute of Limitations, as well as the order concerning attorney fees, will be issued as a full order within 10 days. At that time Claimant's appeal rights will be stated in full. Claimant's time limits for appealing will not begin until the issuance of the full order.

DATE: March 22, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-747-324

ISSUE

1. Whether Respondents have produced clear and convincing evidence to overcome Dr. Hughes' Division Independent Medical Examination (DIME) opinion that Claimant suffered a 19% whole person impairment.

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

STIPULATION

The parties agreed that Claimant is entitled to receive medical maintenance benefits that are reasonably necessary to relieve the effects of his industrial injury or prevent further deterioration of his condition.

FINDINGS OF FACT

1. On October 25, 2007 Claimant suffered an industrial injury to his lower back during the course and scope of his employment with Employer.

2. On November 18, 2008 Claimant underwent a lower back disc replacement

procedure.

3. Employer referred Claimant to ATP Dr. Ladwig for medical treatment. On April 23, 2009 Dr. Ladwig determined that Claimant had reached Maximum Medical Improvement (MMI). He assigned Claimant an 11% whole person impairment rating. The rating consisted of 10% for a specific disorder based on the disc replacement procedure and 1% for range of motion deficits. Dr. Ladwig did not conduct range of motion testing but occupational therapist Donna Leonard measured Claimant's range of motion deficits. Dr. Ladwig also recommended medical maintenance treatment in the form of a surgical visit within six months.

4. On June 11, 2009 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Ladwig's MMI and impairment determinations. Respondents also acknowledged that Claimant was entitled to receive medical maintenance benefits that were reasonable, necessary and related to his compensable lower back injury.

5. On June 24, 2009 Claimant underwent an independent medical examination with Edwin M. Healey, M.D. Dr. Healey agreed that Claimant had reached MMI for his lumbar spine and assigned a 15% whole person impairment rating. The rating consisted of 10% for a specific disorder of the lumbosacral spine and 6% for range of motion deficits. Dr. Healey's 6% whole person impairment rating for range of motion deficits consisted of the following: (1) 4% for lumbar extension; (2) 1% for lumbar right lateral flexion; and (3) 1% for left lateral flexion. He also assigned Claimant a 1% mental impairment. Dr. Healey concluded that Claimant had not reached MMI for the mental disorder and required chronic pain treatment.

6. In reaching his conclusion Dr. Healey determined that Dr. Ladwig relied on lumbar range of motion testing performed by an occupational therapist. He remarked that the occupational therapist noted Claimant suffered only a 1% impairment of the lumbar spine. Dr. Healey explained:

> My review of the lumbo sacral range of motion testing performed by the therapist indicates that [Claimant] had 15º of lumbar extension and was provided only a 0º impairment for this. Therefore, the lumbar range of motion impairment is not valid per AMA Guides and per the teachings of the Level II accreditation course.

7. Claimant challenged the FAL and sought a DIME. On September 25, 2009 Claimant underwent a DIME with John S. Hughes, M.D. Dr. Hughes agreed that Claimant reached MMI on April 23, 2009. He assigned Claimant a 19% whole person impairment rating. The rating consisted of 10% for a specific disorder of the lumbar spine, 9% for lumbar range of motion deficits and 1% for neurological loss. Dr. Hughes agreed with Dr. Healey that Claimant required chronic pain treatment.

8. Regarding range of motion testing, Dr. Hughes obtained the following results: (1) a maximum true lumbar flexion angle of 40º; (2) a maximum true lumbar extension angle of 11º; (3) a maximum right straight leg raise of 73º; and (4) a maximum left straight leg raise of 41º. He determined that Claimant's 9% impairment for lumbar range of motion deficits

consisted of 4% for lumbar flexion and 5% for lumbar extension. In completing the "Straight-Leg Raise (SLR) Validity Test for Lumbar Flexion," Dr. Hughes noted that the results were valid.

9. In summarizing Claimant's range of motion deficits, Dr. Hughes explained:

> Reduced ranges of motion exist and contribute additional impairment. It appeared that Dr. Ladwig did not have the source documentation from the physical therapy center that did range of motion testing in Dr. Healey's case. Findings are more along the lines of those noted by Dr. Healey. Restriction really only exists in flexion and extension of the lumbar spine and lateral flexion is completely preserved.

10. Dr. Ladwig testified through an evidentiary deposition in this matter. He agreed with Dr. Hughes that Claimant suffered a 10% whole person impairment for a specific disorder of the lumbar spine and deferred to Dr. Hughes' range of motion findings. Dr. Ladwig also agreed that Claimant suffered a 1% whole person impairment for neurological deficits and required a chronic pain management program.

11. Claimant underwent a disfigurement evaluation at the hearing in this matter. As a result of his compensable injury, Claimant has a five-inch long horizontal, surgical scar on his abdomen. The scar is just above the belt line. The disfigurement is serious, permanent, and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $1,000.00.

12. Respondents have failed to produce clear and convincing evidence to overcome Dr. Hughes' DIME determination that Claimant suffered a 19% whole person impairment. Doctors Ladwig, Healey and Hughes agreed that Claimant suffered a 10% impairment for a specific disorder of the lumbar spine and a 1% neurological impairment. Respondents specifically challenge the validity of Dr. Hughes' range of motion findings. Dr. Hughes determined that Claimant's 9% impairment for lumbar range of motion deficits consisted of 4% for lumbar flexion and 5% for lumbar extension. In completing the "Straight-Leg Raise (SLR) Validity Test for Lumbar Flexion," Dr. Hughes noted that the results were valid. In summarizing Claimant's range of motion deficits, Dr. Hughes remarked that Dr. Ladwig did not have the source documentation from Claimant's range of motion testing and his findings were consistent with the determinations of Dr. Healey. During his evidentiary deposition, Dr. Ladwig deferred to Dr. Hughes' range of motion findings. Based on a review of AMA Guides §3.3e Dr. Hughes properly applied the AMA Guides in ascertaining Claimant's lumbar range of motion deficits. Therefore, Respondents have failed to produce unmistakable evidence that Dr. Hughes' range of motion impairment determination was incorrect.

CONCLUSIONS OF LAW

1. 1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A

claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. In ascertaining the DIME physician's opinion, the ALJ should consider all of the DIME physician's written and oral testimony. *Lambert & Sons, Inc. v. Industrial Claim Appeals Office,* 984 P.2d 656, 659 (Colo. App. 1998). A DIME physician's determination regarding MMI and permanent impairment consists of his initial report and any subsequent opinions. *In Re Dazzio,* W.C. No. 4-660-149 (ICAP, June 30, 2008); *see Andrade v. Industrial Claim Appeals Office,* 121 P.3d 328 (Colo. App. 2005).

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. A DIME physician is required to rate a claimant's impairment in accordance with the AMA Guides. §8-42-107(8)(c), C.R.S.; *Wilson v. Industrial Claim Appeals Office,* 81 P.3d 1117, 1118 (Colo. App. 2003). However, deviations from the AMA Guides do not mandate that the DIME physician's impairment rating was incorrect. *In Re Gurrola,* W.C. No. 4-631-447

(ICAP, Nov. 13, 2006). Instead, the ALJ may consider a technical deviation from the AMA Guides in determining the weight to be accorded the DIME physician's findings. *Id.* Whether the DIME physician properly applied the AMA Guides to determine an impairment rating is generally a question of fact for the ALJ. *In Re Goffinett,* W.C. No. 4-677-750 (ICAP, Apr. 16, 2008).

7. The AMA Guides detail the method for obtaining range of motion measurements. Under §3.3e, Impairments Due to Range of Motion Abnormalities-Lumbo Sacral Region, the AMA Guides require "a comparison of hip flexion to straight leg raising on the tightest side … [to obtain] validation measure independent of reproducibility." Further, the test for validity should be reproduced if criteria are not met when the tightest straight leg raise, minus the hip flexion, plus hip extension is less than or equal to 10º. The range of motion testing should be repeated three times and, if measurements are not within validity criteria, three additional measurements must be obtained.

8. As found, Respondents have failed to produce clear and convincing evidence to overcome Dr. Hughes' DIME determination that Claimant suffered a 19% whole person impairment. Doctors Ladwig, Healey and Hughes agreed that Claimant suffered a 10% impairment for a specific disorder of the lumbar spine and a 1% neurological impairment. Respondents specifically challenge the validity of Dr. Hughes' range of motion findings. Dr. Hughes determined that Claimant's 9% impairment for lumbar range of motion deficits consisted of 4% for lumbar flexion and 5% for lumbar extension. In completing the "Straight-Leg Raise (SLR) Validity Test for Lumbar Flexion," Dr. Hughes noted that the results were valid. In summarizing Claimant's range of motion deficits, Dr. Hughes remarked that Dr. Ladwig did not have the source documentation from Claimant's range of motion testing and his findings were consistent with the determinations of Dr. Healey. During his evidentiary deposition, Dr. Ladwig deferred to Dr. Hughes' range of motion findings. Based on a review of AMA Guides §3.3e Dr. Hughes properly applied the AMA Guides in ascertaining Claimant's lumbar range of motion deficits. Therefore, Respondents have failed to produce unmistakable evidence that Dr. Hughes' range of motion impairment determination was incorrect.

Disfigurement

9. Section 8-42-108, C.R.S. provides that a claimant may obtain additional compensation if he is seriously disfigured as the result of an industrial injury. As found, Claimant underwent a disfigurement evaluation at the hearing in this matter. As a result of his compensable injury, Claimant has a five-inch long horizontal, surgical scar on his abdomen. The scar is just above the belt line. The disfigurement is serious, permanent, and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $1,000.00.

ORDER

1. Respondents have failed to produce clear and convincing evidence to overcome Dr. Hughes' DIME opinion that Claimant suffered a 19% whole person impairment.

2. Claimant shall receive medical maintenance benefits that are reasonably necessary to relieve the effects of his industrial injury or prevent further deterioration of his condition.

3. Claimant shall receive a disfigurement award in the amount of $1,000.

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

DATED: March 22, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-798-833

ISSUES

1 Did the claimant prove by a preponderance of the evidence that he sustained a compensable injury proximately caused by the performance of service arising out of and in the course of his employment?

2 Did the claimant prove by a preponderance of the evidence that the emergency medical treatment he received on July 25, 2009, was reasonable, necessary and authorized?

3 Did the claimant prove by a preponderance of the evidence that the medical treatment he received from the Monfort Family Clinic and its referrals was reasonable, necessary and authorized?

FINDINGS OF FACT

- The claimant credibly testified that while performing his duties on July 14, 2009, a piece of meat fell and struck him on the right shoulder. This piece of meat weighted approximately 25 pounds. The incident caused the claimant to experience pain and he was taken to Greeley Medical Clinic (GMC) for treatment.

- At GMC the claimant underwent x-rays and was examined by Dr. James Major, M.D. Dr. Gary Peet, M.D., read the x-rays, stating they were "negative for fracture or dislocation." However, Dr. Major noted a visible "small defect" over the AC joint. Dr. Major further stated that, "plain radiographs of the shoulder show a Grade II AC separation." Dr.

Major diagnosed a “shoulder separation, possibly dislocation, which was self-reduced.” Dr. Major prescribed medication, restricted the claimant to no use of the right arm, and gave the claimant a sling.

- On July 21, 2001, Dr. Thomas Lynch, M.D., examined the claimant at GMC. Dr. Lynch noted a “slight prominence on the acromioclavicular joint which is somewhat tender.” Dr. Lynch diagnosed a “shoulder contusion and strain, apparently associated with an a.c. separation.” Dr. Lynch imposed restrictions of no use of the right upper extremity, no lifting over 10 pounds and to wear the sling at work. Dr. Lynch referred the claimant for an orthopedic evaluation and indicated a willingness to arrange advanced imaging studies if indicated. Dr. Lynch also indicated he would refer the claimant for physical therapy (PT) if needed.

- On July 25, 2009, the claimant underwent additional x-rays of the shoulder. Again these were read as demonstrating no fracture or subluxation of the AC joint space.

- On July 25, 2009, the claimant was taken to the North Colorado Medical Center (NCMC) emergency room complaining of shoulder pain. This occurred very early in the morning. The claimant credibly testified that he went to NCMC because the regular provider was closed at this hour. The claimant was given Demerol for his pain and released.

- On July 27, 2007, Dr. Lynch signed a note stating that GMC had been notified “per adjuster” that the claim was being denied as “non-work-related” and “no referrals authorized.”

- On July 30, 2009, the respondents issued a notice of contest indicating their position that the claimant’s shoulder complaints are not related to his employment. The claimant credibly testified that he returned to GMC for treatment, but was told that the insurer had denied coverage and that GMC would not provide further treatment. The ALJ infers from this information that the GMC was refusing to provide treatment for non-medical reasons (lack of insurance coverage) and that the insurer was fully aware of this fact since it had been in contact with GMC and advised that it would not cover the injury and would not authorize further referrals.

- On August 12, 2009, the claimant sought treatment from the NCMC for gastric pain. The ER notes contain the statement that inspection of the “upper extremity” was normal and there was “normal range of motion.”

- On August 25, 2009, the claimant sought treatment at the Monfort Family Clinic (MFC) stating that he was still having shoulder pain associated with the alleged industrial injury. PA-C Brian Stromer examined the claimant and assessed an AC joint separation with suspected “frozen/stiff shoulder following poor rehab for grade II AC joint separation.” PA Stromer stated the claimant “should have only worn sling for 1 week then began rehab exercises.” PA Stromer prescribed ibuprofen and referred the claimant for PT.

- On referral from PA Stromer, North Colorado Sportsmedicine performed PT on the claimant's shoulder from September 1, 2009, through October 1, 2009. On September 1, 2009, DPT Starkovich noted the claimant "continued to wear sling for 6 weeks until seeing a physician at Sunrise who ordered him to not wear sling and sent him for this evaluation." DPT Starkovich noted that the claimant's diagnosis was a right AC joint separation with the "complicating factor" of "not having earlier physical therapy intervention." Over the course of PT the claimant's symptoms of shoulder pain and reduced range of motion (ROM) significantly improved. However, on October 1, 2009, DPT Starkovich noted the claimant was still reporting symptoms of soreness and fatigue with exercise.

- On December 21, 2009, Dr. Neil Pitzer, M.D., performed an IME at the respondents' request. Dr. Pitzer examined the claimant and reviewed the pertinent medical records. Dr. Pitzer offered his opinions in a written report and by deposition. Dr. Pitzer opined the claimant sustained a contusion when the meat fell on his shoulder, but that he did not sustain an AC joint separation as originally diagnosed by Dr. Major. In support of this opinion Dr. Pitzer relied on the July 2009 x-ray results which he considers to be "more definitive" than a physical examination. Dr. Pitzer further opined that the claimant's contusion had probably resolved by August 12, 2009, when he was seen in the NCMC emergency room and his upper extremity examination was reported as normal. Dr. Pitzer also cited the absence of point tenderness over the AC joint and subacromial space as evidence that the claimant had probably sustained a minor contusion, but not an AC joint separation.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102 (1), C.R.S. 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. X-ray*, 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).

COMPENSABLITY OF CLAIM

The claimant alleges that he sustained a compensable injury when the meat fell on his shoulder. The ALJ agrees that the claimant proved that he sustained a compensable shoulder injury.

The claimant was required to prove by a preponderance of the evidence that at the time of the injury he was performing service arising out of and in the course of the employment, and that the injury or occupational disease was proximately caused by the performance of such service. Section 8-41-301(1)(b) & (c), C.R.S. The Act creates a distinction between an "accident" and an "injury." The term "accident" refers to an "unexpected, unusual, or undersigned occurrence." Section 8-40-201(1), C.R.S. In contrast, an "injury" contemplates the physical or emotional trauma caused by an "accident." An "accident" is the cause and an "injury" is the result. No benefits flow to the victim of an industrial accident unless the accident causes a compensable "injury." A compensable injury is one that causes disability or the need for medical treatment. *City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967). *Soto-Carrion v. C & T Plumbing, Inc.,* W.C. No. 4-650-711 (ICAO February 15, 2007).

The ALJ concludes the claimant proved it is more probably true than not that he sustained an injury arising out of and in the course of his employment when a piece of meat fell on and struck the shoulder. As found, the claimant credibly testified that a piece of meat fell on the shoulder while he was performing his duties for the employer. The evidence establishes this piece of meat weighed approximately 25 pounds. The claimant immediately sought treatment for the injury and was noted to have a "defect" on his shoulder.

The claimant also proved it is more probably true than not that the injury caused a compensable AC joint separation injury that necessitated ongoing medical treatment. In this regard, the ALJ credits the report of Dr. Major, the initial treating physician. Dr. Major observed the claimant's shoulder on the day of the injury and noted a "small defect" over the AC joint. Moreover, the ALJ infers from Dr. Major's report that he personally reviewed the July 14, 2009, "plain radiograph" x-rays and, in his opinion, they evidenced a Grade II AC tear. While the ALJ recognizes that Dr. Major disagreed with Dr. Peet's interpretation of the July 14 films, Dr. Major enjoyed the advantage of performing an actual physical examination that resulted in observation of the defect. Dr. Major also explained that he believed the separation or dislocation was "self reduced." Moreover, the ALJ finds that Dr. Major's opinion is corroborated by Dr. Lynch's observation that on July 21 the claimant demonstrated a slight prominence over the AC joint that was "tender." Therefore, the ALJ finds that Dr. Major's opinion that the claimant sustained an AC separation is entitled to the most weight. Evidence and inferences inconsistent with this conclusion are not credible and persuasive.

For many of the same reasons, the ALJ is not persuaded by Dr. Pitzer's opinion that the claimant sustained only a "contusion." Dr. Pitzer apparently did not see the actual x-ray film

from July 14, but relied on the radiologist's report. Neither did Dr. Pitzer examine the claimant at or near the time of the injury. With respect to the August 12, 2009, examination at NCMC, Dr. Pitzer admitted that because the primary purpose of the claimant's visit to the ER was to treat epigastric pain the examination of his upper extremities was "probably very cursory." Dr. Pitzer also admitted that on September 1, 2009, DPT Starkovich probably spent more time examining the claimant's shoulder than the ER personnel did on August 12.

ENTITLEMENT TO MEDICAL BENEFITS

The claimant seeks compensation for the medical expenses incurred at the NCMC emergency room on July 25, 2009, and the treatment provided by MFC and its referrals. The ALJ concludes that these medical expenses are compensable.

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).

Section 8-43-404(5)(a) contemplates that the respondents will designate a physician who is willing to provide treatment without regard to non-medical issues such as the prospects for payment in the event the claim is ultimately denied. *Lutz v. Industrial Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000); *Ruybal v. University of Colorado Health Sciences Center,* 768 P.2d 1259 (Colo. App. 1988). If the designated physician refuses to treat for non-medical reasons the respondents have the immediate obligation to appoint a new physician upon knowledge of the refusal to treat. If the respondents fail to do so the right of selection passes to the claimant. *See Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565 (Colo. App. 1987); *Manning-Manson v. Wal-Mart Stores, Inc.*, WC 4-548-531 (ICAO February 12, 2004).

Medical treatment that a claimant receives prior to the time the employer is provided with sufficient knowledge of a potential claim for compensation is not authorized; therefore, such treatment is not compensable. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006). Of course, the claimant may obtain "authorized treatment" without giving notice and obtaining a referral from the employer if the treatment is necessitated by a bona fide emergency. Once the emergency is over the employer retains the right to designate the first "non-emergency" physician. *Sims v. Industrial Claim Appeals Office,* 797 P.2d 777 (Colo. App.

1990).

The ALJ concludes the claimant proved it is more probably true than not that the medical treatment provided by the MFC and its referrals (including the PT provided by North Colorado Sportsmedicine and DPT Starkovich) was reasonable and necessary to treat the ongoing effects of the AC joint separation caused by the July 14, 2009, industrial injury. The ALJ credits the medical reports of PA Stromer and DPT Starkovich concerning the necessity for the treatments. These reports are corroborated by the report of Dr. Lynch who was considering the use of PT shortly after the occurrence of the industrial injury.

For the reasons stated above, the ALJ also finds that the need for the treatment provided by MFC and its referrals was proximately caused by the industrial injury and consequent AC joint separation.

The ALJ further concludes the claimant proved it is more probably true than not that MFC was authorized to treat the industrial injury because the right of selection passed to the claimant. As determined in Finding of Fact 6, the insurance adjuster notified GMC that the claim was being denied as non-work related and that “no referrals” were authorized. Consistent with this evidence, the ALJ credits the claimant’s testimony that when he returned to GMC he was denied treatment because insurer had denied the claim. As found, the ALJ infers that GMC denied treatment for the non-medical reason that GMC was concerned it would not be paid for its services. Further, the ALJ infers from the fact that the adjuster was in contact with GMC regarding the denial of coverage that the insurer was fully aware that its actions would result in GMC denying additional treatment, and yet the insurer did not appoint a new treating physician willing to provide treatment without regard to the contest. Consequently, the right of selection passed to the claimant and he chose MFC as the authorized provider for the injury. *Cf. Garrett v. McNelly Construction Co., Inc.,* WC 4-734-158 (ICAO September 3, 2008). Referrals by MFC were made in the ordinary course of medical treatment and are also authorized. *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).

The ALJ further finds that the claimant’s visit to the ER at NCMC on July 25, 2009, was authorized because it constituted a bona fide emergency, and the authorized providers were not available at the time the claimant needed the treatment. *See Sims v. Industrial Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). Further, the claimant proved that the need for this treatment was causally related to the effects of the industrial injury of July 14, 2009, and was reasonable and necessary.

ORDER

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

1. The claimant sustained a compensable industrial injury arising out of and in the course of his employment with the employer.

2. The respondents shall pay reasonable and necessary medical expenses including the cost of the treatment provided at the NCMC emergency room on July 25, 2009, and the medical treatment provided by the MFC and its referrals.

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

DATED: March 22, 2010

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-804-021

ISSUES

The issues for determination are compensability, medical benefits, and temporary total disability benefits commencing August 28, 2009. The parties stipulated to an average weekly wage of $1,304.66, and that, if temporary disability benefits are awarded, Respondents would be entitled to an offset for long term disability benefits paid by Employer

FINDINGS OF FACT

1. Claimant had undergone knee surgery in January 2009. Claimant had an episode of back pain in May and June 2009. The pain did not radiate. Claimant was treated with Vicodin, muscle relaxants, and physical therapy.

2. Claimant testified that on August 27, 2009, he felt a 'pop' in his back when he was moving a 200-pound water heater with a co-worker. Claimant was performing the duties of his employment at the time. Claimant continued to work and finished his work that day.

3. The next day, August 28, 2009, was the first day of vacation for Claimant. Claimant awoke with stabbing pain in his back that radiated down to his foot. Claimant sought care from his personal physician, Travis Crawford, M.D.

4. Dr. Crawford examined Claimant on August 28, 2009. Claimant complained of low back pain with radiation down into the left leg. Dr. Crawford noted that Claimant was seen back in June and that his condition had worsened. He noted that "work is becoming very difficult for [Claimant] and he had to call in sick today." Dr. Crawford prescribed medications and referred Claimant for an MRI of the lumbar spine. Dr. Crawford took Claimant off work in a letter dated September 1, 2009.

5. Claimant did not report a work-related injury to Employer until September 2, 2009, when he spoke to Phillips. He told Phillips that he had hurt his back moving a water heater and that he was seeing Dr. Crawford. Phillips did not refer Claimant to another medical care provider. Phillips spoke to Cardin on September 2, 2009, and advised him that Claimant had alleged an injury. Cardin tried to contact Claimant, but was initially unsuccessful.

6. Claimant underwent an MRI on September 9, 2009.

7. Cardin did contact Claimant on September 9, 2009, and directed Claimant to Boulder Community Hospital for evaluation and treatment.

8. Warren Roberts, M.D. examined Claimant on September 11, 2009. Dr. Roberts reviewed the MRI with Claimant and stated that Claimant was a candidate for surgery.

9. Claimant was examined by Boulder Community Hospital on September 14, 2009, by Kevin Page, PA – C. Claimant gave the physician's assistant a history of an injury on August 27, 2009, on the job moving a water heater. Claimant denied any prior back pathology. Page's impression was "low back pain, presumed herniation." He referred Claimant to Dr. Samuel -M- in Longmont and directed Claimant to follow-up in 7-10 days. Claimant followed-up on September 21, 2009. He noted that Claimant would be seeing Dr. -M-.

10. Claimant was examined by Samuel E. -M-, M.D., on September 25, 2009. Dr. -M-'s impression was degenerative disc disease at L5/L5, Lumbar herniated disc at L5/L5, and left sciatica. Dr. -M- stated that Claimant was a candidate for surgery.

11. Dr. Crawford saw Claimant on November 13, 2009, for a pre-surgical evaluation. Dr. Roberts saw Claimant on November 24, 2009. Dr. Roberts again stated that Claimant was a candidate for surgery and that the surgery would be scheduled.

12. Claimant underwent surgery on December 1, 2009. Dr. Roberts performed the surgery.

13. Dr. Crawford examined Claimant on February 8, 2010. He noted that Claimant was not able to return to work because of persistent back issues.

CONCLUSIONS OF LAW

The testimony of Claimant is credible and persuasive. Claimant has established by a preponderance of the evidence that he had an accident on August 27, 2009, in the course and scope of his employment. The accident caused a disk herniation or aggravated Claimant's pre-existing condition. The claim is compensable.

Claimant was disabled on and after August 28, 2009. Insurer is liable for temporary disability benefits less offsets commencing August 28, 2009, and continuing until terminated pursuant to law. Sections 8-42-105(1), 8-42-103(1)(d), and 8-43-105(3), C.R.S.

Employer has the right in the first instance to name the authorized medical care provider. Section 8-43-404(5)(a), C.R.S. Claimant did not report his injury to Employer until September 2, 2009. The treatment he received was not emergency treatment. Insurer is not liable for the medical care Claimant received before September 2, 2009.

Employer did not refer Claimant to a particular medical care provider when first advised of the possible compensable injury on September 2, 2009. Claimant was free to select his own provider. Section 8-43-404(5)(a)(I)(A), C.R.S.; *Rogers v. ICAO,* 746 P.2d 565 (Colo.App. 1987). After September 2, 2009, the MRI on September 11, 2009, was the first care Claimant received for this injury. He received that MRI on referral from Dr. Crawford. Dr. Crawford is an authorized medical care provider. Dr. Crawford referred Claimant to Dr. Roberts who is also authorized.

Section 8-43-404(5)(a)(I)(A), C.R.S., provides a detailed procedure for requesting a change of physician after the initial designated physician has been selected. These procedures apply even if the employer waived its right to select the initial treating physician. *Picket v. Colorado State Hospital*, 32 Colo.App 282, 513 P.2d 228 (1973). After Dr. Crawford was authorized, Employer referred Claimant to Boulder Community Hospital where he was examined by Dr. -M-. However, there is no showing that the proper procedure for a change of physician was followed. Therefore, Dr. -M- is not authorized, and Dr. Crawford remains the authorized treating physician. Dr. Crawford referred Claimant to Dr. Roberts who is also authorized

Insurer is liable for the medical care Claimant receives from Dr. Crawford and Dr. Roberts that is reasonably needed to cure and relieve Claimant from the effects of the compensable injury. Section 8-42-101(1), C.R.S. Liability is limited to those amounts established by the Division of Workers' Compensation fee schedule.

ORDER

It is therefore ordered that:

1. The claim is compensable.

2. Insurer shall pay Claimant temporary total disability benefits commencing August 29, 2009, and continuing until terminated pursuant to law. Insurer may take an offset for long term disability benefits paid by Employer. Insurer shall pay interest at the rate of eight percent per annum on any benefits not paid when due.

3. Insurer is liable for the MRI on September 11, 2009, and for the medical care Claimant received after September 2, 2009, from Dr. Crawford and Dr. Roberts.

4. Issues not determined by this order are reserved.

DATED: *March 22, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-729-510

ISSUES

The sole issue determined herein is claimant's petition to reopen based upon a change of condition.

FINDINGS OF FACT

1. Claimant is a 51-year-old male who worked as a heavy equipment operator for the employer. His job duties included using and maintaining loaders, bulldozers, and crushers and working at the landfill.

2. On June 5, 2007, claimant suffered an admitted injury to his back.

3. Claimant primarily treated with Dr. Barry Ogin and Dr. Richard Lazar. Conservative care, including physical therapy, did not improve Claimant's condition.

4. A magnetic resonance image ("MRI") in July 2007 reflected multi-level degenerative changes most significantly at L4-5 and L5-S1. Injections did not provide any extended relief. A February 5, 2008, electromyography/nerve conduction study ("EMG") showed a right L5 radiculopathy.

5. On March 3, 2008, Dr. Lazar performed surgery, a right L4-5 hemilaminectomy and microdiscectomy.

6. A repeat MRI on May 28, 2008, and was read to reflect postsurgical changes at L4-5, central and lateral recess stenosis L2 through L5 with a residual or recurrent disk protrusion at L4-5, but the appearance was more suggestive of epidural scar formation, probable postsurgical seroma in the surgical defect at the L4-5 level.

7. On June 10, 2008, Dr. Lazar recommended another series of epidural steroid injections ("ESI") and, if they failed, consideration of a spinal cord stimulator. The July 11, 2008, ESI provided limited improvement for claimant.

8. On September 16, 2008, Dr. Ogin placed claimant at maximum medical improvement ("MMI") and rated Claimant with 21% whole person impairment. At that time, Claimant presented with continued back pain and intermittent referral down his leg. Activities such as

prolonged sitting and standing exacerbated his pain. If Claimant mowed the lawn, he needed to stop every 5 - 10 minutes until the pain improved. He was prescribed Lyrica 100 mg b.i.d. Dr. Ogin recommended medical maintenance care including medication (Lyrica), two to three ESIs per year, and three to four physician visits per year to address flare-ups in pain. In his narrative, Dr. Ogin recommended physical restrictions, including no lifting more than 40 lbs occasionally and additional restrictions of repetitive lifting of 25 pounds, push/pull of 40 pounds, one hour of squatting or climbing per day, and no frequent bending or twisting.

9. Dr. Lazar agreed with the physical restrictions. On September 16, 2008, he recommended no lifting over 40 pound, and no repetitive pushing, pulling, or lifting.

10. On October 17, 2008, respondents filed a Final Admission of Liability for permanent partial disability benefits and post-MMI medical benefits, consistent with Dr. Ogin's report.

11. Claimant did not object to the Final Admission of Liability and the case closed by operation of law.

12. On January 13, 2009, claimant returned to Dr. Ogin, complaining of severe low back and right leg pain. Dr. Ogin prescribed an ESI, which offered only slight relief. On February 17, 2009, Dr. Ogin noted that claimant had nerve scarring on the MRI post-surgery.

13. On March 17, 2009, Dr. Ogin reexamined claimant, who reported increasing pain for a "few weeks." Dr. Ogin limited Claimant to 40 pounds occasional lifting a couple of times per hour, 20 pounds lifting one third of the time during an eight hour shift, rarely stooping, squatting, or kneeling, and no crawling. He recommended Claimant position change for more than 30 minutes of sustained sitting, standing, or walking.

14. Dr. Ogin referred Claimant for a follow up MRI on April 16, 2009, which showed no change when compared to previous examinations.

15. Dr. Lazar re-evaluated Claimant April 20, 2009, who complained of increasing right leg pain. He did not recommend surgery. Instead, he repeated his pre-MMI recommendation for a spinal cord stimulator trial.

16. On April 21, 2009, Dr. Ogin evaluated Claimant and reported no change when compared to previous examinations. There was no evidence that his condition worsened structurally, although there was some subjective worsening since MMI.

17. On May 5, 2009, Dr. Ogin reexamined claimant and recommended a trial spinal stimulator by Dr. Lippert. On June 9, 2009, Dr. Lippert examined claimant and recommended a psychological evaluation before the spinal stimulator trial.

18. On July 21, 2009, Claimant returned to Dr. Ogin for a medical maintenance visit and

reported that was improving. Claimant had recently undergone a partial thyroidectomy, following which Claimant felt better. Claimant reported he was doing well as long as he took his medication and did not overdo it. He reported no significant leg pain and that he was exercising. Claimant was not interested in the spinal cord stimulator. Dr. Ogin reported that Claimant remained at MMI. He recommended ongoing medical care and an independent exercise program.

19. On July 23, 2009, Dr. Jack Rook performed an independent medical examination ("IME") for claimant. Dr. Rook examined claimant only two days after Claimant told Dr. Ogin that he was feeling much better. Dr. Rook reported that Claimant presented with increased back and leg pain since MMI. Dr. Rook recommended repeat electrodiagnostic studies to determine if Claimant's pain was due to acute lumbar radiculopathy, a lumbar discography, and consideration of additional surgery. Dr. Rook recommended reopening based on a worsening of condition.

20. On July 31, 2009, claimant filed his petition to reopen based upon a change of condition, attaching the report of Dr. Rook.

21. On September 25, 2009, Dr. Ogin reviewed Dr. Rook's report. Dr. Ogin confirmed that, on July 21, 2009, Claimant was doing better. Dr. Ogin noted that claimant still had some back pain managed with activity modification and medications, but was in much less distress than previously. Dr. Ogin noted that Dr. Rook reported that Claimant continued with significant low back and right leg pain. Dr. Ogin did not disagree with that assessment, but claimant's pain waxed and waned frequently due to activity levels. Dr. Ogin noted that claimant's symptoms are relatively controlled with activity modifications. Dr. Ogin was unaware of any notable change in Claimant's underlying condition. Claimant's right foot pain was present long term. Claimant's postoperative MRI was stable. Dr. Ogin disagreed that claimant's condition had worsened. He concluded that Claimant remained at MMI. Dr. Ogin disagreed with Dr. Rook's recommendation for an EMG and discogram because the results would not change the treatment plan.

22. On December 17, 2009, Dr. Bisgard performed an IME for respondents. Claimant indicated that he was much worse when he saw Dr. Rook because he had to drive 2 ½ hours to see Dr. Rook and it is not uncommon for him to have a temporary increase in symptoms after a long drive. Upon questioning, Claimant told Dr. Bisgard that his condition was overall the same as when discharged at MMI as long as he takes his medications regularly and does not drive more than 30 minutes. He told Dr. Bisgard that his symptoms are the same as before surgery. At times he felt his symptoms were temporarily worse, but his overall pain levels have been the same since his time of discharge. Dr. Bisgard agreed with Dr. Ogin that Clamant reached MMI on September 18, 2008 and remained at MMI.

23. Dr. Rook testified at hearing. In his opinion, Claimant's condition worsened since MMI. He based that opinion on subjective reports of increased pain and intermittent referred pain down

Claimant's leg and mild radicular findings on examination. He admitted that the MRI studies post MMI were read as unchanged when compared with exams prior to MMI. He agreed that the more information a doctor has about a patient the better the analysis. He agreed that it is preferable to personally evaluate a patient than to rely on medical records. He only evaluated Claimant one time on July 23, 2009. On that day, Claimant arrived at Dr. Rook's office after driving several hours. Dr. Rook was aware that driving more than 30 minutes aggravated Claimant's condition; however, Dr. Rook did not ask Claimant if his condition was worse that day after Claimant drove several hours to the appointment. Dr. Rook agreed that Claimant's condition waxed and waned and that his presentation frequently seemed associated with his activity levels. Dr. Rook recommended physical restrictions at the sedentary level. I do not find Dr. Rook's testimony credible.

24. Vocational expert Katie Montoya was retained by Claimant and testified at hearing. Claimant's labor market includes Swink, La Junta, and Rocky Ford. Ms. Montoya testified that she does not consider Claimant employable.

25. Claimant testified at hearing. He has reliable transportation and a valid driver's license. He has no medical driving restrictions and he still drives, although driving aggravates his condition. Claimant's wife works and Claimant makes his own meals, helps out around the house, and makes regular trips to the bank and to the grocery store. In a normal day, Claimant wakes around 6:30 a.m. – 7:00 a.m., fixes coffee, lets the dog out, feeds the dog, makes and eats breakfast, watches TV, does the dishes, helps with laundry, makes and eats lunch, goes to the library or bank or grocery store, fixes and eats supper, watches TV, and goes to bed around 10:00 p.m.

26. Dr. Ogin testified by deposition that he anticipated ups and downs in Claimant's back and leg pain after MMI. There were times when Claimant felt pretty good and talked about getting back to work and getting off the medications. On other occasions, Claimant presented with increased pain and incapable of doing certain activities. Dr. Ogin noted that Claimant's condition flared with increased activity levels, including prolonged driving, and flared due to periodic ups and downs of his condition.

27. Dr. Ogin disagreed with Dr. Rook that Claimant's condition changed for the worse. Dr. Ogin saw Claimant July 21, 2009, at which time Claimant presented feeling better. Dr. Rook evaluated Claimant two days later after Claimant traveled hours by car to the appointment. Dr. Rook reported that Claimant complained of increased pain and discomfort. Dr. Ogin, however, found the change in Claimant's presentation consistent in that occasionally Claimant presented with severe pain and other times it was more tolerable. Dr. Ogin considered Dr. Rook's assessment two days after Dr. Ogin saw Claimant to be merely a random fluctuation and that Claimant's condition has not changed since MMI.

28. Dr Ogin testified that an MRI is more accurate than an x-ray when trying to determine whether or not there's been a change or a worsening of condition regarding pathology and the

post MMI MRI was essentially unchanged from the pre MMI MRI. Dr. Ogin was not aware of any objective evidence supporting a change in condition. In his opinion, changes in medication do not reflect a change or worsening of condition. There was some tinkering with medication up and down, but that was an attempt to maximize the benefit from the Lyrica in combination with potential side effects and does not reflect his condition getting better or worse. Also, the post MMI prescription of Vicodin does not mean Claimant's condition changed for the worse, but reflects another attempt to treat Claimant's severe, ongoing pain. Dr. Ogin testified that the scar tissue and the spine were stable and that Claimant was qualified to take an opioid before MMI. Dr. Ogin, in fact, gave Claimant some opioids, but at a later point Claimant did not want them.

29. Dr. Ogin recommended medical maintenance care because he anticipated periodic flare-ups. He noted that claimant's return for anticipated medical maintenance care does not mean that Claimant's condition changed for the worse. In his opinion, Claimant's pathology is unchanged and his overall status is stable, with expected subjective complaints going up and down. Dr. Ogin referred Claimant to Dr. Lazar because of Claimant's ongoing back and leg pain. A repeat MRI was requested and confirmed, "not surprisingly," that his condition was pretty stable, at least in regards to the pathology. Dr. Lazar repeated his pre MMI recommendation for a spinal cord stimulator. Dr. Ogin did not consider this due to a change in condition but rather continuation of Dr. Lazar's recommendation for a stimulator prior to MMI in 2008.

30. Dr. Ogin clarified that restrictions at the time of MMI and after MMI do not support that a change in condition occurred. Restrictions are slightly different only because he filled out paperwork as the patient left the office and he simply filled out the form without checking against prior restrictions. The fact that they differ slightly is not representative of a change or worsening of his condition.

31. Claimant has failed to prove by a preponderance of the evidence that he suffered a change of condition as a natural consequence of the admitted work injury since being determined at MMI on September 16, 2008. Dr. Ogin, the authorized treating physician, is most persuasive about the stable nature of claimant's condition. Claimant had low back and right leg pain at MMI and that condition has continued after MMI. Claimant, however, has periodic flare-ups of symptoms, especially when he sits or drives for long periods of time. Claimant's temporary flare-ups then improve. Dr. Rook's evaluation occurred after claimant drove for several hours. Dr. Rook found claimant to be worse, but this examination occurred only two days after Dr. Ogin had examined claimant near claimant's residence and claimant was improved. Claimant's condition reflects relative stability with waxing and waning symptoms, as expected by Dr. Ogin at MMI. Dr. Ogin's opinions are supported by the opinions of Dr. Bisgard. Dr. Ogin tinkered with medications and doses in an attempt to maximize the benefit from specific medicine, however, changes in medication do not necessarily reflect a change or worsening of condition. Dr. Ogin recommended medical maintenance care because he anticipated periodic flare-ups and the fact Claimant returned for that anticipated medical maintenance care does not

necessarily reflect a change or worsening of condition. The fact that restrictions differed slightly does not necessarily reflect a change or worsening of condition. The April 16, 2009 MRI did not reflect an objective change when compared to previous examinations.

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). Reopening is appropriate when the degree of permanent disability has changed, or when additional medical or temporary disability benefits are warranted. *Dorman v. B & W Construction Co.*, 765 P.2d 1033 (Colo. App. 1988). Claimant has the burden of proving these requirements, *see Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). 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 failed to prove by a preponderance of the evidence that he suffered a change of condition as a natural consequence of the admitted work injury

ORDER

It is therefore ordered that Claimant's petition to reopen based upon a change of condition is denied and dismissed.

DATED: March 23, 2010

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-649-073

ISSUES

The issues determined herein are maximum medical improvement ("MMI"), permanent partial disability ("PPD"), and post-MMI medical benefits. ICAO set aside the June 19, 2009, order because the Judge apparently erroneously referred to an excluded exhibit KK in determining claimant's credibility. ICAO remanded for a new order on the existing record without considering the excluded exhibit in the credibility determination.

FINDINGS OF FACT

1. Claimant has been employed as a math teacher for the employer for 15 years.

2. Claimant suffered an admitted industrial injury in this case when she sat on a cafeteria bench, which broke, causing claimant to fall to the floor.

3. On February 15, 1993, claimant suffered a previous injury to her low back and arm in a motor vehicle accident.

4. On October 22, 1997, claimant suffered a previous admitted work injury when a television fell, striking her on the head. A magnetic resonance image ("MRI") of her temporomandibular joints ("TMJ") showed degeneration. Claimant was treated for TMJ and headache problems as well as neck and closed head injuries. On February 28, 2000, the insurer in WC 4-397-846 filed a final admission of liability ("FAL") for PPD benefits based upon 27% whole person impairment and for post-MMI medical benefits.

5. On March 8, 2001, claimant suffered a previous admitted work injury when she fell, injuring her low back and left shoulder. A May 4, 2001, MRI of the lumbar spine showed a herniated disc at L5-S1 with severe nerve impingement. A July 21, 2001, MRI of the left shoulder showed a tear in the biceps tendon and in the supraspinatus. Dr. Ciccone injected the left shoulder. Dr. Sung performed surgery on July 31, 2001, to repair the L5-S1 herniated disc. Claimant settled W.C. No. 4-506-872 on August 12, 2002.

6. On December 16, 2003, claimant reported to her principal that she had suffered the accidental injury when the table broke. Claimant reported that her right leg was pinned under the bench and she injured her low back and mid back. Claimant and Mr. Reed prepared a written accident report, on which claimant marked a pain diagram. The original of that document was not produced at hearing, although two different photocopied versions were marked and one was admitted with foundational testimony. The employer prepared an employer's first report of injury that claimant injured her neck, mid back, lower back, and right calf. She was referred to Dr. Fortunato for treatment.

7. On December 16, 2003, Dr. Fortunato examined claimant, who reported a history of previous cephalgia, head injury, hearing loss, tinnitus, low back injury, and other problems. Claimant reported a history of the bench collapsing, striking her right calf, and injuring her back on the left side. Claimant did not report any left shoulder injury at that time. Contrary to claimant's testimony, she did not report a left shoulder injury, which Dr. Fortunato refused to examine or treat. Dr. Fortunato diagnosed right calf contusion and left lumbar injury.

8. By December 26, 2003, Dr. Fortunato noted that the right calf injury was resolved, although claimant continued to suffer low back pain.

9. A February 29, 2004, MRI showed an annular tear and disc bulge at L4-5 without nerve root compression. Dr. Fortunato referred claimant to Dr. Castro for chiropractic treatment.

10. On March 19, 2004, Dr. Castro examined claimant, who reported the history of the table collapsing, striking her calf. She did not report any left shoulder injury, although Dr. Castro was specifically treating the low back injury. He provided chiropractic treatment through July 7, 2004, with only some improvement.

11. On June 3, 2004, Dr. Richman examined claimant, who reported the history of the bench breaking, causing claimant to fall onto her buttocks with immediate onset of low back and buttock pain. Claimant did not report any left shoulder injury. She reported her previous low back injury, but did not report her previous left shoulder injury.

12. On June 23, 2004, Dr. Malis examined claimant, who reported the history of the bench collapsing, catching her leg under it. Claimant did not report any left shoulder injury. Dr. Malis did not refuse to examine or treat a left shoulder injury because the employer's first report of injury did not list the left shoulder injury.

13. On August 12, 2004, Dr. Richman reexamined claimant and suspected lumbar facet origins for claimant's continuing low back pain. He referred her to Dr. Baer for medial branch blocks. Dr. Baer administered two sets of the blocks, with good symptom response by claimant.

14. On February 1, 2005, Dr. Malis referred claimant to Dr. Sacha for consideration of a medial nerve ablation (radiofrequency rhizotomy). On February 25, 2005, Dr. Sacha examined claimant, who reported the history of the bench breaking, causing her to fall. She also reported the history of her two previous work injuries. Dr. Sacha recommended a rhizotomy at L4-5 and L5-S1, with a goal of 50% reduction of pain symptoms. Dr. Sacha did not inform claimant that she had only a 50% likelihood of success from the rhizotomy. Dr. Sacha indicated that he would want to reexamine claimant two weeks after the rhizotomy.

15. On March 31, 2005, Dr. Sacha reported that he performed the two-level rhizotomy. Claimant denies that the procedure occurred and denies that she took off work on that day. She produced a computer record printout of her leave use during the relevant time period, but the employer did not have a computerized leave system at the relevant time. Any leave used by claimant had to be manually input into the computer system in order for the computer record to show leave used in 2005.

16. On April 19, 2005, Dr. Hattem examined claimant, who reported that she had decided not to have the rhizotomy because she was not satisfied with the prospect of only 50% reduction in her pain symptoms. Claimant reported that she suffered pain of 8 or 9 on a 1 to 10 scale at that time. Dr. Hattem determined that claimant was at MMI. He determined 10% permanent impairment based upon 5% for specific disorders of the lumbar spine and 5% for range of motion loss. Dr. Hattem then considered the December 27, 2001, determination of 8% for specific disorders and 5% for range of motion due to the prior low back injury. He then determined that claimant had no permanent impairment from the current injury.

17. On May 4, 2005, the insurer filed a FAL, denying liability for PPD and post-MMI medical

benefits.

18. Claimant requested a Division Independent Medical Examination ("DIME"). The attorney for claimant struck the name of another physician, allowing Dr. Kenneth Finn to be selected as the DIME physician. On September 28, 2005, Dr. Finn performed the DIME. Claimant reported a history of the bench falling, causing injury to her low back, left shoulder, and bilateral wrists. Dr. Finn reviewed the medical records, which showed no report of any left shoulder injury after the December 16, 2003, injury. Dr. Finn also reviewed medical records of the left shoulder injury following the 2001 work injury. Dr Finn concluded that claimant did not suffer left shoulder and wrist injuries as a result of the admitted 2003 injury. Claimant reported that she did not have a rhizotomy. Dr. Finn reviewed the March 31, 2005, record by Dr. Sacha of the rhizotomy and concluded that claimant had received the rhizotomy. Dr. Finn agreed with Dr. Hattem that claimant was at MMI on April 19, 2005. Dr. Finn measured 5% impairment due to loss of lumbar range of motion. He also determined 7% impairment for specific disorders of the lumbar spine due to the L4-5 annular tear. Dr. Finn noted that claimant already suffered 13% impairment from the 2001 injury to the lumbar spine. He determined that claimant had no impairment from the 2003 work injury.

19. On October 10, 2005, the insurer filed a FAL. On October 26, 2005, the insurer filed an amended FAL to correct the amount of temporary disability benefits admitted. The insurer denied liability for any PPD benefits, but admitted for post-MMI medical benefits.

20. Claimant timely objected and applied for hearing. The April 5, 2006, hearing before Judge Walsh dealt only with respondents' argument that the claim was closed by FAL and with claimant's allegation that the DIME determination by Dr. Finn should be invalidated due to a conflict or appearance of a conflict on the part of Dr. Finn. Judge Walsh determined that the claim was closed by FAL. The Court of Appeals ultimately reversed and remanded for determination of the DIME conflict issue that had been tried at the April 5, 2006, hearing. On May 22, 2008, Judge Walsh issued his order denying claimant's request to strike the DIME report by Dr. Finn.

21. On January 8, 2009, Dr. Watson performed an IME for respondents. Claimant reported a history of falling on her low back and left arm, injuring her left shoulder, left arm, and low back. She also reported grinding her teeth due to pain from the injury. Dr. Watson agreed that claimant was at MMI on April 19, 2005. Dr. Watson agreed that claimant had no permanent impairment from the 2003 injury after the previous injury impairment rating was apportioned.

22. On February 12, 2009, Dr. Hall performed an IME for claimant. Dr. Hall had previously treated claimant in the aftermath of her 1997 head and neck injury. Claimant reported that in 2003, she fell on her low back and then on her upper back and shoulder area. Claimant also reported increased TMJ problems due to clenching of her teeth. Dr. Hall informed claimant that she had better than 50% probability of success from the rhizotomy. Dr. Hall concluded that claimant was not at MMI. He recommended that she proceed with the rhizotomy and with TMJ treatment. Dr. Hall also concluded that claimant had injured her left shoulder in the 2003

injury. He criticized Dr. Finn for diagnosing posterior element or sacroiliac ("SI") joint pain and then determining 7% impairment for specific disorders based upon the L4-5 annular tear.

23. Dr. Hall testified that he did not think that the L4-5 annular tear was of clinical significance. He agreed that facet dysfunction was the most likely diagnosis, although he also thought that SI joint dysfunction could be a secondary problem. He recommended SI injections if the rhizotomy did not succeed. Dr. Hall did not think that claimant's headaches or TMJ dysfunction was separately ratable.

24. No clear and convincing evidence demonstrates that the MMI and impairment determinations by the DIME are incorrect. Usually, the MMI and rating determinations involve some questions of medical judgment by the physicians. In this very strange case, claimant denies having the rhizotomy by Dr. Sacha, in spite of the medical record of the procedure. Certainly, mistakes can be made. "Chart lore" can develop in which mistakes get repeated from physician to physician. Patient charts can be confused. It is odd that the record evidence does not contain any reexamination by Dr. Sacha after performing the rhizotomy.

25. On the other hand, other strange conflicts in the record evidence exist. Claimant alleges that she told Dr. Fortunato and Dr. Malis about a left shoulder injury, but they told her they refused to treat such an injury because it was not in the employer's report. Their records contain not even a history of such complaints. Dr. Finn first recorded a history of a left shoulder injury from the 2003 accident. He then carefully determined that the left shoulder problem was not due to the latest accident.

26. The lack of medical history of a left shoulder injury report to Dr. Fortunato or Dr. Malis and the dispute regarding the occurrence of the rhizotomy lead the finder of fact to find that claimant's testimony is false and not reliable.

27. Claimant's attack on Dr. Finn for a conflict or an appearance of a conflict of interest misses the mark. Although claimant was precluded from relitigating the motion to strike the DIME report because Judge Walsh had already determined that issue, she was permitted to argue that a "conflict" helped to demonstrate that the DIME determinations were overcome. Claimant continued to argue that Dr. Finn had a duty to disclose an adversarial relationship with claimant's attorney. Nothing in the WCRP requires a DIME disclosure. If the DIME has a conflict or appearance of conflict, he must not accept the DIME assignment for the case. Disclosure and waiver of a conflict is not an option. Dr. Finn's destruction of his file regarding his complaint to the Supreme Court about claimant's attorney has little impact on the facts of this case. Dr. Finn's opinion about claimant's attorney is of little consequence. Claimant's allegation of an adversarial relationship is not persuasive. Dr. Finn testified persuasively that he evaluates all patients and DIME claimants without regard for their attorney. Furthermore, the issues in this case do not involve the usual DIME medical judgments about further treatment. Dr. Finn, quite normally, relied on the medical records to determine that claimant did not injure her left shoulder and that she had already had the rhizotomy. The finder of fact has also found those same facts. Nothing in Dr. Finn's report shows the slightest indication that his

determinations are driven by some ongoing animosity toward claimant's attorney.

28. Consequently, claimant was at MMI on April 19, 2005, as determined by Dr. Finn, Dr. Hattem, and Dr. Watson. Dr. Hall's contrary opinion that claimant is not at MMI because she needs the rhizotomy, TMJ treatment, and left shoulder evaluation is not persuasive.

29. Claimant suffered no permanent impairment as a result of the 2003 work injury. Dr. Finn made a considered medical judgment that the proper analysis was to provide a 7% rating based upon the L4-5 annular tear in addition to the 5% for range of motion deficits. That same 5% impairment for range of motion deficits was found for the 2001 injury. Dr. Finn, in addition to Dr. Hattem and Dr. Watson, apportioned the previous 2001 award of 13% impairment and concluded that claimant had no additional impairment due to the 2003 injury.

30. Claimant has failed to prove by a preponderance of the evidence that she needs post-MMI treatment in the form of the rhizotomy, injection treatment of the annular tear, evaluation and treatment of the left shoulder, evaluation of tinnitus, and evaluation of TMJ dysfunction and headache. As found, claimant had the rhizotomy, apparently with not much success. As found, she did not injure her left shoulder in the 2003 injury. The record evidence does not demonstrate that claimant's preexisting tinnitus, TMJ dysfunction, and headache were aggravated by the 2003 injury, requiring additional treatment. Claimant had low back pain from the 2003 injury. Claimant's later reports of other problems are not credible or persuasive. Dr. Hall's recommendation of additional treatment for the 2003 injury is not persuasive.

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. The DIME determination of causation is binding unless overcome by clear and convincing evidence. *See Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Cudo v. Blue Mountain Energy Inc.*, W.C. No. 4-375-278 (Industrial Claim Appeals Office, October 29, 1999). 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. Finn, determined that claimant was at MMI on April 19, 2005. Consequently, claimant must prove by clear and convincing evidence that this determination is incorrect.

"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. Finn is incorrect.

2. The medical impairment determination of the DIME is also binding unless overcome by clear and convincing evidence. Section 8-42-107(8), C.R.S.; *see Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186, 189-190 (Colo. App. 2002); *Sholund v. John Elway Dodge Arapahoe,* W. C. No. 4-522-173 (ICAO October 22, 2004); *Kreps v. United Airlines,* W.C. Nos. 4-565-545 and 4-618-577 (ICAO January 13, 2005). *Cudo v. Blue Mountain Energy Inc.*, W.C. No. 4-375-278 (Industrial Claim Appeals Office, October 29, 1999). As found, claimant has failed to prove by a preponderance of the evidence that the DIME determination of no impairment 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 by authorized providers after MMI. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The insurer admitted liability for reasonably necessary medical benefits after MMI. The insurer remains 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 she needs post-MMI treatment in the form of the rhizotomy, injection treatment of the annular tear, evaluation and treatment of the left shoulder, evaluation of tinnitus, and evaluation of TMJ dysfunction and headache.

ORDER

It is therefore ordered that:

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

2. Claimant's claim for additional medical benefits for a rhizotomy, injection treatment of the annular tear, evaluation and treatment of the left shoulder, evaluation of tinnitus, and evaluation of TMJ dysfunction and headache is denied and dismissed.

3.

DATED: March 23, 2010 Martin D. Stuber

Administrative Law Judge

SUPPLEMENTAL ORDER
WORKERS' COMPENSATION NO. WC 4-730-506

ISSUE

The sole issue presented at the time of the hearing was medical benefits, specifically, whether the injury, which Claimant received to his left shoulder and left upper extremity is causally related to the original admitted injury to his right shoulder.

FINDINGS OF FACT

1. Claimant received an injury to his right shoulder in the course and scope of his employment on July 22, 2007. This right shoulder injury was admitted by Respondents, and Claimant has been receiving temporary disability benefits and medical benefits for his right shoulder injury.

2. Michael Hewitt, M.D. performed a surgical repair of Claimant's right shoulder in September 2007.

3. Claimant continued to experience problems with his right shoulder injury subsequent to his surgery. Those problems included, pain, weakness, loss of range of motion, numbness, diminished strength, and a diminished ability to control his right shoulder and arm. Claimant did not have a good surgical outcome from his right shoulder surgery.

4. Subsequent to his surgery, Claimant came under the care of Phillip Stull, M.D. Inasmuch as Claimant was continuing to experience significant problems with his right shoulder, Dr. Stull scheduled another surgery. The second right shoulder surgery is scheduled to take place on October 26, 2009.

5. On or about January 7, 2009, Claimant went up on the roof of his garage to inspect for possible damage from a windstorm the day before. Claimant was concerned about possible damage to the roof, because stored in the garage were tools and books, which he needed for his livelihood. Claimant credibly testified that he stored $75,000 worth of tools and books in the garage. He did not want them to be damaged by moisture.

6. Prior to going up on the roof, Claimant attempted to get someone else to go up on the roof and check it for him, but to no avail. He also attempted to go into the neighbor's yard so that he could survey any possible roof damage from the ground, but that proved also to be unsuccessful. Claimant chose not to pay someone to inspect his roof.

7. While in the process of climbing down from the roof on the ladder, Claimant reached with his right arm to gain his balance. However, as he did so, he felt a pain in his right shoulder, and the right shoulder gave way. This caused Claimant to fall to the ground. While he was

falling, Claimant tried to turn his body so as to protect his injured right shoulder, and he fell on his left side. As a result of this incident, Claimant received injuries to his left shoulder.

8. On July 11, 2008, Dr. Hewitt imposed permanent work restrictions of “a thirty-pound over the head weight restriction.” Claimant was not exceeding his work restrictions on January 7, 2009, at the time his right shoulder collapsed and caused him to fall off the ladder. Claimant used his right upper extremity to balance himself not for the purpose of supporting his weight.

9. Claimant acted reasonably in climbing on the garage roof to check the condition of the roof in order to avoid moisture damage to his tools and books, which were used for Claimant’s livelihood and stored in his garage.

10. Claimant's admitted work injury to his right shoulder caused this body part to be in a weakened condition. The weakened condition of Claimant's right shoulder was a causative factor in the injury to his left shoulder, which occurred on January 7, 2009. Claimant's right shoulder "collapsed" and "gave way" on January 7, 2009, because of its weakened condition as a result of the July 22, 2007, admitted right shoulder injury.

CONCLUSIONS OF LAW

1. The purpose of the Workers’ Compensation Act of Colorado (Act), Sections 8-40-101, C. R.S., *et seq.*, is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 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. Section 8-41-301(1)(c), C.R.S., provides that an injury is not compensable unless "proximately caused by an injury or occupational disease arising out of and in the course of" employment. The element of proximate cause is met if an industrial injury leaves the body in a weakened condition, and the weakened condition is the proximate and natural cause of a reinjury. *Chambers v. Lyle’s Construction CO., Inc., and Colorado Compensation Insurance Authority,* W. C. No.4-180-470 (November 18, 1998); *Standard Metals Corp. v. Ball*, 172 Colo. 510, 474 P.2d 622 (1970). Conversely, if the evidence shows that a claimant's reinjury is the

result of an efficient intervening cause, compensation will not be awarded merely because the claimant did not retain his former physical powers after the industrial injury. *Post Printing and Publishing Co. v. Erickson*, 94 Colo. 382, 30 P.2d 327 (1934); *Chambers v. Lyle's Construction CO., Inc., and Colorado Compensation Insurance Authority, supra*.

4. The determination of whether a reinjury is a proximate result of a prior industrial injury is generally a question of fact for determination by the ALJ. *Lutgen v. Teller County School District No. 2*, W.C. No. 3-846-454 (June 12, 1996), aff'd., *Teller County School District No. 2 v. Industrial Claim Appeals Office*, (Colo. App. 96CA1194, December 27, 1996) (not selected for publication). It is only where reasonable minds could draw but one inference that the issue of proximate cause becomes one of law for the ALJ. *See Schrieber v. Brown & Root, Inc.,* 888 P.2d 274 (Colo. App. 1993).

5. In the Colorado Court of Appeals case, *Jarosinski v. ICAO*, 62 P.3rd 1082 (Colo. App. 2002), and the Colorado Supreme Court case, *Standard Metals v. Ball,* 172 Colo. 510, 474 P.2d 622 (1970), the courts held that if the work injury leaves a claimant's body in a weakened condition, and the weakened condition plays a causative role in a subsequent injury, then the additional injury is compensable. The evidence established that this is what happened in this case.

6. The record reflects that Claimant received an admitted injury to his right shoulder on July 22, 2007. Although he underwent surgery for his shoulder, he did not have a good surgical outcome, and the injury, which Claimant received to his right shoulder, resulted in that body part being left in a weakened condition. He continued to experience pain and weakness in his right shoulder and right upper extremity, so much so that another surgery on his right shoulder has been scheduled.

7. The evidence established that Claimant climbed on to the roof on January 7, 2009, because he was concerned that there had been wind damage to the roof, which might damage tools and books Claimant stored in his garage and needed for his livelihood. When he went up on the roof, Claimant did not violate his work restrictions since he credibly testified that he used his right upper extremity to balance himself and not to hold his weight.

8. Accordingly, it is determined that the work related injury of July 22, 2007, left Claimant's body in a weakened condition, and the weakened condition played a causative role in the January 7, 2009, injury, therefore, the January 7, 2009, injury is compensable. More specifically stated, it is concluded that Claimant's right shoulder played a causative role in his fall from the ladder causing injury to his left shoulder. Therefore, it is concluded that the injuries Claimant received on January 7, 2009, are compensable and that he is entitled to receive medical benefits to cure and relieve him from the effects of that injury. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988).

ORDER

It is hereby ORDERED, ADJUDGED AND DECREED that:

1. Respondents shall provide and pay for all authorized, reasonably necessary and related medical benefits, which are needed by Claimant, to cure and relieve him from the effects of the January 7, 2009, injury to his left shoulder.

2. All matters not determined herein are reserved for further decision.

DATED: March 23, 2010

Margot W. Jones
Administrative Law Judge

ORDER DISMISSING RESPONDENTS' PETITION TO REVIEW

Hearing in this matter was held on January 8, 2010, before Administrative Law Judge Donald E. Walsh. On February 24, 2010, the Judge entered Findings of Fact, Conclusions of Law, and Order (FFCLO). The Order was electronically mailed to counsel of record on February 24, 2010. The Order specified that any Petition To Review must be filed in the Denver Office of the Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, Colorado 80202; within 20 days from the date the order was served. The deadline for filing a petition to review was March 16, 2010.

On March 17, 2010, the Colorado Springs office of the Office of Administrative Courts (OAC) received a Respondents' Petition to Review and Designation of Record, signed by Respondents' counsel on March 16, 2010, with a Certificate of Mailing dated March 16, 2010. Upon receipt of this petition in the Colorado Springs office of the OAC, its filing was rejected, as it did not conform to the instructions indicated in the FFCLO, indicating that any Petition to Review was to be filed with the Denver office of the OAC.

Upon rejection of the petition on March 17, 2010, Respondents' counsel filed a Respondents' Petition to Review and Designation of Record with the Denver Office of OAC, which was received by that office on March 17, 2010. This petition was signed by Respondents' counsel on March 17, 2010, with a Certificate of Mailing dated March 17, 2010.

Respondents' petition to review was not timely, as required by section 8-43-301(2), C.R.S. (2009). That section states that the petition "shall be filed within twenty days after the date of the certificate of mailing of the order, and, unless so filed, the order shall be final."

The ALJ concludes that the order issued on February 24, 2010 is final.

Failure to file a timely petition to review is a jurisdictional defect. *Buschmann v. Gallegos Masonry, Inc.*, 805 P.2d 1193 (Colo. App. 1991); *Lambert v. Sema Construction*, W.C. No. 4-504-756 (Industrial Claim Appeals Office, March 9, 2006); *Gezaghn v. Supershuttle International*, W.C. No. 4-607-353 (Industrial Claim Appeals Office, May 11, 2006).

It is therefore ordered that:

1. Respondents' petition to review is dismissed.

DATE: March 24, 2010 /s/ original signed by:
Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-788-214

ISSUES

Did claimant prove by a preponderance of the evidence that he sustained an injury arising out of the course and scope of his employment?

FINDINGS OF FACT

- Employer operates a landscaping business. At all relevant times, Pedro Flores was employer's manager of operations and one of claimant's supervisors. Claimant worked for employer as a salaried supervisor until he quit on February 6, 2009. Claimant quit because he would not accept a demotion from a salaried employee to hourly. Employer demoted a number of employees at the same time as claimant because of the downturn in the economy.

- On March 7, 2009, claimant sought medical treatment for lower back pain at the Emergency Department (ER) of Denver Health Medical Center. Claimant reported various mechanisms of injury, ranging from a fall at work while carrying a heavy load to a fall down 3 steps that morning at home while carrying a 50-pound bag. Claimant also reported falling off a stair onto his right hip. On March 8th, claimant reported to Sara E. Pinski, M.D., that his low back pain resultled from lifting a heavy object on March 7th. A social worker's note on March 8th indicated claimant reporting a fall at work while carrying a heavy load. During a spine consultation on March 8th, claimant reported to the ER physician that he was moving boxes in his garage on March 7th when he experienced an acute onset of lower back pain and weakness in his right leg. The ER physician diagnosed a disk herniation at the L5-S1 level of claimant's lumbar spine, ordered a magnetic resonance imaging (MRI) scan, and referred him to Orthopedic Surgeon Anthony Dwyer, M.D., for a consult.

- Claimant underwent the MRI scan on March 17, 2009, which showed a right-sided

disk herniation at the L5-S1 level. Dr. Dwyer evaluated claimant on March 17th and recorded claimant reporting a one-year history of lower back problems unassociated with any injury. Dr. Dwyer recorded that claimant sustained an acute exacerbation without any predisposing cause on March 8th. Dr. Dwyer recommended surgery, but claimant declined. Claimant later underwent lower back surgery performed by Dr. Dwyer on March 30, 2009.

- On March 24, 2009, claimant filed his Workers Claim for Compensation (WCC), alleging he injured his back on November 15, 2008, while loading 50-pound bags of ice melt from a pallet into a truck. Claimant stated on the WCC that he slipped on wet ground and fell sideways while holding a bag of the ice melt.

- Insurer received the WCC in April of 2009, and contacted –T-, employer's contract administrator and safety manager, who was unaware of claimant's claim. Ms. -T- investigated claimant's injury and learned that November 15th was a Saturday on which none of employer's employees worked. Ms. -T- later learned that claimant had changed his story, reporting an injury on December 11, 2008, around 8:00 p.m.

- Claimant reported to Henry J. Roth, M.D., on June 22, 2009, that he injured himself on November 15, 2008, moving 10-pound bags of salt from a pallet. Claimant told Dr. Roth he felt acute pain in his back while lifting the 7th or 8th bag. Claimant did not mention to Dr. Roth anything about slipping on ice while moving the bags of salt. Claimant told Dr. Roth that he continued working until 1:00 a.m. the following morning and that he reported his injury to his supervisor around 6:00 a.m. on November 16th. It is undisputed that claimant did not work on November 15th.

- Claimant testified to the following: Around 2:00 p.m. on December 11, 2008, Mr. -U- directed claimant to be prepared to spread mag chloride at several properties because of forecasted snow. Mr. -U- told claimant to be ready to start spreading the mag chloride around 8:00 p.m. on December 11th. Claimant injured himself around 8:00 p.m. on December 11, 2008, while moving 10 bags of ice melt from one pallet to another because the pallet of ice melt had been stored in front of the tank of mag chloride, preventing him from accessing the tank. Claimant lifted the 7th or 8th bag and felt a snap in his back.

- Claimant's testimony was inconsistent with his statements on the WCC: Claimant changed the date of injury from November 15th, a date he did not work, to December 11th. Claimant also changed his story concerning the mechanism of injury from moving bags of ice-melt from a pallet into a truck to moving them from one pallet to another in order to gain access to the tank of mag chloride. Claimant further changed his story from slipping on wet ground while holding a bag of ice melt to merely experiencing a snap in his back when lifting one of the bags.

- -V- testified that claimant telephoned him on the evening of December 11th, telling him he hurt his back and asking him to help spread deicer. Mr. -V- stated that he agreed to

help claimant out of friendship and without pay. According to Mr. -V-, claimant told him he fell on ice while holding a 50-pound bag of salt. This mechanism of falling onto ice while holding a bag is inconsistent with claimant's testimony. Mr. -V- stated that he helped claimant spread mag chloride on the evening of December 11th. The Judge finds Mr. -V- unreliable as a witness because of his past criminal history involving fraud, criminal impersonation, and lying to a police officer.

- Claimant served a subpoena upon employer's customer, -W-, and obtained claimant's Exhibit 12. Neither party questions the reliability of Exhibit 12. Exhibit 12 is contrary to claimant's testimony that he spread mag chloride at -W- on the evening of December 11th. There is no other record evidence from employer, such as a work-order, invoice, or time sheet, supporting claimant's testimony that he spread mag chloride at -W- on the evening of December 11th. Crediting the testimony of Ms. -T-, employer operates a business that provides a service. Employer's contract with -W-, requires a call from the customer requesting mag chloride. Employer would not automatically spread mag chloride at -W- based upon a forecast for snow absent a call from the customer. Employer does not perform those services for free. Had claimant been sent by Mr. -U- to spread mag chloride at -W- on the evening of December 11th, employer would have generated a work-order, invoice, or corresponding time sheet. None of employer's employees engaged in snow removal work on December 10th or 11th. Snow reports show that it snowed on December 8th and 13th, but not on December 11th or 12th.

- Claimant testified that he reported his injury to Mr. -U- on December 11th and 12th. Claimant stated he was afraid to report the injury to anyone other than Mr. -U-. Between December 11th and the time he quit on February 6th, claimant did not report an injury to any other supervisor or anyone else at employer. Crediting employer's records and witnesses, claimant continued to work his regular hours and regular work for employer from December 11, 2008, through February 6, 2009. Even though he quit on February 6th, claimant did not report his injury to anyone at employer until he filed his WCC toward the end of March, after Dr. Dwyer recommended surgery.

- Claimant has reported other work-related injuries to employer: Claimant had a work-related finger injury on November 14, 2008, that he reported to employer and for which employer referred him for medical treatment. Claimant also was involved in a minor motor vehicle accident (MVA) while working for employer on January 12, 2009. Claimant reported the MVA to his supervisor, who sent him to Concentra Medical Centers for treatment. Claimant's testimony that he was afraid to report a back injury on December 11th but was not afraid to report the prior finger injury and, one month later, to report the MVA and seek medical attention is inconsistent and unreliable. Because of this, the Judge credits the testimony of Mr. -U- in finding it improbable that claimant reported an injury to Mr. -U-. In addition, Mr. -U- testimony was amply supported by testimony of Ms. -T- and employer's other witnesses.

- Sometime in late March, claimant told his neighbor and coworker, -X-, that he needed to undergo surgery. Mr. -X- had been claimant's supervisor while working for employer

during January and February of 2009. Claimant told Mr. -X- that he hurt his back while carrying something outside his house when he fell on the curb. Claimant also mentioned an injury while working for employer. While Mr. -X- observed claimant limping in March of 2009, claimant did not have a limp while working for employer in January and February of 2009. Claimant had never reported a back injury to Mr. -X- during the time he was claimant's supervisor in January and February of 2009.

- Claimant failed to sustain his burden of showing it more probably true than not that he sustained a lower back injury while working for employer on December 11, 2008. As amply shown by the above findings, claimant has told many different stories regarding the date and mechanism of his alleged injury. These various accounts include the story on the WCC, different stories to various witnesses, and different stories to various medical providers. Indeed, claimant initially reported an injury on a date (November 15th) when he did not work but changed that story after realizing that fact. While claimant asks the Judge to credit the story he told when testifying over the other versions, claimant's testimony lacks reliability when weighed against the various stories he has told. The Judge is unable to credit claimant's testimony.

CONCLUSIONS OF LAW

Claimant argues he has proven by a preponderance of the evidence that he sustained a back injury arising out of the course and scope of his employment. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102 (1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and scope of his 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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

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

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). 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).

Here, the Judge found claimant failed to show it more probably true than not that he sustained a lower back injury while working for employer on December 11, 2008. Claimant thus failed to prove by a preponderance of the evidence that he sustained a compensable lower back injury.

As found by the Judge, claimant told many different stories regarding the date and mechanism of his alleged injury. These various accounts included the story on the WCC, different stories claimant told to various witnesses, and different stories claimant told to various medical providers. Indeed, claimant initially reported an injury on a date (November 15th) when he did not work but changed that story after realizing that fact. While claimant requested that the Judge credit the story he told when testifying over other versions he told, the Judge was unable to credit claimant's testimony. The Judge instead found claimant's testimony lacked reliability when weighed against the various stories he has told.

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

ORDER

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

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

DATED: _March 24, 2010_

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-745-387

ISSUES

Whether Claimant has overcome the opinion of the DIME physician finding that Claimant reached MMI as of March 18, 2009.

Whether Claimant has proven that a referral to a pain management specialist, for a repeat MRI and a neurosurgical consultation are reasonable and necessary medical care.

FINDINGS OF FACT

1. Claimant sustained an admitted injury to his low back on November 23, 2007. Claimant worked for Employer as a stocker. Following the injury Claimant was referred by Employer to Concentra Medical Center for treatment and began treatment with Dr. Felix Meza, M.D.

2. Claimant was referred to Dr. Brian Reiss, M.D. for orthopedic consultation. Dr. Reiss initially evaluated Claimant on July 2, 2008. Dr. Reiss noted that Claimant had been treated with epidural injections by Dr. Ogin that had not helped. Dr. Reiss noted that an MRI done in January 2008 showed central protrusion of the L5-S1 disc with degeneration. Dr. Reiss referred Claimant for a new MRI prior to re-evaluation. Dr. Reiss stated in his report that there was a possibility of the need for a diskectomy and fusion.

3. Dr. Reiss again evaluated Claimant on August 5 and August 13, 2008. Dr. Reiss noted that Claimant had had additional epidural injections that had not provided pain relief. Claimant indicated to Dr. Reiss that he wanted surgery and Dr. Reiss discussed this with Claimant on both August 5 and August 13, 2008. Dr. Reiss stated that at Claimant's age he would like to avoid a fusion and discussed with Claimant the advantages and disadvantages of just performing a microdiskectomy. Dr. Reiss discussed with Claimant the possibility that if the microdiskectomy did not work Claimant may need a fusion in the future.

4. Dr. Suzanne Kenneally, Ph.D performed a psychological assessment of Claimant on July 24, 2008 upon referral from Dr. Ogin. Dr. Kenneally noted the Claimant had complaints of constant low back pain with radiation down the backs of his legs. Dr. Kenneally performed psychological testing that she felt was valid. Dr. Kenneally noted, and it is found, the MCMI-III test results were consistent with conversion of psychosocial stress into physical and pain symptoms. On the PPI test Dr. Kenneally noted significantly elevated results indicating a significant contribution of non-physiological factors to Claimant's pain report. Dr. Kenneally also noted presence of marked level of clinical depression. Dr. Kenneally opined that Claimant was a poor surgical candidate until improvement could be made in his depression and sleep disorder. Dr. Kenneally evaluated Claimant again on August 14, 2008 following a series of

eight treatment sessions. Dr. Kenneally felt that Claimant's anticipation that his depression would resolve after surgery and decrease in his pain level was reasonable.

5. Dr. Reiss performed surgery on August 25, 2008 consisting of a microscopic laminotomy and decompression at L5-S1. Claimant was evaluated by Dr. Reiss in follow up on October 8, 2008. At that visit, Dr. Reis obtained a history from Claimant that he was doing a lot better until his pain increased three days prior when getting out of bed.

6. Dr. Reiss again evaluated Claimant on December 24, 2008. Dr. Reiss opined that it was unlikely that any further surgery would be helpful. Dr. Reiss ordered a new MRI to complete the evaluation. Claimant returned to Dr. Reiss on February 6, 2009 following the MRI. Dr. Reiss noted the MRI showed marked degenerative change at L5-S1 and that Claimant was mostly complaining of back pain with virtually no leg pain. Dr. Reiss stated to Claimant that his options for treatment were to live with the pain, do his exercises, take his medications versus the possibility of a fusion that Dr. Reiss stated had a "fair chance of being helpful". Dr. Reiss further stated the Claimant would need to stop smoking before such a surgery but "the possibility of L5-S1 fusion is certainly reasonable to consider.

7. Claimant was evaluated by Dr. Darrell Quick, M.D. on February 18, 2009 as the result of Dr. Quick assuming the care for Claimant from Dr. Meza as of December 10, 2008. Dr. Quick noted that Claimant presented in a non-physiologic fashion with invalid lumbar flexion. Dr. Quick noted that a lumbar fusion had been discussed and that he recommended against such a surgery, a recommendation Claimant disputed.

8. Claimant was evaluated by Dr. James Ogsbury, M.D., a neuro-surgeon, on February 26, 2009 upon referral from Dr. Quick. Dr. Ogsbury had previously evaluated Claimant prior to the surgery perform by Dr. Reiss. Dr. Ogsbury noted that Claimant had pain primarily in the middle of the low back. Dr. Ogsbury stated that performing a fusion was within neurosurgical and Colorado Medical Treatment guidelines but would have less than 50% chance of significant improvement of Claimant's condition. Dr. Ogsbury stated that if Claimant wished to proceed with fusion, understanding the low odds, he would support that decision but, in addition, Claimant would have to fulfill the requirements of smoking cessation and continued psychological support.

9. In a letter dated March 5, 2009 Dr. Ogsbury further explained his opinion regarding the proposed fusion surgery. Dr. Ogsbury noted that he had not been optimistic about the initial surgery and was not even less optimistic that a fusion procedure would produce significant improvement, although Dr. Ogsbury noted that lumbar fusions are reasonable options for degenerative disc disease.

10. Dr. Peter J. Vicente, Ph.D performed a psychological evaluation of Claimant on November 12, 2008 upon referral from Dr. Meza. Claimant reported to Dr. Vicente that the medicines he was taking just made him tired without helping the pain. Dr. Vicente performed psychological testing and stated that what was most evident and of importance for clinical

management was a marked tendency by Claimant to overfocus, oversimplify, and over-respond to physical sensations. Dr. Vicente opined, and it is found, that Claimant presented with pain disorder with psychological and medical factors of a chronic nature, including delayed recovery.

11. Dr. Vicente again evaluated Claimant on February 25, 2009. At this visit Dr. Vicente noted that Claimant did not view himself as reaching MMI because of his perception that a fusion surgery was being strongly recommended. Dr. Vicente noted that Claimant continued to strongly view himself as disabled. Dr. Vicente opined, and it is found, that an illness conviction such as this remained problematic for Claimant to benefit from rehabilitation and medical interventions.

12. At the request of Respondents Dr. Jeffery Sabin, M.D., an orthopedist, reviewed medical records from Claimant's treatment and issued a report dated March 2, 2009. Following his review of the medical records Dr. Sabin opined that the psychological evaluations in combination with a poor response to the first surgery indicated that a further fusion surgery would have a very high risk of having poor results.

13. Dr. Quick placed Claimant at MMI as of March 18, 2009 and reiterated his earlier opinion that he did not believe Claimant "would fare well" with the lumbar fusion. Dr. Quick assigned work restrictions of lifting, carrying, pushing and pulling up to 20 pounds with occasional bending.

14. Dr. Carlos Cebrian, M.D. performed a DIME on August 10, 2009. Dr. Cebrian agreed with Dr. Quick's assessment that Claimant reached MMI as of March 18, 2009. Dr. Cebrian specifically agreed with Dr. Quick that the psychological issues identified by Dr. Vicente made Claimant a very poor candidate for a fusion surgery. Dr. Cebrian opined, and it is found, that even if Claimant were to stop smoking a lumbar fusion would not be recommended due to the psychological findings.

15. Dr. Ogin re-evaluated Claimant on September 14, 2009. Dr. Ogin stated that while it was possible Claimant underlying pain was discogenic, based upon all the other factors he agreed further surgery was not warranted. Dr. Ogin recommended further pain management.

16. Insurer filed an Amended Final Admission of Liability on September 23, 2009 admitting for post MMI maintenance care from authorized physicians that was reasonable and necessary.

17. Claimant currently resides in Peoria, Ill. After moving to Illinois Claimant came under the care of Dr. Sureka, a physical medicine and rehabilitation physician. Respondents did not dispute that Dr. Sureka should be considered an authorized physician. Dr. Sureka initially evaluated Claimant on December 7, 2009 and referred Claimant for physical therapy and to Dr. Kevin Henry for pain management. On December 28, 2009 Dr. Sureka referred Claimant to Illinois Neurological Institute and Claimant was evaluated by Dr. Klopfenstein on January 21, 2010 who recommended an MRI and further evaluation.

18. Claimant testified at hearing that he believes he cannot work at all. Claimant testified that he believes further surgery will “cure” him and “fix” his problem, meaning that he will have more ability that he now does and that he has an expectation that he might be pain-free.

19. The ALJ finds that Claimant has failed to overcome the opinion of the DIME physician, Dr. Cebrian, that he reached MMI as of March 18, 2009.

20. Claimant has proven by a preponderance of the evidence that a referral for a pain management evaluation to Dr. Henry, a repeat MRI and follow up evaluation by Dr. Klopfenstein are reasonable and necessary to evaluate and provide Claimant with treatment to maintain his condition after MMI.

CONCLUSIONS OF LAW

21. 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. In most instances, 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. X-ray*, 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.

22. 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).

23. Claimant bears the burden of proof, by clear and convincing evidence to overcome the opinion of the DIME physician that Claimant was at MMI. §8-42-107(8)(c), C.R. S. 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.

24. As found, Claimant has failed to overcome the opinion of Dr. Cebrian the DIME physician who agreed with Dr. Quick that Claimant reached MMI as of March 18, 2009. Claimant principally relies upon the records of Dr. Reiss and Dr. Ogsbury to support the

proposition that Claimant is not at MMI because a further fusion surgery has been recommended and would improve Claimant's condition. The ALJ concludes that Claimant mis-interprets the opinions of Dr. Reiss and Dr. Ogsbury regarding the recommendation for further surgery. Dr. Reiss stated the fusion surgery was a "possibility" that had a "fair chance" of success. Dr. Ogsbury stated that the fusion surgery fell within treatment guidelines but had less than a 50% chance of significantly improving Claimant's condition. The ALJ concludes that the opinions of Dr. Reiss and Dr. Ogsbury fail to show that it is more likely than not that a fusion surgery would improve Claimant's condition and such evidence falls short of the clear and convincing evidence needed by Claimant to overcome Dr. Cebrian's opinion that Claimant was a poor candidate for such surgery and was at MMI. Claimant argues that Dr. Ogsbury indicated he would agree with surgery though he had reservations about its likelihood of success. The ALJ concludes that Dr. Ogsbury's opinion is not just a mere reservation about the likelihood of success but rather that the surgery does not have a likelihood of improving Claimant's condition. Claimant argues that Dr. Cebrian based his MMI opinion on Dr. Quick's report of psychosocial issues without any substantiation from psychological or psychiatric reports. The ALJ disagrees. Both Dr. Kenneally and more strongly Dr. Vicente expressed opinions that Claimant's psychological testing results evidenced pain disorders, depression, and illness attitudes that would be problematic for Claimant to benefit from further rehabilitation and medical treatment. Claimant's testimony at hearing that he considers himself totally unable to work despite being released to work within certain restrictions and his testimony that he believes the fusion surgery will "cure" and "fix' him so he might be "pain-free" is actually consistent with the concerns expressed by Dr. Vicente. The opinions of Dr. Sabin and Dr. Ogin provide further support for Dr. Cebrian's opinion that Claimant is at MMI on the basis that Claimant is a poor candidate for fusion surgery and that it will not likely improve his condition.

25. 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).

26. In their Amended Final Admission Insurer admitted for reasonable and necessary medical treatment after MMI. At hearing, Respondents indicated on the record that they would authorize the pain management consultation with Dr. Henry that had been recommended by Dr. Sureka. As found, the repeat MRI and consultation with Dr. Klopfenstein is also reasonable and necessary as maintenance treatment. While an MRI could be a precursor to a surgery, it is also a reasonable test to determine if there has been any deterioration of Claimant's condition over time that may impact the need for maintenance medical treatment. The same can be said of a consultation with a neuro-surgeon to review the MRI results and make recommendations about further maintenance care. As found, Claimant has proven that an MRI and consultation with Dr. Klopfenstein to review the MRI results is reasonable and necessary maintenance care.

ORDER

It is therefore ordered that:

1. Claimant has failed to overcome the DIME physician's opinion by clear and convincing evidence that he reached MMI as of March 18, 2009.

2. Insurer shall pay the medical expenses for a pain management evaluation with Dr. Kevin Henry, for a repeat MRI and for a follow-up evaluation with Dr. Klopfenstein after completion of the MRI. Insurer shall pay these medical expenses in accordance with the Official Medical Fee Schedule of the Division of Workers' Compensation.

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: March 25, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-794-283

ISSUES

1 Did claimants prove by a preponderance of the evidence that they are dependents of decedent and are entitled to death benefits?

FINDINGS OF FACT

- Employer operates a security business. On March 11, 2009, employer hired decedent to work as a security guard. On May 29, 2009, decedent sustained a fatal injury from gunshot wounds while working for employer as a security guard. At the time of his death, decedent was attempting to break up a fight among patrons of a nightclub. Decedent's date of birth is October 9, 1976; his age at the time of his death was 32 years.

- The Judge adopts insurer's judicial admission of liability for decedent's death. Insurer has admitted liability for death benefits based upon an average weekly wage (AWW) of $54.56. The Judge granted claimant's request to reserve the issue of AWW for later determination. Decedent had not worked from January of 2007 until employer hired him in March of 2009.

- -A-, C1, C2, C3, and C4 are claimants seeking death benefits.

- On November 15, 2005, decedent completed an Affidavit of Common-Law Marriage. Decedent's signature on the Affidavit was notarized. In the Affidavit, decedent affirmed that he and Ms. -A- had lived together continuously from March 2004; that they had professed to be husband and wife; and that they had held themselves out to the community as being married.

- Ms. -A-'s testimony was credible. Ms. -A- holds herself out as decedent's wife. At the time of his death, decedent resided with Ms. -A- in her home. The mortgage for the home is titled only in Ms. -A-s name. Ms. -A- also owns a rental property (home) that is titled only in Ms. -A-s name. At the time of his death, decedent was remodeling the bathroom in the rental home. Prior to that, decedent replaced windows and refinished the floor in the bathroom of the rental home.

- Decedent also performed maintenance on the couple's residence, which is an old house requiring lots of work to maintain. Although decedent provided Ms. -A- little financial support, decedent's work on the couple's residence and on the rental home saved Ms. -A- from paying wages to a handyman to perform that work.

- Decedent also provided Ms. -A- emotional support and help with every-day problems, such as, help with car problems. When decedent worked, he helped pay the mortgage and helped pay for groceries. Decedent also bought presents for Ms. -A- and cooked meals for her.

- Decedent also acknowledged in the Affidavit that he was father of the following minor children: C1, C2, C3, and C4. Birth certificates for the minor children further establish that decedent is the father of the following minor children: C1 (DOB 8/9/); C2 (DOB: 4/6/); C3 (DOB 6/10/) and C4 (DOB: 6/10/). Decedent's minor children reside with their mother in Mexico. Decedent periodically sent the minor children money and presents.

- Ms. -A- showed it more probably true than not that she was the common-law wife of decedent, that she is decedent's widow, and that she was partially dependent upon him for support at the time of his death. While Ms. -A- primarily supported the couple financially, decedent contributed financially when he worked and earned a wage. Decedent worked and earned a wage at the time of his death. Decedent thus contributed financially to the couple at the time of his death. In addition, decedent brought to the marriage his handyman skills, which provided a financial benefit to Ms. -A-. Respondents failed to overcome with competent evidence the presumption that Ms. -A-, as decedent's widow, was wholly dependent upon him for support.

- The Judge finds it more probably true that decedent left the following minor children, who are presumed to be wholly dependent upon decedent for support at the time of his death: C1, C2, C3, and C4. The minor children are presumed to be wholly dependent on

decedent because the decedent has a duty to support them, and he in fact provided support on a sporadic basis. Respondents failed to overcome with competent evidence the presumption of dependency of the minor children.

- The Judge finds it equitable to apportion the payment of death benefits as follows: Decedent's minor children should each receive a 15% portion of the death benefits, until terminated by statute. -A- should receive 40% of the benefits plus any percentage no longer due to a dependant by operation of statute. Should Ms. –A- no longer be eligible to receive death benefits by operation of statute, her share should be apportioned among the eligible minor dependent children.

CONCLUSIONS OF LAW

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102 (1), *supra*. Claimants generally shoulder the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. However, he burden of proof may shift to 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 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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

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

Section 8-41-503(1), *supra*, provides that the Judge shall determine a dependent's right to death benefits and the extent of dependency as of the date of the injury to the decedent. Sections 8-41-501(1) and (1)(a), *supra*, provide that a widow is presumed wholly dependent upon the decedent, irrespective whether she receives all or only part of her support from deceased. This presumption may be overcome by competent evidence showing the widow was voluntarily separated and living apart from the spouse at the time of the injury or death or was not dependent in whole or in part on the decedent for support. Section 8-41-501(1)(a),

supra. A widow may be entitled to benefits where, despite having her own substantial sources of support, the decedent made some contribution to her support. The presumption afforded by the statute is overcome only by a finding that the widow receives no support from the deceased. *Michalski v. Industrial Claim Appeals Office*, 781 P.2d 183 (Colo. App. 1989).

Here, the Judge found that Ms. -A- showed it more probably true than not that she was the common-law wife of decedent, that she is decedent's widow, and that she was partially dependent upon him for support. The Judge further found it more probably true that decedent left the following minor children, who are presumed to be wholly dependent upon decedent for support upon decedent for support at the time of his death: C1, C2, C3, and C4. The Judge found that respondents failed to overcome with competent evidence the presumption that Ms. -A-, as decedent's widow, was wholly dependent upon him for support. The Judge further found that respondents failed to overcome with competent evidence the presumption of dependency of the minor children.

As found, Ms. -A- provided primary financial support to the marriage; however, decedent contributed financially when he worked and earned a wage. Decedent worked and earned a wage at the time of his death. Decedent thus contributed financially to the couple at the time of his death. In addition, decedent brought to the marriage his handyman skills, which provided a financial benefit to Ms. -A-.

The Judge found the minor children are presumed to be wholly dependent on decedent under §§8-41-501(1)(b) and (c), *supra*, because the decedent has a duty to support them, and he in fact provided support on a sporadic basis.

The Judge concludes that insurer should pay death benefits, based upon the admitted AWW of $54.56, as follows: Decedent's minor children should each receive a 15% portion of the death benefits, until terminated by statute. Ms. -A- should receive 40% of the benefits plus any percentage no longer due a dependant because of operation of statute. Should Ms. Ruffati no longer be eligible to receive death benefits by operation of statute, her share should be apportioned among the eligible minor dependent children.

ORDER

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

1. The following minor children are decedent's dependents: C1, C2, C3, and C4.

2. -A- is decedent's dependent widow.

3. Insurer shall pay aggregate death benefits to the dependents, based upon the admitted AWW of $54.56.

4. Insurer shall pay each of decedent's minor children a 15% portion of the death benefits,

until terminated by statute.

5. Insurer shall pay Ms. -A- a 40% portion of the death benefits, plus any percentage no longer due to any of the dependant minor children because of operation of statute.

6. Should circumstances change, such that by operation of statute Ms. –A- is no longer eligible to receive death benefits, insurer shall apportion Ms. -A-'s share among the remaining minor children who are eligible at the time to receive such benefits.

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

8. The issue of AWW is reserved to the parties for future determination.

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

DATED: __March 25, 2010___

Michael E. Harr
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-707-792

PROCEDURAL BACKGROUND

On August 5, 2009 ALJ Cannici issued Findings of Fact, Conclusions of Law and Order (Order) in this matter. The Order concluded that Claimant failed to overcome the Division Independent Medical Examination (DIME) physician's opinion that she had reached Maximum Medical Improvement (MMI) on April 27, 2007. The Order also noted that, because Claimant was not entitled to additional Temporary Total Disability (TTD) benefits, a determination of her Average Weekly Wage (AWW) was unnecessary.

Claimant appealed the Order. She asserted that the ALJ erred in concluding she failed to produce clear and convincing evidence to overcome the DIME physician's MMI determination. Claimant also contended that the ALJ erred in failing to determine her AWW.

The Industrial Claim Appeals Office (ICAP) concluded that the ALJ's MMI determination was supported by substantial evidence in the record. However, the ICAP set aside the Order and remanded the matter because the ALJ failed to address the issue of Claimant's AWW. The ICAP specifically noted that "[o]n remand, the ALJ shall make findings of fact and conclusions of law on the issue of AWW."

ISSUE ON REMAND

A determination of Claimant's AWW.

FINDINGS OF FACT ON REMAND

1. In September 2006 Claimant began working for Employer as a welder. On October 24, 2006 Claimant suffered an admitted industrial injury to her cervical spine during the course and scope of her employment with Employer.

2. Respondents designated Jeremiah J. Cogan, M.D. of Concentra Medical Centers as Claimant's Authorized Treating Physician (ATP). Dr. Cogan subsequently referred Claimant to Robert I. Kawasaki, M.D. of Advanced Medical Specialists for concurrent medical treatment.

3. Claimant received conservative care that included chiropractic and acupuncture treatments. She also underwent a Functional Capacity Evaluation (FCE).

4. On April 16, 2007 Dr. Cogan released Claimant to full duty employment. On April 27, 2007 Dr. Kawasaki concluded that Claimant had reached MMI and assigned her a 6% whole person impairment rating.

5. Based on the opinions of doctors Cogan and Kawasaki, Respondents filed a Final Admission of Liability (FAL) on June 4, 2007. The FAL specified that Claimant had reached MMI on April 27, 2007 and sustained a 6% whole person impairment rating.

6. The FAL also noted that Claimant earned an AWW of $480.80. The AWW was based on an hourly wage of $14.00 for a 34.34-hour workweek. Because Claimant was injured during her fifth week of employment, Respondents divided her total work hours by five.

7. Claimant testified at the hearing in this matter. She explained that she underwent training during her first week of employment and thus only worked 16 hours. Claimant commented that she worked 40 hours each week for the next three weeks, but only worked for 35 hours during the week that she was injured.

8. Claimant acknowledged that she earned $14.00 per hour when she was injured on October 24, 2006. However, Claimant's wage records and testimony reflect that approximately two and one-half weeks after her industrial injury she received a raise to $14.85 each hour. She noted that she would have worked 40 hours each week but her hours were reduced because of various doctor appointments related to her industrial injury. Claimant was released from employment on February 5, 2007. Claimant thus did not begin collecting TTD benefits until she ceased employment with Employer.

9. Employer's First Report of Injury reveals that Claimant earned an AWW of $560.00 on the date of her industrial injury. The AWW was based on earnings of $14.00 per

hour for 40 hours each week.

10. Respondents admitted AWW of $480.80 does not constitute a fair approximation of Claimant's wage loss and diminished earning capacity as a result of her industrial injury. Claimant acknowledged that she earned $14.00 per hour when she was injured on October 24, 2006. However, Claimant's wage records and credible testimony reflect that approximately two and one-half weeks after her industrial injury she received a raise to $14.85 each hour. She also credibly noted that she would have worked 40 hours each week but her hours were reduced because of various doctor appointments related to her industrial injury. Furthermore, Claimant did not begin to collect TTD benefits until she was released from employment on February 5, 2007. Because Claimant's earnings increased shortly after the date of her injury it is appropriate to apply §8-42-102(3), C.R.S. and exercise discretionary authority in the calculation of Claimant's AWW. Fairness requires the AWW to be calculated based upon Claimant's earnings during her disability and not on her earnings on the date of the injury. Claimant thus earned $14.85 per hour for 40 hours each week. Therefore, an AWW of $594.00 is a fair approximation of Claimant's wage loss and diminished earning capacity.

CONCLUSIONS OF LAW ON REMAND

1. 1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. Section 8-42-102(2), C.R.S. requires the ALJ to determine a claimant's AWW based on her earnings at the time of injury. The ALJ must calculate the money rate at which

services are paid to the claimant under the contract of hire in force at the time of injury. *Pizza Hut v. ICAO,* 18 P.3d 867, 869 (Colo. App. 2001). However, §8-42-102(3), C.R.S. authorizes an ALJ to exercise discretionary authority to calculate an AWW in another manner if the prescribed methods will not fairly calculate the AWW based on the particular circumstances. *Avalanche Industries, Inc. v. X-ray,* 198 P.3d 589, 592 (Colo. 2008); *Campbell v. IBM Corp.,* 867 P.2d 77, 82 (Colo. App. 1993). Specifically, §8-42-102(3), C.R.S. grants the ALJ discretionary authority to alter the statutory formula if for any reason it will not fairly determine the claimant's AWW. *Coates, Reid & Waldron v. Vigil,* 856 P.2d 850 (Colo. 1993). The overall objective in calculating an AWW is to arrive at a fair approximation of a claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997). Where the claimant's earnings increase periodically after the date of injury the ALJ may elect to apply §8-42-102(3), C.R.S. and determine that fairness requires the AWW to be calculated based upon the claimant's earnings during a given period of disability and not the earnings on the date of the injury. *Avalanche Industries, Inc.,* 198 P.3d at 597-98.

5. As found, Respondents admitted AWW of $480.80 does not constitute a fair approximation of Claimant’s wage loss and diminished earning capacity as a result of her industrial injury. Claimant acknowledged that she earned $14.00 per hour when she was injured on October 24, 2006. However, Claimant’s wage records and credible testimony reflect that approximately two and one-half weeks after her industrial injury she received a raise to $14.85 each hour. She also credibly noted that she would have worked 40 hours each week but her hours were reduced because of various doctor appointments related to her industrial injury. Furthermore, Claimant did not begin to collect TTD benefits until she was released from employment on February 5, 2007. Because Claimant's earnings increased shortly after the date of her injury it is appropriate to apply §8-42-102(3), C.R.S. and exercise discretionary authority in the calculation of Claimant’s AWW. Fairness requires the AWW to be calculated based upon Claimant's earnings during her disability and not on her earnings on the date of the injury. Claimant thus earned $14.85 per hour for 40 hours each week. Therefore, an AWW of $594.00 is a fair approximation of Claimant’s wage loss and diminished earning capacity.

ORDER

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

Claimant earned an AWW of $594.00.

DATED: March 25, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-011-820

ISSUES

The issues for determination include petition to reopen based on fraud, medical benefits including termination of attendant care services, medical benefits, and medications for non-related medical conditions, retroactive withdraw of admissions of liability pursuant to *Vargo v. Industrial Commission,* 626 P. 2d 1164 (Colo. App. 1981), credit against future benefits for false statements under Section 8-43-304(2) and 8-43-402, C.R.S., waiver, estoppels, and latches.

FINDINGS OF FACT

1. Claimant received an award of permanent total disability and ongoing medical benefits in 1993, arising out of a 1991 ankle sprain. In the 1993 Order, the court credited evidence submitted by the claimant that he had developed RSD/CRPS as result of his ankle sprain and that he had to wear braces at all times on both his hands and feet. He was awarded assistive care and special coats and shoes to accommodate his braces and his need to "maintain a constant body temperature." The Respondents have paid benefits based on the 1993 Order, and based on Claimant's ongoing representations about his condition and abilities. Order, Respondents' Submissions, Ex E; Depo. of -M-, p.36, ll.5-11.

2. At hearing, Respondents agreed that Claimant is permanently and totally disabled. Respondents did not list or argue petition to reopen the award of permanent total disability benefits on the grounds that his permanent and total disability is not due to the admitted work-related injury and the parties did not litigate this issue. Therefore, whether Claimant is permanently and totally disabled as a result of his industrial injury is not an issue for determination in this order.

3. On June 26, 2006, during an independent medical examination, Claimant stated to Respondents' IME physician Dr. Gregory Reichhardt that he needed to wear his braces "24/7", necessitating assistive care, that besides watching TV, he does "not a zip", that he never goes shopping, that he is unable to walk more than half a block at a time, that he hurts everywhere, and that he can do almost nothing at all and is weak over his whole body. Upon his exam by Dr. Reichhardt, inconsistencies were noted by Dr. Reichhardt, and Dr Reichhardt stated in his report that there were no clear findings of CRPS (formally RSD). Respondents' Submissions, Ex G.

4. On November 13, 2008, Respondent's representative investigator Richard Baldwin interviewed the Claimant at his home. Mr. Baldwin testified by deposition that during this interview, the Claimant presented in a fetal position on his couch, and made statements to Respondent's representative investigator Richard Baldwin that he could not walk without

assistance, that he could do nothing for himself, that he had very little grip strength, that he was 100% disabled, that he could only stand for a couple of minutes on his own, that he could not bend at the waist, kneel, stoop, bend at the knees, push something away, or grab a pop can; that he wore his braces 24 hours a day, seven days a week, that his disease process had "closed his hand", and that he could not lift a glass of water or pick something up from floor level. Claimant stated to Mr. Baldwin that he had been incapable of doing anything, including working in his yard or walking across a street, for 10 to 15 years and that his condition had worsened over time. The interview was conducted with the permission of the Claimant, and the Claimant acknowledged that he understood it was recorded and that his answers were true. Rick Baldwin Depo., Ex A, pp. 8-16,18, 20-22,32-33.

5. The evidence showed that the Claimant had presented for a second independent medical examination conducted by Dr. Reichhardt on January 27 2009. For that IME, Claimant presented in a wheelchair, and made statements to Respondents' IME physician Dr. Reichhardt that he had to wear his braces "24/7", that he could not use the bathroom by himself because "it hurt too much to take (the braces) off", that he hurt too much to go outside, he could not move about freely, and that he could only watch TV. Claimant stated to Dr. Reichhardt that he was 75% worse than in June of 2006, that his pain was a 10 out of 10, that in order to eat, he had to Velcro utensils to his hands, and that he could not even read a newspaper without his wife propping it up in front of him. Some surveillance of the Claimant had been obtained prior to this IME, and Dr. Reichhardt reviewed it, and offered to review it with the Claimant. The Claimant refused to review the video. In his IME report, Dr Reichhardt, opined Claimant did not need the splints, special coat or regular attendant care. Respondents' Submissions, Ex G.

6. Respondents' obtained video surveillance of the Claimant in January 2008, June 2008, October 2008 and January and February 2009, and the video surveillance was admitted into evidence. The Claimant declined to view the video at hearing. On the video, Claimant is shown doing all of the activities he stated to Respondents' representative he was incapable of doing, including walking without assistance, bending at the waist and knees, stooping, pushing, holding and drinking out of a pop can, picking things up from ground level, shopping and working in his yard. He is seen on the video obtained in October 2008 changing a tire, including vigorously using a tire jack, loading a full size tire into his vehicle, and loading and unloading two cases of pop at once, and what appeared to be a full bucket of cat litter. These activities were undertaken by the Claimant within 4 weeks of making the above referenced statements regarding his abilities and activities to Respondents' representative uring the November 13 interview. The surveillance conducted in January and February 2009 showed the Claimant carrying and changing a car battery, and these activities were undertaken within two weeks of his second IME with Dr. Reichhardt, where the Claimant made statements regarding his activities and abilities that were relied on by Respondents.

7. The evidence showed that the Claimant made statements that he had to wear hand and foot braces 24 hours a day, seven days a week, necessitating 24 hour, seven days a week attendant care services. The video surveillance showed Claimant undertaking a variety of

activities, without wearing his braces. The video surveillance only showed the Claimant wearing his braces as he entered and exited the Greeley Medical Clinic. The same day he wore the braces briefly to the clinic, Claimant was immediately thereafter recorded to be lifting bags of fertilizer at what appeared to be a home improvement store, and then was seen on the video unloading them at home, two at time.

8. The evidence showed that the Claimant's wife, via checks paid directly to the Claimant, had been receiving payment of $5.00 an hour, 24 hours a day, and seven days a week since October of 1998, for an annual tax free income of $43,800.00 a year. The video surveillance showed that the Claimant doing a variety of activities completely unassisted by his wife. The Claimant and his wife were receiving $2,535.32 a month prior to October of 1998 for home health care, which included approximately $100.00 for food. Since October 1998, Respondents have paid them $485,400.00 for home health care. Since the June 2006 IME with Dr. Reichhardt, Respondent paid $153,000.00 for home health care. Depo. of -M- and payment log, Ex B.

9. The evidence showed that Claimant represented that temperatures affected him so adversely that he was a required to have special coats, and coats that would fit over his hand braces. Claimant was seen throughout the video surveillance either coatless or wearing regular coats even in cold winter months, and not wearing the braces. Respondents have paid $4,520.43 to claimant for "special shoes." They have paid $2,438.97 for coats and gloves. Depo. of -M- and payment log, Ex B.

10. Claimant represented in his recorded interview with Rick Baldwin on November 13, 2008 that his condition has worsened over the preceding 10 to 15 years. Respondents have paid Claimant $2,197,615.22 in benefits to date. Depo. of Deb -M- and payment log, Ex B.

11. Dr Reichhardt testified at hearing. Dr. Reichhardt had reviewed medical records, all of the video surveillance conducted and had performed two IMEs of the Claimant. His testimony was credible and persuasive and his opinions are found as fact. He opined that Claimant does not need attendant care services. Dr. Reichhardt recommended Claimant undergo objective testing to determine if he has CRPS and tapering of narcotic medications. This recommendation is credible and persuasive. Dr. Reichhardt opined that Claimant's use of Nexium and Lopid are not related to his worker's compensation injury. Dr. Reichhardt opined that Claimant does need a shoe lift, but does not require the use of a special coat and shoes as a result of his work-related injury. Dr. Reichhardt credibly opined that Claimant's diabetes is not causally related to Claimant's work-related injuries. Claimant's treating physician, Dr. Loecke, opined that he cannot say that the diabetes was caused by Claimant's CRPS. (See Dr. Loecke depo p. 11-12).

12. It is found as fact that Claimant made false statements regarding his medical condition, including his need for assistive care, abilities and activities. These statements were material to his workers compensation claim and were made either for self-gain and/or for the benefit of his wife. Claimant's false statements were made for the purpose of obtaining benefits,

compensation, and/or payment under the provisions of articles 40 to 47 of the Workers Compensation Act.

13. Respondents presented testimony that any delay in submitting an Application for hearing following evidence of Claimant's false statements, was due to a desire to obtain video over a variety of occasions and seasons, and to proceed cautiously and reasonably prior to making allegations of fraud.

CONCLUSIONS OF LAW

1. An "ALJ has broad discretion in the conduct of evidentiary proceedings." *Martinez v. Senior Resource,* W.C. No. 4-748-216 (October 14, 2009), citing IMPC *Transportation Co. v. Industrial Claim Appeals Office*, 753 P.2d 803 (Colo. App. 1988). An ALJ's credibility determinations and her resolution of conflicts in the evidence, including the medical evidence, require deference. See *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411(Colo. App. 1995).

I. Medical Benefits and Authorized Provider

2. Respondents are not responsible for payment of attendant care services to Claimant's wife or other providers; Respondents are not responsible for payment for Claimant's use of Nexium and Lopid; Respondents are not responsible for payment for a coat and shoes, but Respondents shall provide a shoe lift; and Respondents are not responsible for Claimant's diabetes treatment. Respondents shall designate a level II accredited pain management physician to become claimant authorized provider and who will provide the treatment recommended by Dr. Reichhardt, including undergoing objective testing to determine if Claimant has CRPS and institution of a tapering of his narcotic medications.

II. Vargo Fraud and Credit/ Offsets under Section 8-43-402, C.R.S. and Section 8-43-304(2),

3. Section 8-43-402, C.R.S. provides: "If, for the purpose of obtaining any order, benefit, award, compensation, or payment under the provisions of articles 40 to 47 of this title, either for self-gain or for the benefit of any other person, anyone willfully makes a false statement or representation material to the claim, such person commits a class 5 felony and shall be punished as provided in section 18-1-105, C.R.S., and shall forfeit all right to compensation under said articles upon conviction of such offense." Respondents request for an order finding that Claimant has forfeited all rights to compensation and benefits obtained through willfully made false statements or representations pursuant to Section 8-43-402, C.R.S. is denied. Although Respondents proved by a preponderance of the evidence that Claimant willfully made false statements or representations pursuant to Section 8-43-402, C.R.S., the language of this statute is clear that a criminal conviction must occur before forfeiture of benefits is permitted. The ALJ does not have jurisdiction to order a forfeiture of compensation and benefits without a criminal conviction under this section.

4. Respondents request for a credit or offset under Section 8-43-304(2), C.R.S. for monies paid as a result of misrepresentation made by Claimant and a finding of fraud pursuant to Section 8-43-402, C.R.S is denied. As set forth in paragraph 2 above, Section 8-43-402, C.R. S. requires a criminal conviction. Section 8-43-304(2), C.R.S. provides for a credit or offset of previously paid benefits against further benefits when the "worker admits to having obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud." Under this section, an ALJ would only be authorized to allow respondents to take a credit or offset if the claimant admitted he obtained his worker's compensation benefits through fraud, or if a civil judgment or criminal conviction for fraud had already been entered, and was presented to the ALJ.

5. Respondents argument that the ALJ's order is a "civil judgment" as required in this section is rejected, as is Respondents' argument that Section 8-43-207(1)(q), C.R.S provides for the ALJ to remedy fraudulently obtained benefits by ordering repayment under these circumstances. Although respondents have proven by a preponderance of the evidence that Claimant willfully made false statements or representations, upon which Respondents relied in continuing to provide benefits, Claimant did not admit to obtaining his worker's compensation benefits through fraud. As Respondents did not elicit an admission from the Claimant, or submit into evidence any civil judgment or criminal conviction entered against Claimant for having obtained his benefits through fraud, the ALJ may not authorize a credit or offset under Section 8-43-304(2), C.R.S.

6. Although the proximity in time of the video and Claimant's statements prove by a preponderance of the evidence that Claimant willfully made false statements or representations to gain benefits, Respondents' argument that this rises to the level of a constructive admission, is rejected.

7. Respondents' request to retroactively withdraw their admission of liability under *Vargo v. Industrial Commission,* 626 P. 2d 1164 (Colo. App. 1981) is denied. Respondents have failed to prove by a preponderance of the evidence that Claimant's initial claim for benefits was fraudulently made.

III. Waiver, Estoppel, and Latches

8. Respondents delay in submitting an Application for hearing following evidence of Claimant's false statements was due to a desire to obtain video over a variety of occasions and seasons, and to proceed cautiously and reasonably prior to making allegations of fraud, and did not constitute a factual basis to support Claimant's arguments of waiver, estoppel, and/or latches.

ORDER

It is therefore ordered that:

1. Respondents may cease payment for attendant care services to Claimant's wife or other providers.

2. Respondents may cease payment for Claimant's use of Nexium and Lopid.

3. Respondents may cease payment for Claimant's diabetes treatment.

4. Respondents may cease payment for Claimant's coat and shoes.

5. Respondents shall provide a shoe lift.

6. Respondents shall designate a level II accredited pain management physician to become Claimant authorized provider and who will provide the treatment recommended by Dr. Reichhardt, including undergoing objective testing to determine if he has CRPS and institution of a tapering of his narcotic medications.

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

DATED: March 24, 2010

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-793-450

ISSUES

Did claimant sustain a work related low back injury on February 11, 2009?

FINDINGS OF FACT

1. Claimant alleges that he injured his low back on February 11, 2009 when he tripped while raking leaves and fell backwards over a concrete step onto his tailbone. Claimant stated that this occurred at 9:00 a.m. and he immediately went inside to rest.

2. That same date, at around 2:00 p.m., claimant went to Exempla St. Joseph's emergency room with complaints of pain in his right great toe. Claimant did not complain of back pain to the emergency room physician. Claimant testified that he did not tell the

emergency room physician about back pain at the time because it was not really hurting.

3. On February 24, 2009, Claimant returned to Exempla St. Joseph's emergency room with complaints of back pain. The emergency room report states that two days prior Claimant slipped on carpeted stairs and fell down two steps onto his low back.

4. On March 27, 2009, Claimant sought treatment for back pain at Exempla St. Joseph's Hospital. The medical report for that date of service reveals no apparent mechanism of injury for claimant's back pain.

5. The April 1, 2009 report from the Medical Center of Aurora emergency room states that Claimant was complaining of back pain with onset several weeks ago and the onset was gradual. The note also states, "Patient denies an injury."

6. Claimant was also seen at Bruner Family Medicine on March 10, 2009 and April 3, 2009 but did not report the work-related injury of a fall while raking leaves on February 11, 2009.

7. The first mention of a work-related fall while raking leaves on February 11, 2009 reported by a medical provider was on April 9, 2009 by Ronald Waits, NP at Concentra.

8. Claimant saw Dr. Wunder on April 16, 2009 and reported the same mechanism of injury as reported to Ronald Waits, NP. Dr. Wunder's notes indicate that Claimant had no previous history of low back injury or treatment. The note states, "He reported he had intermittent low back aching and saw a chiropractor a few times in the past but not on a regular basis. He has never had any physical restrictions, missed work time, or taken any medications for back pain." This is incorrect. Claimant suffered a work-related low back injury on August 5, 2002 resulting in a 16% permanent impairment rating and permanent work restrictions.

9. On October 8, 2009, after reviewing additional medical records, Dr. Wunder issued a report wherein he stated, "None of this additional information would change my opinions in this case. I was not ever given a copy of the first report of injury. There may have been simply some confusion about the initial date of injury. However, the mechanism of injury as reported to me and the ER report of 02/24/2009 are consistent." This opinion is not persuasive. The emergency room report of February 24, 2009 contains a different mechanism of injury from that noted in Dr. Wunder's April 16, 2009 report.

10. In her December 10, 2009 report, Dr. Fall noted the inconsistent history of injury reported by Claimant to the various medical providers. She also noted the inconsistent date of injury reported by Claimant as well as incorrect past medical history. Dr. Fall opined that the medial records are not consistent with a work injury on February 11, 2009. Dr Fall's opinion that claimant did not sustain an industrial injury on February 11, 2010 is deemed credible and persuasive.

11. Claimant failed to prove that he sustained a work related low back injury on February 11, 2009. Claimant's testimony is not persuasive. Claimant's testimony as to the mechanism of injury and onset of symptoms are inconsistent with the medical records from Exempla St. Joseph's Hospital.

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 benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. § 8-40-120(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. § 8-43-210, 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. X-ray*, 592 P.2d 792 (Colo. 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. § 8-43-201.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936). A Workers' Compensation case is decided on its merits. § 8-43-210. The ALJ's factual findings concern only the evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

3. 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. (2009). As found, claimant failed to prove by a preponderance of the evidence that he sustained a low back injury on February 11, 2009.

ORDER

It is therefore ordered that:

1. Claimant has failed to prove by a preponderance of the evidence that he sustained a work related low back injury on February 11, 2009. Claimant's claim for workers' compensation benefits is denied and dismissed.

DATED: March 24, 2010

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-768-347

ISSUE

Whether Claimant has established by a preponderance of the evidence that a second left shoulder surgery is a reasonable and necessary medical treatment designed to cure and relieve the effects of his industrial injury.

FINDINGS OF FACT

1. On July 3, 2008 Claimant suffered an admitted industrial injury to his left shoulder during the course and scope of his employment with Employer.

2. Employer initially directed Claimant to Authorized Treating Physician (ATP) Philip Smaldone, M.D. for medical treatment. However, Claimant requested a change of physician and was directed to alternative ATP Sander Orent, M.D. Dr. Orent determined that Claimant had suffered a rotator cuff tear that had not improved with conservative treatment. He thus referred Claimant to orthopedic surgeon Joseph Hsin, M.D. for a surgical consultation.

3. Dr. Hsin determined that Claimant suffered from a small, partial thickness rotator cuff tear. He thus performed a subacromial decompression and debridement of the partial tear on February 19, 2009. Dr. Hsin characterized the tear as "a small articularsided tear of the insertion of the supraspinatus tendon." He explained that he did not perform an open repair of the injury because the more conservative subacromial decompression and debridement was appropriate for Claimant's 10% rotator cuff tear.

4. On March 10, 2009 Claimant returned to light-duty work for Employer. He also underwent physical therapy for his left shoulder. Nevertheless, Claimant continued to suffer from persistent left shoulder pain. He thus underwent an MRI on July 31, 2009. The MRI revealed an enlargement of Claimant's rotator cuff tear. Dr. Hsin thus recommended a second left shoulder surgery.

5. Respondents denied Claimant's request for a second left shoulder surgery based on the opinion of F. Mark Paz, M.D. After performing an independent medical examination, Dr. Paz commented that the pathology identified on the July 31, 2009 MRI was not causally related to Claimant's July 3, 2008 industrial injury. Dr. Paz specified that there was

no mechanism of injury to explain why Claimant suffered an extension of his rotator cuff tear.

6. In an October 1, 2009 letter Dr. Orent expressed concerns about Dr. Paz's opinion. He initially noted that, because Dr. Paz was an occupational medicine physician, the opinion should not override the recommendation of orthopedic surgeon Dr. Hsin. Dr. Orent also remarked that Dr. Paz's opinion focused on the causation of Claimant's July 3, 2008 industrial injury instead of the need for a second left shoulder surgery. He noted that the initial cause of Claimant's left shoulder injury had already been determined.

7. Claimant underwent a second left rotator cuff surgery through his personal insurance with Dr. Hsin on October 8, 2009. Dr. Hsin explained through an evidentiary deposition that Claimant had suffered an extension of his original tear and characterized Claimant's condition as a "20 to 30 percent inner surface tear." He remarked that Claimant had not responded to a "simple debridement of the rotator cuff" and thus "would do much better with completion of the tear and reattachment of healthy tendon." Dr. Hsin summarized that Claimant required a second surgery because the first surgery had failed. He thus concluded that there was a direct causal connection between Claimant's industrial injury and the second surgery.

8. On November 10, 2009 orthopedic specialist James T. Johnson, M.D. conducted a records review of Claimant's condition. In addressing whether Claimant's left rotator cuff tear was causally related to his July 3, 2008 industrial injury, Dr. Johnson explained that he was "uncertain if [Claimant's] actual tear progressed from 20-40/50% or this simply occurred at the time of debriding of his rotator cuff." Dr. Johnson remarked that a second left shoulder surgery was appropriate for Claimant and that Dr. Hsin's standard rehabilitation procedure should be followed.

9. Dr. Paz testified at the hearing in this matter. He reiterated that there was no causal connection between Claimant's July 3, 2008 industrial injury and the need for a second left shoulder surgery. Dr. Paz explained that Claimant suffered from fraying in his left shoulder that was not caused by an acute injury. Instead, repeated rubbing on the clavicle caused the fraying. Dr. Paz summarized that there was no physical explanation for the increased tear in Claimant's left shoulder.

10. Claimant has demonstrated that it is more probably true than not that a second left shoulder surgery is a reasonable and necessary medical treatment designed to cure and relieve the effects of his industrial injury. Dr. Hsin persuasively explained that a second left shoulder surgery was causally related to Claimant's July 3, 2008 industrial injury. He remarked that Claimant had suffered an extension of his original tear and characterized Claimant's condition as a "20 to 30 percent inner surface tear." Dr. Hsin commented that Claimant had not responded to a debridement of the rotator cuff and required "completion of the tear and reattachment of healthy tendon." He summarized that the second surgery was required because of the failure of the first surgery. Moreover, Dr. Johnson did not dispute that the size of Claimant's surface tear had increased, but was uncertain whether the increase occurred at the time of the original debridement. In contrast, Dr. Paz concluded that there was no causal

connection between Claimant's industrial injury and the need for a second left rotator cuff surgery. However, his opinion is not persuasive because he simply could not identify a physical explanation for the increased size of the tear in Claimant's left shoulder. Finally, Dr. Orent noted that Dr. Paz incorrectly focused on the cause of Claimant's July 3, 2008 industrial injury instead of the need for a second left shoulder surgery. Therefore, Respondents are financially responsible for Claimant's second left shoulder surgery on October 8, 2009.

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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). The determination of whether a particular treatment modality is reasonable and necessary to treat an industrial injury is a factual determination for the ALJ. *In re of Parker*, W.C. No. 4-517-537 (ICAP, May 31, 2006); *In re Frazier,* W.C. No. 3-920-202 (ICAP, Nov. 13, 2000). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

5. As found, Claimant has demonstrated by a preponderance of the evidence that a second left shoulder surgery is a reasonable and necessary medical treatment designed to

cure and relieve the effects of his industrial injury. Dr. Hsin persuasively explained that a second left shoulder surgery was causally related to Claimant's July 3, 2008 industrial injury. He remarked that Claimant had suffered an extension of his original tear and characterized Claimant's condition as a "20 to 30 percent inner surface tear." Dr. Hsin commented that Claimant had not responded to a debridement of the rotator cuff and required "completion of the tear and reattachment of healthy tendon." He summarized that the second surgery was required because of the failure of the first surgery. Moreover, Dr. Johnson did not dispute that the size of Claimant's surface tear had increased, but was uncertain whether the increase occurred at the time of the original debridement. In contrast, Dr. Paz concluded that there was no causal connection between Claimant's industrial injury and the need for a second left rotator cuff surgery. However, his opinion is not persuasive because he simply could not identify a physical explanation for the increased size of the tear in Claimant's left shoulder. Finally, Dr. Orent noted that Dr. Paz incorrectly focused on the cause of Claimant's July 3, 2008 industrial injury instead of the need for a second left shoulder surgery. Therefore, Respondents are financially responsible for Claimant's second left shoulder surgery on October 8, 2009.

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 second left shoulder surgery on October 8, 2009.

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

DATED: March 25, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-695-093

ISSUES

Whether the low back surgeries performed by Dr. Roger Sung, M.D. were causally related to the admitted injury of June 1, 2006.

Whether Insurer is liable for the medical treatment received by Claimant and paid for by her private health insurer Tri-Care.

FINDINGS OF FACT

1. Claimant was employed at US Airways Group, Inc. as a passenger service agent. Claimant's duties involved working the ticket counter and transferring luggage onto a conveyor to be loaded onto aircraft.

2. Claimant has suffered prior injuries to her low back while working for Employer, including an injury on or about March 14, 2002 when Claimant was un-jamming a bag belt moving fencing equipment when she experienced a "pinch in her lower back". On or about April 3, 2004, Claimant suffered an injury while working for Employer. On the date of this incident, Claimant injured the middle and right side of her lower back after lifting bags.

3. Claimant suffered an admitted injury to her low back on June 1, 2006. On that date Claimant was moving a bag from a belt and noted an increase in her low back pain. Claimant did not immediately seek care for this injury. Subsequently, on July 23, 2006 Claimant was moving a bag off a rail on the jetway and suffered a marked increase in her low back pain.

4. Claimant was referred by Employer to Briargate Medical Clinic for treatment where she was evaluated on July 31, 2006 by Nurse Practitioner Michael Lafayette. Nurse Practitioner Lafayette noted a history of previous low back problems and that Claimant had previously had an MRI of the back. Nurse Practitioner Lafayette noted complaints of pain in the right hip into the right thigh and down to the right foot with numbness and tingling in the right foot and lower leg. Nurse Practitioner Lafayette prescribed medication and physical therapy and requested records from Claimant's prior treatment at Emergicare and from Air Force Academy and Peterson Air Force base medical facilities.

5. Dr. Roger Sung, M.D., an orthopedic surgeon, initially evaluated Claimant on September 7, 2006 upon referral from Dr. John Ogrodnick, M.D. of Broadmoor/Briargate Medical Clinic. Dr. Sung noted that Claimant had injured her back on June 1, 2006 doing lifting of heavy luggage at work. Dr. Sung reviewed an MRI of the lumbar spine done on July 24, 2006 at Air Force Academy Hospital that showed a posterior annulus rupture at L4-5 with a small amount of disk material extrusion and a posterior disk rupture at L5-S1 with herniation of a small amount of disk material. Dr Sung referred Claimant for an EMG.

6. Dr. William Griffis, M.D. performed an EMG on September 20, 2006 upon referral from Dr. Ogrodnick. Dr. Griffis found electrodiagnostic evidence of a right lumbosacral radiculopathy at the L5 level affecting the posterior myotomes.

7. Claimant previously underwent an MRI of the lumbar spine on April 28, 2004. The April 24, 2004 MRI revealed mild facet joint hypertrophy at L4-5 without definite features indicative of herniation of the nucleus pulposis. The L5-S1 level was normal.

8. Claimant returned to Dr. Sung for evaluation on October 18, 2006 following a right L5 nerve block. Dr. Sung noted that Claimant had continued right leg pain. Dr. Sung again reviewed the recent MRI scan and recommended an L4-5 decompression and fusion with interbody work.

9. Dr. Ogrodnick evaluated Claimant on December 26, 2006. Dr. Ogrodnick noted that Dr. Sung had recommended surgery that had not been authorized as being work related. Dr. Ogrodnick opined that the need for surgery should be considered part of Claimant's June 1, 2006 injury as the recent MRI had revealed the disc extrusion and separate herniation that were not present on the 2004 MRI. On January 24, 2007 Dr. Ogrodnick signed a medical report that included the notation "Please authorize surgery".

10. Dr. Ogrodnick again evaluated Claimant on February 28, 2007 and referred Claimant to Dr. Griffis for pain management control noting that there remained a dispute between Claimant's private health insurance, Tri-Care, and Insurer over authorization of the surgery recommended by Dr. Sung.

11. Dr. Sung performed surgery on April 2, 2007 consisting of an L4-5 decompression, L4-5 posterior column arthrodesis with L4-5 pedicle screw instrumentation.

12. Dr. Ogrodnick again evaluated Claimant on May 23, 2007. Dr. Ogrodnick reiterated his opinion that Claimant's surgery should be considered work related based on the 2006 MRI and EMG results. Dr. Ogrodnick did not treat Claimant after May 23, 2007 because the claim for workers' compensation benefits continued to be denied by Insurer.

13. Following the April 2007 surgery Claimant continued to be treated by Dr. Sung. Dr. Sung evaluated Claimant on April 26, 2007 and referred her to physical therapy on May 24, 2007. In November 2007 Dr. Sung referred Claimant to Dr. Ford for injections for chronic right buttock pain.

14. Prior to November 2007 Dr. Ford had treated Claimant with injections upon referral of Dr. James Bee, M.D. on August 17, 2006. Dr. Bee began evaluated Claimant on August 15, 2006 upon referral from Dr. Carroll, a military physician.

15. Nurse Practitioner Lafayette in became employed by Dr. David Richman, M.D. in March 2007 and evaluated Claimant on March 15, 2007 upon referral from Dr. Alexander, Claimant's primary care physician at Peterson Air Force base.

16. Dr. Brian J. Beatty, D.O. evaluated Claimant for an independent medical examination at the request of Respondents on February 5, 2008 and issued a report on that date. Dr. Beatty performed a lengthy review of medical records covering Claimant's treatment both before and after the June 1, 2006 work injury and performed a physical examination. Dr. Beatty specifically noted Claimant's history of low back pain and injury prior to June 1, 2006. Dr.

Beatty opined that in comparing the 2004 and 2006 MRI results a change in pathology in the lumbar spine could be seen. Dr. Beatty opined that there had been a new injury associated with the July 1, 2006 (sic) date of injury with new injury to L5-S1and L4-5 of posterior annular rupture. Dr. Beatty further noted that Claimant had an underlying grade I spondylolisthesis that was unstable and was the reason for a spinal fusion at L4-5. Dr. Beatty further opined that there had been both an aggravation of an underlying condition and a new injury from the July 1, 2006 (sic) injury.

17. Following Dr. Beatty's report Insurer filed a General Admission of Liability on March 13, 2006 admitting to a low back injury with a date of injury of June 1, 2006.

18. Dr. Sung again evaluated Claimant on August 7, 2008 and noted that Claimant had had severe bilateral buttock and thigh pain for the past two to three weeks. Dr. Sung reviewed an MRI scan that showed a new herniation at the L3-4 level above the level of the prior surgery. Dr. Sung recommended one epidural steroid injection and that if this did not improve Claimant's pain she would be a candidate for an L3-4 decompression and fusion.

19. Dr. Sung again evaluated Claimant on January 21, 2009. Dr. Sung noted the results of a new MRI scan from January 9, 2009 and recommended that because Claimant was having so much pain the further surgery would include extending the fusion to the L5- S1 level. Claimant underwent further surgery with Dr. Sung consisting of an L3 – S1 fusion.

20. Dr. Ogrodnick testified at hearing. In his testimony Dr. Ogrodnick opined that although initially he questioned if Claimant's condition was work related after comparison of the 2004 and 2006 MRI scans he felt it was clear that the disc pathology shown on the 2006 MRI was a consequence of the 2006 work injury and was consistent with the mechanism of bag from a belt. Dr. Ogrodnick opined that the surgery done by Dr. Sung in 2007 was reasonable, necessary and related to the June 1, 2006 injury. Dr. Ogrodnick testified that he agreed with the conclusions reached by Dr. Beatty. In explaining his opinion, Dr. Ogrodnick testified that disc herniations and extrusions were not usually part of the aging or degenerative process but were more likely from trauma or lifting.

21. Dr. Sung issued an office note dated November 1, 2006 in which he stated an opinion that Claimant's current condition and need for surgery were not work-related. In a subsequent letter dated May 9, 2007 Dr. Sung stated he would defer any conclusions on causation to Dr. Ogrodnick. In his deposition testimony Dr. Sung stated that he did not get into the details or subtleties of whether Claimant's condition was work related or not, that he was not the best person to make such a decision and that he simply didn't know if Claimant's condition was work-related or not.

22. Dr. Sung testified at deposition, and it is found, that if Claimant's original surgery to the L4-5 level was determined to be work related then the subsequent surgery extending the fusion from L3-4 to L5-S1 was work related because they were all part of the same issue and were

related.

23. At the request of Respondents Dr. Henry Roth performed an extensive review of medical records concerning Claimant's medical care and treatment both before and after the June 1, 2006 injury. Dr. Roth did not examine Claimant because she did not appear for the scheduled appointment.

24. Dr. Roth prepared a lengthy medical report and testified by deposition. Dr. Roth's essential opinion was that Claimant's low back condition and disc pathology represented entirely pre-existing degenerative changes that were wholly non-work related and that any need for surgery was not medically reasonable or appropriate under workers' compensation. Dr. Roth opined that there was no specific time or place of injury described for the July 1, 2006 (sic) injury. Although Dr. Roth opined that the need for surgery was not work-related, he opined that under the circumstances it was a reasonable procedure.

25. The ALJ finds the opinions of Dr. Ogrodnick and Dr Beatty concerning causation of Claimant's low back condition, disc pathology and the need for surgery as being work related to be more persuasive than the opinion of Dr. Roth. Dr. Sung's opinion from November 2006 is not persuasive as Dr. Sung later deferred to Dr. Ogrodnick and then effectively withdrew his opinion in his testimony. Claimant has proven by a preponderance of the evidence that the medical treatment received by Claimant from authorized physicians after July 31, 2006 and the surgeries performed by Dr. Sung in April 2007 and in early 2009 were causally related to the admitted work injury of June 1, 2006.

26. The ALJ finds that the authorized treating physicians are Broadmoor/Briargate Medical Clinic, Dr. Ogrodnick, Dr. Sung, Dr. Griffis and Dr. Ford subsequent to November 2007, and any referrals from these physicians made in the normal progression of authorized treatment. Dr. Ford was not an authorized physician prior to November 2007 until Claimant was referred to him by Dr. Sung at that time.

27. The physicians at Peterson Air Force base/Air Academy Hospital, Dr. James Bee, Dr. Richman/Nurse Practitioner Lafayette after March 15, 2007, and Dr. Ford prior to November 2007 were not authorized physicians.

CONCLUSIONS OF LAW

28. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 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*.

29. 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*.

30. 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).

31. 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).

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

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

34. The Claimant is required to prove by a preponderance of the evidence that the conditions for which she seeks medical treatment were proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(c), C.R.S. The Claimant must prove a causal nexus between the claimed disability and the work-related injury. Singleton v. Kenya Corp., 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. Duncan v. Industrial Claim Appeals Office, 107 P.3d 999 (Colo. App. 2004); H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990). However, the mere occurrence of symptoms at work does not require the ALJ to conclude that the duties of employment caused the symptoms, or that the employment aggravated or accelerated any pre-existing condition. Rather, the occurrence of symptoms at work may represent the result of or natural progression of a pre-

existing condition that is unrelated to the employment. See F.R. Orr Construction v. Rinta, 717 P.2d 965 (Colo. App. 1995); Cotts v. Exempla, Inc., W.C. No. 4-606-563 (August 18, 2005). 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).

35. 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).

36. 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).

37. Section 8-43-404(5)(a), C.R.S. contemplates that respondents will designate a physician who is willing to provide treatment without regard to non-medical issues such as the prospects for payment in the event the claim is ultimately denied. Lutz v. Industrial Claim Appeals Office, 24 P.3d 29 (Colo. App. 2000); Ruybal v. University of Colorado Health Sciences Center, 768 P.2d 1259 (Colo. App. 1988). However, the fact that an ATP stops providing treatment based on the medical determination that further treatment is not warranted does not automatically authorize the claimant to change physicians. Rather, the claimant must seek applicable statutory remedies such as submitting a request for a change of physician or seeking a DIME. See Bilyeu v. Babcock & Wilcox Inc., W.C. No. 4-349-701 (July 24, 2001), aff'd., Bilyeu v. Industrial Claim Appeals Office, (Colo. App. No. 01CA1505, April 11, 2002) (not selected for publication). Whether the ATP has refused to provide treatment for non-medical reasons is a question of fact for the ALJ. Ruybal v. University of Colorado Health Sciences Center, supra. If the designated treating physician refuses to treat the claimant for non-medical reasons, the respondents' duty to select a replacement physician arises immediately upon knowledge that the designated physician has refused to treat. If a replacement physician is not selected, the right of selection of an authorized physician passes to the claimant. Tellez v. Wal-Mart Stores Inc., W.C. No. 4-413-780 (ICAO July 20, 2000).

38. The ALJ has authority to determine the proper payor for medical expenses and to enter an order requiring a workers' compensation insurer to reimburse another insurance carrier for medical expenses paid by that carrier that are the liability of the workers' compensation insurer. See, *Oxford Chemicals Inc. v. Richardson,* 782 P.2d 843, (Colo. App.

1989).

39. As found, Claimant has proven by a preponderance of the evidence that her low back condition and resultant disc pathology at the L3-4 through L5-S1 levels is causally related to the June 1, 2006 injury and that the medical treatment from authorized providers and the surgeries performed by Dr. Sung were reasonable, necessary and related to the June 1, 2006 injury.

40. The ALJ has considered the lengthy and detailed report and opinions of Dr. Roth. As found, Dr. Roth's essential opinion is that none of Claimant's low back condition is work related. Dr. Roth's analysis is not persuasive on the issue of causation as it is more directed at the issue of whether Claimant sustained any injury related to her work with Employer, i.e. an issue of compensability. The issues of causation and compensability although often intertwined are, however, separate and distinct. Compensability is not at issue here as Insurer has admitted that Claimant sustained a compensable injury on June 1, 2006. Dr. Roth focuses his analysis and opinion towards stating that no injury occurred. The ALJ is not persuaded that Dr. Roth provided a real analysis of the issue of causation as opposed to his clearly strongly held opinion that none of Claimant's low back problems are work related. Dr. Roth denies that there had been any interval change in Claimant's condition after the June 1, 2006 injury despite the changes between the 2004 MRI and the 2006 MRI noted by Dr. Ogrodnick and Dr. Beatty and which are evident to the ALJ in comparing the reports of these two diagnostic studies. At one point in his testimony, Dr. Roth even acknowledged that the concept of an annular tear implied an acute and traumatic event, although such tears also are present in the asymptomatic population and by themselves are not indicative of trauma. Here, there this an admitted traumatic incident at work. Dr. Roth's analysis is more applicable to a cumulative trauma or repetitive motion type injury than the acute injury involved here. As found, the opinions of Dr. Ogrodnick and Dr. Beatty are more persuasive on the issue of causation than the opinion of Dr. Roth. Dr. Sung's opinion is persuasive on the issue of the relatedness of Claimant's second fusion procedure done by Dr. Sung and there is no persuasive evidence in the record to contradict this opinion.

41. Although it is not clear from the record, the ALJ infers that Employer referred Claimant to Broadmoor/Briargate Medical Center and Dr. Ogrodnick once Employer was made aware by Claimant that she had sustained a work injury which necessitated medical treatment. Thus, Claimant's medical care with military physicians prior to July 31, 2006 was unauthorized treatment for which Insurer is not liable. Similarly, Claimant's continued treatment with these physicians and their referrals was also unauthorized care for which Insurer is not liable. Although Dr. Ogrodnick did not continue to treat Claimant after May 23, 2006, Dr. Sung, an authorized physician, did continue to provide treatment to Claimant. Because Dr. Sung as an authorized physician continued to treat Claimant, the right of selection of the authorized physician did not pass to Claimant during the pendency of the denial of Claimant's claim.

42. No evidence was offered at hearing regarding the specific medical expenses paid by Claimant's health insurer, Tri-Care, or by Claimant herself. The ALJ therefore is without sufficient evidence to order reimbursement of specific medical expenses to Tri-Care or to Claimant other than the reimbursement of any medical expenses from the authorized physicians that was paid for by Tri-Care.

ORDER

It is therefore ordered that:

1. Insurer shall pay the medical expenses from Broadmoor/Briargate Medical Clinic, Dr. Ogrodnick, Dr. Sung, Dr. Griffis, and Dr. Ford subsequent to November 2007 and their referrals in accordance with the Official Medical Fee Schedule of the Division of Workers' Compensation.

2. Insurer shall reimburse Claimant's health insurer, Tricare, in accordance with the Official Medical Fee Schedule of the Division of Workers' Compensation, for the amount of medical expenses paid by Tricare from authorized physicians and their referrals.

3. Claimant's claim for medical benefits for the treatment provided by Peterson Air Force base clinic, Air Academy Hospital, Dr. James Bee, M.D., Dr. Ford prior to November 2007 and Dr. Richman/Nurse Practitioner Lafayette is denied and dismissed.

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: March 29, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-767-068

ISSUES

Whether Respondents have proven by a preponderance of the evidence that Claimant is precluded from receiving Temporary Total Disability (TTD) benefits beginning on April 7, 2009 because she was responsible for her termination from employment under §8-42-105(4) C.R.S

and §8-42-103(1)(g) C.R.S. (collectively "termination statutes").

STIPULATION

The parties agreed that Claimant earned an Average Weekly Wage (AWW), including health insurance benefits, of $807.33.

FINDINGS OF FACT

1. Claimant initially began working for Employer on December 15, 2006 but left to pursue other employment on June 15, 2007. On July 9, 2007 Claimant returned to work for Employer in the promotional products division as a production process auditor. On August 8, 2009 she was temporarily promoted to a supervisory position that involved overseeing the work of high school students.

2. In October of 2007 Claimant received a written warning for multiple violations of company policy regarding computer use and security. The violations were detailed in a November 6, 2007 employee warning notice and included failure to secure her computer when she was away from her desk.

3. On March 10, 2008 Claimant returned to her non-supervisory position performing customer service duties in the promotional products division.

4. On July 30, 2008 Claimant suffered admitted industrial injuries to her right knee, back and neck during the course and scope of her employment with Employer. She slipped on hand sanitizer that had been spilled on the floor.

5. Claimant returned to modified employment after her injuries. On August 6, 2008 Claimant was scheduled to visit a medical provider for her injuries. She reported to supervisor -MA- that she would call after the appointment and update her status for the remainder of the day so coverage of her duties could be arranged. However, Claimant failed to contact Employer. Therefore, on August 7, 2008 Claimant received a write-up for failing to contact Employer on the prior day. Claimant signed the write-up and checked the box that she "agreed with Employer's Statement" that she was a no call/no show the prior day.

6. Ms. -MA- testified at the hearing in this matter. She stated that Employer forced her to write-up Claimant on August 7, 2008 and she did not agree with the action. In contrast, Ms. -MA- noted that she always had notice of Claimant's medical appointments. She also commented that she was hired to terminate Claimant and several other employees.

7. On August 22, 2008 Employer conducted a team meeting and announced that there would be higher levels of accountability for the department. Ms. -MA- was expected to be responsible for the higher level of accountability in the promotional products division. At the meeting Employer informed Claimant and a coworker that a professional atmosphere was expected. There would be no more shouting, singing, throwing toys, bickering and vulgarity

that had been tolerated by prior supervisors. All who attended the meeting agreed that the unprofessional environment had contributed to errors and that changes were necessary. Claimant expressed her support for the changes.

8. Despite the August 22, 2008 meeting Claimant received an oral warning on August 29, 2008. Employer noted that Claimant's attitude problems had made coworkers feel uncomfortable. Claimant acknowledged that she was aware of the problem and would improve her attitude.

9. On August 29, 2008 Claimant also underwent her annual review. Employer reminded Claimant that she had made errors that caused financial concerns and damaged Employer's reputation. Claimant had "dropped the ball on a few orders that have created larger problems for the department and the company." There were systems in place that would have prevented the errors or caught them more quickly, but Claimant declined to follow Employer's procedures. Claimant also failed to follow company policy regarding the entry of computer data. Claimant's problems with orders were documented in warnings.

10. The performance review also specified that Claimant needed to improve her work efficiency because she took longer than necessary to complete tasks. Employer also noted Claimant's problems with management and specified:

> [Claimant] has always been very respectful of her previous manager, but sometimes crossed the line in appropriateness for most employment environments. [Claimant] has a new manager now and that has been a tense situation. [Claimant] should accept the changes occurring and embrace them as a positive change for her and the company.

CFO and COO of Employer Red Jordan commented on Claimant's performance review that Claimant could "rise from the ashes of this review and become the superstar she is capable [of becoming]."

11. On September 5, 2008 Claimant and a coworker met with Human Resources Director -PE- and CEO -SC- to discuss their job performances and supervisor. Mr. -PE- and Mr. -SC- advised Claimant and her coworker that they exhibited poor attitudes. Mr. -PE- and Mr. -SC- also informed Claimant and her coworker that they could leave employment or improve their department through accepting changes in processes and procedures. Claimant chose to continue working for Employer.

12. On September 11, 2008 Claimant received additional warnings for failure to timely return from a medical appointment and leaving her computer unsecured.

13. On February 6, 2009 Employer terminated Ms. -MA- from employment. -HN- was promoted to manage Employer's promotional products division. Claimant and her coworkers were advised of the changes and informed that under Ms. -MA-' supervision the department had made insufficient progress.

14. Ms. -HN- testified at the hearing in this matter and identified key problems in her department. She noted that Claimant had failed to document in the computer system the specifics of orders placed with the department. Ms. -HN- communicated regularly with Claimant regarding her need to better document her orders so that the production department could accurately complete the orders. She commented that she worked with Claimant for two months regarding the proper documentation of orders. Ms. -HN- attempted to motivate Claimant and warned her that failing to follow required procedures would lead to her termination. She e-mailed Claimant with a number of concerns including mistakes with shipping information, documentation, proofing, billing information and meeting deadlines.

15. During March 2009 Claimant made a series of mistakes in properly entering order information into her computer system. In one order Claimant failed to document the amount a customer should be billed for shipping. In another order Claimant entered a delivery date that could not be fulfilled. Claimant also continued to have problems entering the correct e-mail for customers' paperless billing. In another order Claimant failed to update the correct credit card number on an account. Finally, on April 1, 2009 Claimant repeated an earlier mistake she had made regarding shipments to Canada and the time required for delivery.

16. On April 7, 2009 Claimant was terminated from employment with Employer. Ms. -HN- remarked that she and Mr. -JD- made the decision to terminate Claimant. She explained that Claimant was terminated because she failed to properly follow Employer's processes and procedures. Ms. -HN- specified that Claimant failed to follow-up with customers and correctly enter date into the computer system. She also commented that she had detailed her concerns in e-mails to Claimant.

17. Mr. -PE- also testified regarding Claimant's termination from employment. He reiterated that Claimant was terminated because of her failure to follow Employer's processes and procedures. Mr. -PE- specified that Claimant had a history of difficulties following procedures.

18. On January 21, 2009 Claimant reached Maximum Medical Improvement (MMI) for her July 30, 2008 industrial injuries. Respondents subsequently filed a Final Admission of Liability (FAL) consistent with the MMI determination. However, Claimant challenged the FAL and sought a Division Independent Medical Examination (DIME). On July 27, 2009 the DIME physician concluded that Claimant had not reached MMI. Respondents filed a General Admission of Liability (GAL) consistent with the DIME determination. Claimant has subsequently received medical treatment based on the DIME physician's recommendations.

19. Claimant testified at the hearing in this matter. She explained that she was terminated from employment with Employer because of her work-related injuries. Claimant specified that she had received write-ups more frequently after her injuries and did not agree with the information in the write-ups. She acknowledged that she occasionally had difficulties with processing credit card payments, but noted that coworkers also committed similar errors because of Employer's procedures. Claimant commented that she requested website training

but was largely ignored. She remarked that she was trying to improve her performance and attitude at the time of her termination.

20. Respondents have demonstrated that it is more probably true than not that Claimant committed a volitional act or exercised some control over her April 7, 2009 termination from employment with Employer. The record reveals that Claimant received numerous warnings regarding her work habits and attitude in the performance of her job duties. An August 29, 2008 annual performance review reflects that Claimant had made errors that cost Employer financially and damaged Employer's reputation. Claimant failed to follow proper procedures or company policy regarding the entry of computer information. The performance review also documented that Claimant needed to improve her work efficiency and relationship with management. Ms. -HN- explained that she worked with Claimant for two months regarding the proper documentation of orders. She also e-mailed Claimant with a number of concerns including mistakes with shipping information, documentation, proofing, billing information and meeting deadlines. Finally, during March 2009 Claimant made a series of mistakes regarding the proper entry of order information into her computer system.

21. On April 7, 2009 Claimant was terminated from employment with Employer. Ms. -HN- explained that Claimant was terminated because she failed to properly follow Employer's processes and procedures. She specified that Claimant did not follow-up with customers or correctly enter data into the computer system. Mr. -PE- reiterated that Claimant was terminated because of her failure to follow Employer's processes and procedures. He remarked that Claimant had a history of difficulties following procedures. Although Claimant explained that she was terminated from employment because of her work-related injuries and did not agree with the information in her write-ups, the record reveals that Claimant was terminated for her job performance and inability to follow Employer's procedures. Accordingly, Claimant precipitated her termination by a volitional act that she would reasonably expect to cause the loss of employment.

CONCLUSIONS OF LAW

1. 1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues

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

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

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

5. As found, Respondents have demonstrated by a preponderance of the evidence that Claimant committed a volitional act or exercised some control over her April 7, 2009 termination from employment with Employer. The record reveals that Claimant received numerous warnings regarding her work habits and attitude in the performance of her job duties. An August 29, 2008 annual performance review reflects that Claimant had made errors that cost Employer financially and damaged Employer’s reputation. Claimant failed to follow proper procedures or company policy regarding the entry of computer information. The performance review also documented that Claimant needed to improve her work efficiency and relationship with management. Ms. -HN- explained that she worked with Claimant for two months regarding the proper documentation of orders. She also e-mailed Claimant with a number of concerns including mistakes with shipping information, documentation, proofing, billing information and meeting deadlines. Finally, during March 2009 Claimant made a series of mistakes regarding

the proper entry of order information into her computer system.

6. As found, on April 7, 2009 Claimant was terminated from employment with Employer. Ms. -HN- explained that Claimant was terminated because she failed to properly follow Employer's processes and procedures. She specified that Claimant did not follow-up with customers or correctly enter data into the computer system. Mr. -PE- reiterated that Claimant was terminated because of her failure to follow Employer's processes and procedures. He remarked that Claimant had a history of difficulties following procedures. Although Claimant explained that she was terminated from employment because of her work-related injuries and did not agree with the information in her write-ups, the record reveals that Claimant was terminated for her job performance and inability to follow Employer's procedures. Accordingly, Claimant precipitated her termination by a volitional act that she would reasonably expect to cause the loss of employment.

ORDER

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

1. Claimant earned an AWW of $807.33.

2. Claimant is not entitled to receive TTD benefits subsequent to April 7, 2009 because she was responsible for her termination from employment.

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

DATED: March 29, 2010.

Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-205-967

ISSUES

Respondents allege a mutual mistake of material fact in the settlement agreement and seek reformation of that agreement.

FINDINGS OF FACT

1. Claimant was injured in a work-related accident on January 28, 1994.

2. Claimant and Respondents entered into negotiations for the settlement of Claimant's workers' compensation claim. On November 30, 2001, at the request of Mid Century Insurance Company, Carter at Ringler Associates faxed a November 28, 2001, settlement proposal to Claimant's attorney. The settlement proposal provided the following payments:

a. $50,000 cash paid up front to Claimant;

b. $1,119.21 per month for 5 years, payable from January 17, 2002, through December 17, 2006;

c. $5,000 cash to fund a Custodial Medical Agreement;

d. $622.94 per month for 7 years and 11 months for prescriptions, payable January 17, 2002, through November 17, 2009; and

e. $133.26 per month for 22 years and 11 months for medical services, payable January 17, 2002, through November 17, 2024.

3. The total cost of the settlement was $186,999 which was broken down as follows: $50,000 cash paid up front to Claimant; $5,000 to fund the Custodial Medical Agreement; and $131,999 to purchase the annuities. The annuities were ultimately purchased for $132,000 for a total settlement cost of $187,000.

4. In a December 4, 2001, letter to Slade of Mid Century Insurance Company, Claimant's attorney stated that "[Claimant] has instructed me to accept the settlement offer of $187,000.00 with benefits to be paid as outlined in the settlement proposal from Ringler Associates dated November 28, 2001." Claimant's attorney requested that settlement documents be drafted incorporating the figures from the November 28, 2001, settlement proposal and sent to him immediately.

5. A letter confirming the settlement of the claim was sent by Ms. Carter to Ms. Slade. On December 7, 2001, Ms. Carter sent letters to Claimant's attorney and the attorney retained by Respondents to draft the settlement documents, confirming the terms of the settlement of Claimant's workers' compensation claim.

6. The annuity benefits were purchased by Mid Century Insurance Company for a cost of $132,000. Ms. Carter requested that the check for the annuity benefits be issued to Farmers New World Life Insurance Company. A check in the amount of $132,000 was issued on December 11, 2001, to purchase the annuities. Additionally, Ms. Carter requested that the check to fund the Medical Custodial Agreement be issued to "Medi-Bill, Inc. Custodian for [Claimant]." A check in the amount of $5,000 was issued on December 20, 2001, to "Medi-Bill, Inc. @ Custodian for [Claimant]" to fund the Medical Custodial Agreement.

7. Respondent Mid Century Insurance Company transferred its liability to Farmers New World Life Insurance Company to make the payments for Claimant's prescription and medical services annuity. The "Periodic Payment Reinsurance Agreement" states that "[Mid Century Insurance Company] cedes and [Farmers New World Life Insurance] assumes that portion of the liabilities of [Mid Century Insurance Company] for periodic payments for the claimant in the amounts set forth in the Addendum(s)." This agreement was executed on February 12, 2002, by Mid Century Insurance Company, Farmers New World Life Insurance Company, and Ringler Associates.

8. Claimant signed the settlement agreement on December 19, 2001, and the settlement was approved by an Administrative Law Judge on December 20, 2001. After the settlement was approved, Mid Century Insurance Company purchased the annuities to carry out the settlement agreement. For the annuities purchased as part of the settlement agreement, Claimant also signed the "Custodial Agreement for Future Medical Expenses of __" on December 19, 2001.

9. Long after the settlement was approved and after annuities were purchased, Respondents discovered what it considers to be two errors in the settlement agreement. Specifically, paragraphs 6(c)(2) and 6(c)(3) relating to the medical annuities were drafted with incorrect annuity dates. Respondents now seek to reform the settlement agreement to eliminate the typographical errors and correct the settlement agreement.

10. Slade testified credibly that the dates the annuity was to be paid in the settlement agreement were in error due to a mistake.

11. Claimant testified credibly that she wanted coverage to age 65, and that the reformation proposed by Respondents will not provide that coverage. Claimant testified persuasively that she did not make a mistake, that when she signed the settlement agreement she believed that she would received the payments provided for in that settlement agreement, and that she would not have signed the settlement agreement had it not provided for the annuity period as stated in the settlement agreement.

CONCLUSIONS OF LAW

A party to a settlement agreement may reopen the settlement agreement upon a showing of a mutual mistake of a material fact. Section 8-43-303(1), C.R.S. A mutual mistake is one that is reciprocal and common to both parties to an agreement, and both parties must share the same misconception as to the terms and conditions of the agreement. *See Maryland Casualty Co. v. Buckeye Gas Products Co.,* 797 P.2d 11 (Colo.1990).

Respondent presented persuasive testimony that they made a mistake. Claimant testified persuasively that she did not make a mistake, that when she signed the settlement agreement she believed that she would received the payments provided for in that settlement agreement. Respondents have not established by a preponderance of the evidence that there was a mutual mistake of material fact.

Further, there are no grounds in the Workers' Compensation Act for the relief that Respondents request. Respondent seek reformation of the settlement to reflect the amounts set forth in the letters exchanged between the attorneys for the parties. Those amounts were not written into the settlement agreement, were not signed by Claimant, and were not approved by an Administrative Law Judge as required by Section 8-43-204, C.R.S. If Respondents had shown a mutual mistake, the settlement agreement would have been reopened, not reformed. Claimant would be entitled to receive those benefits she was receiving immediately prior to the settlement approval.

ORDER

It is therefore ordered that Respondents request for reformation of the settlement agreement is denied.

DATED: *March 29, 2010*
Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-773-227

ISSUES

Did Claimant suffer an acute episode on or about August 24, 2008 resulting in a compensable claim for mental impairment under the Workers' Compensation Act of Colorado?

If so, is Claimant's major depressive order occurring in September 2009 compensable as being related to the August 24, 2008 incident?

FINDINGS OF FACT

1. Claimant was hired on January 2, 2008 as a Corrections Officer I with the Respondent-Employer. All new hires began employment on the night shift, which was a training shift.

2. Claimant successfully completed training at the Academy in January and February 2008. The courses he passed included Use of Force, Restraints/Transports, and Forced Cell Moves.

3. By May or June 2008, Claimant found the job boring and he would drink alcohol before he went in to work. He continued to binge drink beer and tequila in the summer of 2008.

4. On August 25, 2008, Claimant experienced an anxiety attack during a forced cell entry, a procedure during which the correctional officers suit up with a facemask, body armor, and

shield and remove an inmate through force. Claimant was seen that night at the emergency room of St. Thomas More Hospital in Canon City and diagnosed with an acute anxiety reaction.

5. Diane Alvies saw Claimant at CCOM in Canon City on August 27, 2008. At that time, he was placed at maximum medical improvement with no permanent impairment.

6. On October 1, 2008, Ms. Alvies again saw Claimant because of two more anxiety attacks, one at work and one at the dentist's office. At that visit, he was given a permanent restriction of no use of any equipment that covers his face.

7. On November 18, 2008, Dr. David Hopkins, a neuropsychologist, saw Claimant. Dr. Hopkins' report mentions an October 1, 2008 panic attack while practicing using a self-contained breathing apparatus (SCBA) in the prison yard. Dr. Hopkins states that the Claimant presented with a fair amount of underlying and overt anger toward the situation at work due to the facemask restriction. The doctor diagnosed specific phobia and features of histrionic personality style.

8. The Claimant was administratively separated from his employment at the Respondent-Employer's on November 25, 2008. He filed a complaint with the state personnel board and settled his employment claims by agreeing to return to work on the same shift as of December 8, 2008.

9. In early 2009, the Respondent-Employer transferred Claimant to a lower security facility. While employed there, the Claimant did, on one occasion, successfully complete a training exercise wearing the SCBA.

10. The Claimant was admitted to Parkview Medical Center on September 17, 2009 for major depression and chronic alcohol abuse with suicidal ideation. The records document a drinking history of 1 ½ to 2 cases of beer and 2 to 3 pints of tequila per week. In the social history given to Eileen Spangler in the psychiatric history and physical section, it indicates that the Claimant's job with the Respondent-Employer is boring, the inactivity is very difficult for him, and working night shift is becoming increasingly difficult. It also indicated that he is not working "up to his potential, but lacks motivation" to change his situation.

11. In the Parkview Behavioral Medicine Clinical Notes, it states, "He did state that he most likely [will] not return to work at the prison as he felt that it is not just the shift but the entire career choice that he is not happy with."

12. On October 8, 2009, Dr. Steven Martin's progress note states "Reports doing well."

13. Dr. Gary Gutterman performed an independent medical examination of the Claimant on December 8, 2009. It was Dr. Gutterman's opinion that the August 25, 2008 anxiety attack and the September 2009 major depressive episode were due to a variety of stressors specific to the Claimant, i.e., excessive alcohol consumption, lack of sleep, unhappiness with the type

of work he was doing and the atmosphere at the DOC.

CONCLUSIONS OF LAW

1. This claim is governed by the mental impairment statute, C.R.S. 8-41-301(2), which defines "mental impairment" as "a recognized, permanent disability arising from an accidental injury arising out of the and in the course of employment when the accidental injury involves no physical injury and consists of a psychologically traumatic event that is generally outside of a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. A mental impairment shall not be considered to arise out of and in the course of employment if it results from . . . a job transfer taken in good faith by the employer. The mental impairment that is the basis of the claim shall have arisen primarily from the claimant's then occupation and place of employment to be compensable."

2. The Supreme Court of Colorado held, in *Davison v. ICAO*, 84 P.3d 1023 (2004), "Specifically, the expert must establish that the claimant has a recognized, permanent disability resulting from a psychologically traumatic event" under 8-41-301(2), at 1026. Claimant has not proven that he has a recognized permanent disability. Although Nurse Alvies at CCOM gave him a permanent restriction of no use of equipment that covers his face on October 1, 2008, the Claimant did subsequently complete an exercise using the SCBA. Also, on October 8, 2009, Dr. Steven Martin's progress note states "Reports doing well." The ALJ finds that Claimant has not proven that he has a recognized permanent disability.

3. The Claimant has not satisfied the statutory requirement that he suffered a psychologically traumatic event outside of his usual experience and one that would evoke the same distress in other similar workers. The panic attack the Claimant experienced on August 25, 2008 stemmed from wearing a face mask during a work duty, which was a fundamental part of the job for which Claimant was hired as a correctional officer. It was not outside of the usual experience for that occupation; training in performing forced cell extractions was required to be completed before a person is hired as a corrections officer. The Claimant successfully completed this training.

4. The measure of what is stressful for a typical employee is determined by comparison to the requirements in that particular occupation. In *Hughes-Choyce v. The Children's Hospital*, W.C. 4-444-713 (ICAO October 24, 2002), the Panel held that the question of whether the traumatic event would evoke symptoms of distress in a worker in similar circumstances is a question of fact to be judged on an objective worker with the experience, training and duties similar to the Claimant's.

5. There was no evidence presented by the Claimant that any other coworkers had a panic attack requiring a trip to the emergency room from the wearing of a facemask during a forced cell extraction.

6. The ALJ finds Dr. Gutterman more credible on the above issue. He found that the

Claimant's panic attack was due to stressors specific to him. Claimant has not satisfied the statutory requirement the event was outside of his usual work experience as a correctional officer or that a similarly situated employee would experience a panic attack.

7. The aspect of this claim involving Claimant's major depression, suicidal ideation, and excessive drinking, which he blamed on working nights, is not compensable and does not satisfy any element of the mental impairment statute. Working a night shift is not a psychologically traumatic event but was a condition of employment for which Claimant voluntarily applied for and affirmed his willingness to perform. Had the Claimant remained at work, he would have eventually been moved to day shift as personnel changed.

8. Unhappiness with certain conditions of employment is common to all fields of employment, which also defeats the claim under C.R.S. 8-41-301(2)(c). The transfer of the Claimant to a new facility, which required him to start on night shift as a matter of seniority, was a good faith attempt by the Respondent-Employer to give him another chance in a lower security environment, and was the result of the Claimant's legal action to recover his job. Under C.R.S. 8-41-301(2)(a), the good faith transfer protects the employer from liability for this claim.

9. The Claimant has the burden of proving every element of a claim of mental impairment, and the failure to prove any one element is fatal to the claim. *U v. Carlin Dodge,* (Colo. App. No. 96CA0273, August 15, 1996). Claimant has not proven the elements of a mental impairment claim under the Worker's Compensation Act.

ORDER

It is therefore ordered that:

The Claimant's claims for compensation based on mental impairment arising out of and in the course of his employment with the Respondent-Employer is hereby denied and dismissed.

DATE: March 30, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-789-425

ISSUES

The issue determined herein is compensability of an occupational disease.

FINDINGS OF FACT

1. The Claimant worked for various employers for 34 years at the industrial plant in Pueblo now owned by the employer. For most of that time, he worked as a grinder; however, claimant worked for the employer only starting January 7, 2008, as a production supervisor. The Claimant's testimony dealt largely with the functions he performed as a grinder. This work was considerably different than the functions he performed as a supervisor for this employer. As a production supervisor, the Claimant used a grinder only for short periods of time to train new employees, particularly in September and October 2008. Even then, grinding was limited to a few minutes at a time during only a portion of a day and only over about a two-week period. He spent 50% of his time in the general "frog shop" area, but spent the other 50% of his work day in his office.

2. In contrast, the Claimant described his job for other employers as a grinder as one in which he would use an 8 inch grinder machine, weighing 35 pounds, to grind on metal in order to get it to fit correctly into the rail plates, or 'frogs', that were being assembled to modified steel train rails. The frog shop on the North side of the building had six to ten employees using power grinders and impact wrenches for the assembly. The grinding wheels, at least in later years, contained aluminum and zirconium. The grinding process generated a lot of dust. He would work at this job for his entire shift. Claimant would usually go home at the end of the day with his clothes dusty and covered with metal filings and with dust in his mouth and nose.

3. The fabrication shop on the West side of the building used cutters with drill and dye cutters that contained tungsten carbide with cobalt and zirconium. The Melin cutting tool was used in various places throughout the shop area. A planer/grinder machine located about 30 feet from claimant's grinding bench used a water-soluble oil coolant sprayed on the planning surface. Vapors from that spray were blown into claimant's grinding station.

4. Claimant did not smoke cigarettes and had no exposures outside his workplace to aluminum, tungsten carbide with cobalt, or zirconium dust. Two of claimant's sisters and one of his nephews suffered from lupus, autoimmune disease.

5. In August 2008, claimant began experiencing shortness of breath. He became weaker and lost stamina. He did not seek medical treatment at that time.

6. On October 30, 2008, claimant resigned his employment in order to begin work for Mills, where he worked only three weeks. He then returned to work for the employer on November 17, 2008, as Plate Shop Supervisor and then as Panel Supervisor.

7. In January 2009, claimant developed pneumonia and was hospitalized. He was seen by Dr. Harry Keefe. On February 19, 2009, Dr. Keefe noted that the computed tomography ("CT") scan showed diffuse ground glass opacities in claimant's lungs.

8. On March 12, 2009, Dr. Shapiro, a pulmonologist, examined claimant and diagnosed lung disease due to claimant's workplace exposure to manganese. On March 30, 2009, Dr. Shapiro opined that claimant's lung disease was due to manganese, dust, and grinding at work. He instructed claimant to avoid exposure to dust. Dr. Keefe then excused claimant from work after April 13, 2009. Claimant then reported his workers' compensation claim to the employer.

9. On April 16, 2009, the employer had an industrial hygiene study of selected stations, including claimant's old grinder table in the frog shop. The study of ambient air at claimant's former grinding station showed excess manganese and iron oxide. Tungsten carbide was not measured.

10. Dr. Keefe suspected lupus and referred claimant to Dr. Timms, a rheumatologist. Dr. Timms concluded that claimant did not suffer from lupus.

11. On May 11, 2009, Dr. Repsher, a pulmonologist, examined claimant upon referral by claimant's attorney. Claimant reported a history of working 28 years as a grinder and six years as a supervisor. He reported his grinder job involved grinding for 30 hours per week. Dr. Repsher reviewed Material Safety Data Sheets ("MSDS") provided by the employer and concluded that the grinding wheels used by claimant did not contain tungsten carbide or cobalt. He diagnosed pneumonitis, but no hard metal lung disease.

12. Dr. Repsher sent biopsy samples to Dr. Leslie at the Mayo Clinic. Dr. Leslie was of the opinion that claimant had interstitial inflammation and fibrosis. He thought that these findings were explained by autoimmune disease.

13. In June 2009, claimant was evaluated at National Jewish Hospital. Dr. Hamzeh noted that the medical literature did not associate manganese with interstitial lung disease. Dr. Mayer noted that claimant's history was that until the 1980's, he used grinding wheels composed of tungsten, cobalt, and tantalum. He also noted that manganese was not associated with interstitial lung disease. Dr. Mayer issued an addendum to his report, noting that the biopsy results were not consistent with hard metal lung disease. He noted that his history was that claimant used aluminum and zirconium grinding wheels. He did not think that claimant had zirconium-induced hypersensitivity pneumonitis.

14. In September 2009, claimant was hospitalized at Parkview Medical Center in Pueblo due to renal failure. In addition to using bottled oxygen for his breathing disability, he also undergoes dialysis for his kidney disease.

15. On November 9, 2009, Dr. Repsher wrote that he had reviewed additional MSDS and that cobalt-cemented tungsten carbide was used on cutters in the shop where claimant had worked as a grinder. In his subsequent deposition testimony, Dr. Repsher noted that dust in

one shop location could be moved to other parts of the building. Dr. Repsher reported that he also had become aware of a Mr. Schmitt dying from pulmonary fibrosis as a result of his exposures as a grinder in the same shop where claimant had worked. Dr. Repsher reported that the medical literature showed a wide spectrum of interstitial lung disease associated with hard metal dust. He thought it was unlikely to be mere coincidence that two employees in the same shop would contract a very rare lung disease.

16. In his deposition testimony, Dr. Repsher conceded that the lung biopsy looked like lupus pneumonitis. He agreed that claimant did not have a classic case of giant cell pneumonitis, but he thought that was not a necessary finding for hard metal lung disease. He agreed that hard metal lung disease could mimic lupus. He had not ruled out lupus in claimant's case, but the MSDS showing cobalt-cemented tungsten carbide convinced him that claimant had an occupational disease. He explained that cobalt or portions of cemented carbide could react with carbide, producing very high electrical charges on particles, leading to lung tissue injury.

17. On December 22, 2009, Dr. Mayer also wrote that she thought that Claimant's lung symptoms are consistent with exposure to cobalt/tungsten carbide, aluminum, and zirconium at work. She noted that claimant had elevated exposure levels at grinder table number two, had daily exposure for years as a grinder, and worked with a coemployee who also suffered interstitial lung disease. Dr. Mayer's report states that her opinion relates to exposures that Claimant sustained "over the course of 34 years."

18. Claimant has proven that he suffers from interstitial lung disease as a result of his many years of work for multiple employers as a grinder. The record evidence does not show that claimant suffers from lupus. Claimant, however, has not proven by a preponderance of the evidence that he sustained his occupational disease as a natural consequence of his work as a production supervisor. Claimant never worked as a grinder for this employer. The record evidence shows that claimant's lung disease is progressive. The finder of fact cannot infer that claimant's four plus years of work for this employer as a production supervisor involved exposure to sufficiently high levels of aluminum, tungsten carbide with cobalt, or zirconium dust so that it would cause his lung disease. He used a grinder only for short periods of time to train new employees. He spent 50% of his time in the general "frog shop" area, but spent the other 50% of his work day in his office. The medical opinions of Dr. Repsher, Dr. Mayer, and Dr. Shapiro all address the relationship between claimant's grinder employment and his lung disease. Those opinions are credible and persuasive, but those providers did not address the issue of causation due to claimant's supervisory employment.

CONCLUSIONS OF LAW

1. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers'

compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 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.; *C-M-x 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); *-E- 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). In *Monfort v. Rangel*, 867 P.2d 122 (Colo. App. 1993), the Court held that claimant must show that, while working for the employer, he sustained sufficient exposure to an injurious agent that, over time, would have caused his occupational disability. The test is the concentration of the exposure rather than the length of time of the exposure. Nevertheless, claimant must prove the requisite concentration of exposure. As found, he probably suffers from interstitial lung disease as a result of his many years of work for multiple employers as a grinder. He did not join as parties any previous employers for whom he worked as a grinder. As found, claimant has failed to prove by a preponderance of the evidence that he sustained his occupational disease as a natural consequence of his work as a production supervisor.

ORDER

It is therefore ordered that:

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

DATED: March 30, 2010

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-787-775

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered a compensable right shoulder injury on December 5, 2008 during the course and scope of his employment with Employer.

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

3. Whether Claimant has proven by a preponderance of the evidence that he is entitled to receive Temporary Total Disability (TTD) benefits for the period January 6, 2009 until February 18, 2009.

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

FINDINGS OF FACT

1. Employer is a distributor of pipe and steel materials. Claimant worked for Employer as a warehouse supervisor. His job duties involved ordering materials, climbing a ladder to check incoming and outgoing freight loads and supervising employees. Claimant earned $23.50 per hour for 40 hours each week. He thus earned an AWW of $940.00.

2. On December 5, 2008 Claimant was walking across Employer's parking lot to review an incoming truckload. He slipped on a piece of sheet metal that was covered with snow and fell on his right shoulder.

3. Claimant informed Operations Manager -A- that he had injured his right shoulder after he slipped and fell in Employer's parking lot. Claimant initially declined Mr. -A-'s offer to visit Workers' Compensation provider Concentra Medical Centers (Concentra) for his injury.

4. Claimant returned to work after the fall but continued to experience right shoulder pain. He thus again visited Mr. -A- and stated that he wanted to receive medical treatment. Claimant explained that he did not want to visit Concentra because he was concerned about its treatment of injured workers and he would receive the "run around." He stated that he would locate a shoulder specialist in the phone book and Mr. -A- replied "that is fine." Claimant chose

Michael Bagley, D.O.

5. On December 8, 2008 Claimant visited Dr. Bagley for an evaluation. Claimant reported that his shoulder had been bothering him for several months but his pain had increased over the last two months. He explained that the right shoulder was more painful, stuck and would not move. Claimant stated that both “shoulders are pretty much useless.” Dr. Bagley determined that Claimant suffered from left shoulder “impingement syndrome with rotator cuff tendinopathy,” right-sided “adhesive capsulitis (severe)” and right-sided “mild adhesive capsulitis.” He recommended an MRI of both shoulders.

6. On December 12, 2008 Claimant underwent an MRI. The MRI revealed a right rotator cuff tear. Dr. Bagley recommended a right shoulder surgical repair.

7. Claimant explained that he discussed the recommended shoulder surgery with Mr. -A-. Mr. -A- authorized Claimant to undergo right shoulder surgery. He also stated that Claimant would receive six weeks of paid vacation/sick leave for the period January 6, 2009 through February 18, 2009.

8. On January 6, 2009 Claimant underwent right shoulder rotator cuff surgery with Dr. Bagley. Claimant wore a right arm sling from January 6, 2009 through February 18, 2009 and was unable to perform his job duties for Employer.

9. Claimant’s January 6, 2009 surgery did not improve his right shoulder condition. On March 18, 2009 Claimant underwent a right shoulder MRI. The test revealed a full thickness right rotator cuff tear. Dr. Bagley recommended a second right shoulder surgery.

10. On March 18, 2009 Claimant told Mr. -A- that he might require a second right shoulder surgery. Mr. -A- responded that Claimant did not have any more vacation or sick leave. He thus filed a Workers’ Compensation claim and directed Claimant to Concentra.

11. On March 19, 2009 Mr. -A- completed a First Report of Injury. He noted that Claimant slipped and fell at work on December 5, 2008.

12. On March 19, 2009 Claimant visited Glenn Peterson, PA for an evaluation. PA Peterson noted that Claimant had slipped and fallen at work on December 5, 2008. He explained, “[i]nitially, this was done under [Claimant’s] own insurance not on worker’s comp and now they are trying to get it done under worker’s comp.” PA Peterson determined that Claimant had suffered a right shoulder rotator cuff tear, undergone surgery and experienced a re-tear. After reviewing Claimant’s history and performing a physical examination PA Peterson concluded that there was a greater than 50% probability that Claimant’s right shoulder condition was work-related.

13. On March 20, 2009 Claimant returned to Dr. Bagley for an evaluation. Dr. Bagley noted that Claimant’s MRI revealed a re-tear of the right supraspinatus. He recommended a repeat rotator cuff repair. Dr. Bagley specifically suggested a full open procedure with an

augmentation repair.

14. Claimant continued to receive conservative treatment for his right shoulder condition through Concentra. Work restrictions included no lifting, pushing or pulling in excess of five pounds with the right arm.

15. On December 14, 2009 Claimant underwent an independent medical examination with John S. Hughes, M.D. Dr. Hughes conducted a physical examination and reviewed Claimant's medical history. He commented that Claimant had "emerging symptoms of bilateral shoulder pain at the time he was injured in a fall at work on December 5, 2008." Dr. Hughes noted that Claimant's December 5, 2008 slip and fall caused a complete right shoulder rotator cuff tear that required surgical repair. He remarked that Claimant "has sustained a re-tear of the rotator cuff in the right shoulder, and this has probably occurred as a natural progression of the work-related injury." Dr. Hughes concluded that Claimant had not reached Maximum Medical Improvement (MMI) because he required a right shoulder rotator cuff repair.

16. Claimant has demonstrated that it is more probably true than not that he injured his right shoulder during the course and scope of his employment with Employer on December 5, 2008. Claimant credibly explained that he was walking across Employer's parking lot to review an incoming truckload. He slipped on a piece of sheet metal that was covered with snow and fell on his right shoulder. Claimant reported his shoulder injury to Mr. -A-. He visited Dr. Bagley on December 8, 2008 and reported that his shoulders had been bothering him for several months. However, he explained that his right shoulder was more painful, stuck and would not move.

17. Claimant underwent a right rotator cuff repair but the procedure did not improve his shoulder condition. A subsequent MRI revealed a full thickness right rotator cuff re-tear. On March 19, 2009 Claimant underwent an evaluation with PA Peterson. After reviewing Claimant's history and performing a physical examination PA Peterson concluded that there was a greater than 50% probability that Claimant's right shoulder condition was work-related. Dr. Hughes also concluded that Claimant's December 5, 2008 slip and fall caused a complete right shoulder rotator cuff tear that required surgical repair. He remarked that Claimant "has sustained a re-tear of the rotator cuff in the right shoulder, and this has probably occurred as a natural progression of the work-related injury." Although the record reveals that Claimant suffered from shoulder problems prior to his December 5, 2008 slip and fall, the incident aggravated, accelerated, or combined with the pre-existing condition to produce a need for medical treatment.

18. Claimant has established that it is more probably true than not that he received authorized medical treatment that was reasonable and necessary to cure or relieve the effects of his right shoulder injury. On December 5, 2008 Claimant reported his injury to Mr. -A-. Mr. -A- authorized Claimant to obtain treatment from shoulder specialist Dr. Bagley. Dr. Bagley subsequently performed a right rotator cuff repair but Claimant continued to experience right shoulder symptoms. On March 18, 2009 Claimant told Mr. -A- that he might require a second right shoulder surgery. Mr. -A- filed a Workers' Compensation claim and directed Claimant to

Concentra. Dr. Bagley recommended a repeat rotator cuff repair. As noted by Dr. Hughes, Claimant's need for a second surgery occurred as a natural progression of the December 5, 2008 slip and fall. Therefore, all of the medical treatment Claimant obtained through Dr. Bagley and Concentra was reasonable, necessary and related to his December 5, 2008 industrial injury. Furthermore, the proposed second right rotator cuff repair surgery is reasonable and necessary to cure or relieve the effects of Claimant's industrial injury.

19. Claimant has proven that it is more probably true than not that he is entitled to receive TTD benefits for the period January 6, 2009 through February 18, 2009. On January 6, 2009 Claimant underwent right shoulder rotator cuff surgery with Dr. Bagley. Claimant wore a right arm sling from January 6, 2009 through February 18, 2009 and was unable to perform his job duties for Employer. Claimant has thus demonstrated that his December 5, 2008 industrial injury caused a disability that contributed to a subsequent wage loss.

CONCLUSIONS OF LAW

1. 1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

Compensability

4. For an injury to be compensable under the Act, it must "arise out of" and "occur within the course and scope" of employment. *Price v. Industrial Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. § 8-

41-301(1)(c) C.R.S.; *Faulkner v. Industrial Claim Appeals Office,*12 P.3d 844, 846 (Colo. App. 2000). The question of causation is generally one of fact for determination by the ALJ. *Faulkner,* 12 P.3d at 846.

5. 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 demonstrated by a preponderance of the evidence that he injured his right shoulder during the course and scope of his employment with Employer on December 5, 2008. Claimant credibly explained that he was walking across Employer's parking lot to review an incoming truckload. He slipped on a piece of sheet metal that was covered with snow and fell on his right shoulder. Claimant reported his shoulder injury to Mr. -A-. He visited Dr. Bagley on December 8, 2008 and reported that his shoulders had been bothering him for several months. However, he explained that his right shoulder was more painful, stuck and would not move.

7. As found, Claimant underwent a right rotator cuff repair but the procedure did not improve his shoulder condition. A subsequent MRI revealed a full thickness right rotator cuff re-tear. On March 19, 2009 Claimant underwent an evaluation with PA Peterson. After reviewing Claimant's history and performing a physical examination PA Peterson concluded that there was a greater than 50% probability that Claimant's right shoulder condition was work-related. Dr. Hughes also concluded that Claimant's December 5, 2008 slip and fall caused a complete right shoulder rotator cuff tear that required surgical repair. He remarked that Claimant "has sustained a re-tear of the rotator cuff in the right shoulder, and this has probably occurred as a natural progression of the work-related injury." Although the record reveals that Claimant suffered from shoulder problems prior to his December 5, 2008 slip and fall, the incident aggravated, accelerated, or combined with the pre-existing condition to produce a need for medical treatment.

Medical Benefits

8. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met her burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

9. As found, Claimant has established by a preponderance of the evidence that he

received authorized medical treatment that was reasonable and necessary to cure or relieve the effects of his right shoulder injury. On December 5, 2008 Claimant reported his injury to Mr. -A-. Mr. -A- authorized Claimant to obtain treatment from shoulder specialist Dr. Bagley. Dr. Bagley subsequently performed a right rotator cuff repair but Claimant continued to experience right shoulder symptoms. On March 18, 2009 Claimant told Mr. -A- that he might require a second right shoulder surgery. Mr. -A- filed a Workers' Compensation claim and directed Claimant to Concentra. Dr. Bagley recommended a repeat rotator cuff repair. As noted by Dr. Hughes, Claimant's need for a second surgery occurred as a natural progression of the December 5, 2008 slip and fall. Therefore, all of the medical treatment Claimant obtained through Dr. Bagley and Concentra was reasonable, necessary and related to his December 5, 2008 industrial injury. Furthermore, the proposed second right rotator cuff repair surgery is reasonable and necessary to cure or relieve the effects of Claimant's industrial injury.

TTD Benefits

10. Section 8-42-103(1), C.R.S. requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subsequent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997). To demonstrate entitlement to TTD benefits a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that she left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The term "disability," connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earning capacity as demonstrated by claimant's inability to resume her prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999).

11. As found, Claimant has proven by a preponderance of the evidence that he is entitled to receive TTD benefits for the period January 6, 2009 through February 18, 2009. On January 6, 2009 Claimant underwent right shoulder rotator cuff surgery with Dr. Bagley. Claimant wore a right arm sling from January 6, 2009 through February 18, 2009 and was unable to perform his job duties for Employer. Claimant has thus demonstrated that his December 5, 2008 industrial injury caused a disability that contributed to a subsequent wage loss.

AWW

12. Section 8-42-102(2), C.R.S. requires the Judge to determine a claimant's AWW based on her earnings at the time of injury. The Judge must calculate the money rate at which services are paid to the claimant under the contract of hire in force at the time of injury. *Pizza Hut v. ICAO,* 18 P.3d 867, 869 (Colo. App. 2001). However, §8-42-102(3), C.R.S. authorizes a Judge to exercise discretionary authority to calculate an AWW in another manner if the prescribed methods will not fairly calculate the AWW based on the particular circumstances. *Campbell v. IBM Corp.,* 867 P.2d 77, 82 (Colo. App. 1993). The overall objective in calculating

an AWW is to arrive at a fair approximation of a claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997). Therefore, §8-42-102(3), C.R.S. grants an ALJ substantial discretion to modify the AWW if the statutorily prescribed method will not fairly compute a claimant's wages based on the particular circumstances of the case. *In Re Broomfield,* W.C. No. 4-651-471 (ICAP, Mar. 5, 2007). As found, Claimant earned an AWW of $940.00.

ORDER

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

1. Claimant suffered a compensable right shoulder injury during the course and scope of his employment with Employer on December 5, 2008.

2. Claimant shall receive reasonable and necessary medical treatment, including a second right shoulder surgery, which is designed to cure or relieve the effects of his December 5, 2008 industrial injury.

3. Claimant shall receive TTD benefits for the period January 6, 2009 through February 18, 2009.

4. Claimant earned an AWW of $940.00.

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

DATED: March 30, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-778-988

ISSUES

1 Whether Claimant sustained an injury to his left shoulder and neck while in the course and scope of his employment;

2 Whether Claimant is entitled to medical benefits to treat the injuries;

3 Whether Claimant is entitled to temporary total disability (TTD) benefits;

4 Whether Claimant was responsible for the termination of his employment with Employer; and

5 Whether Respondents are entitled to offsets due to Claimant's receipt of Social Security Disability payments.

FINDINGS OF FACT

1. Claimant is a 22-year old former employee of Employer. Employer hired him hired as a Welding Assistant/Laborer on November 10, 2008. The Claimant worked at least 40 hours per week and he received $12.00 per hour. Accordingly, Claimant's average weekly wage is $480.00.

2. On November 24, 2008, Claimant was assigned to work on a crew with a foreman named Jz. His job duties required him and a co-worker to move pipes that were between 15' and 20' long and weighed approximately 90-200 pounds. In order to move the pipe, Claimant and the co-worker lifted them up and onto their shoulders. Claimant placed his end of the pipe on his left shoulder. After carrying the pipes to the designated location, Claimant and the co-worker would drop the pipes to the ground. Claimant then held the pipes in place while other workers welded them to the pipeline.

3. Claimant reported that, while lifting a pipe he felt a "pulling" sensation in his left shoulder and neck. In the middle of the night and again the next morning the Claimant had severe left shoulder and neck pain.

4. Claimant called Employer the next morning and advised Jz that he had injured himself the day before. Claimant went into the Employer's office and met with Jz and another supervisor named Cr. Neither Jz nor Cr referred Claimant to a medical provider during that meeting. Claimant advised them that he wanted to seek medical treatment. Cr believes that he told Claimant to do as he wished. Thus, Claimant reported to the emergency room at North Colorado Medical Center.

5. Claimant reported to the emergency room immediately after that meeting on November 25, 2008. The attending physician noted that Claimant reported an onset of left shoulder pain following "lifting heavy equipment" at work the day prior.

6. Upon his release from the emergency room, Claimant reported to Nt who is the safety coordinator for the Employer. Nt advised Claimant to report to Concentra Medical Centers for future medical treatment.

7. The next day, on November 26, 2008, Claimant reported to Concentra Medical Center for an evaluation. Claimant was evaluated by Keith Meier, NP. Mr. Meier noted that Claimant had injured himself lifting at work and diagnosed a left sided cervical strain and cervical radiculopathy. Mr. Meier referred Claimant to Scott Parker, D.C., for chiropractic care and

imposed restrictions of no lifting, pushing or pulling over 25 pounds and no reaching above the shoulders.

8. Employer never offered modified duty to Claimant. Instead, the Employer terminated Claimant's employment on or about December 2, 2008. The Employer's records reflect Claimant was terminated for insubordination and lying. No credible or persuasive evidence was offered as to what volitional acts Claimant committed that Employer characterized as insubordination and lying.

9. Claimant continued his medical care with Concentra Medical Center and was evaluated by Dr. Rosalina Pineiro on December 5, 2008. Dr. Pineiro noted that the x-ray showed muscle spasms and continued the 25-pound lifting restriction.

10. On December 10, 2008, Dr. Pineiro opined that the Claimant's condition had worsened and that he was medically unable to work.

11. Claimant remained on restrictions prohibiting him from working until January 14, 2009, when Mr. Meier imposed restrictions of no lifting more than 10 pounds and referred the Claimant to Dr. Jeffrey Wunder, a physiatrist, for medical treatment recommendations.

12. On January 16, 2009, Dr. Wunder evaluated Claimant. Dr. Wunder noted that the Claimant had injured himself carrying pipe with a co-worker and noted that the Claimant had tenderness and muscle spasms in the supraclavicular area on the left side. Dr. Wunder recommended physical therapy and assigned work restrictions of no lifting, pushing, pulling, or carrying more that 10 pounds and no overhead work.

13. Claimant commenced physical therapy and returned to Dr. Wunder on February 13, 2009. Dr. Wunder noted muscle spasm and tenderness in the left upper trapezius distribution, prescribed a TENS unit and opined that the Claimant could lift, carry, push and pull a maximum of 20 pounds.

14. Claimant was referred to Dr. Jeffrey Seigel on March 9, 2009, for a neurological examination due to dizziness Claimant associated with his work injury. Dr. Seigel was unable to account for the presence of his symptoms.

15. On March 20, 2009, Dr. Wunder noted that while Claimant's cervical condition was improving that he continued to have mild muscle spasms in the left upper trapezius. Dr. Wunder increased Claimant's restrictions to a 50-pounds lifting, pushing and pulling limit.

16. Claimant began helping his grandparents on their farm around February 2009. In the physical therapy notes dated February 9, 2009, Claimant reported feeling sore and stiff after riding a tractor plowing fields for two days. Claimant also performed other farm work that mostly involved driving. Claimant did not have driving restrictions as a result of his work injury.

17. Claimant did not earn wages for the work he performed on the farm. Claimant's farm duties appeared to be within his physical restrictions.

18. On May 8, 2009, Dr. Wunder determined that the Claimant had reached maximum medical improvement (MMI) for his work-related injury with no work restrictions. He further stated that the Claimant required six months of maintenance medications and assigned a five percent impairment of the whole person for cervical spine dysfunction. Dr. Wunder also noted that Claimant had been performing heavy farm work for a relative, but that it had not significantly increased his symptoms.

19. In April 2009, Claimant applied for Social Security Disability Income (SSDI) based upon a disability unrelated to his industrial injury. He began receiving SSDI sometime in May 2009; however, the amount of his monthly income was not developed by the record.

20. On July 13, 2009, Claimant saw Dr. Robert Watson for an independent medical examination. Dr. Watson's opinions on causation rely heavily on the subjective reports of the Claimant and the Employer. Dr. Watson testified that if Claimant performed the job duties as Claimant described them, then the mechanism of the injury was consistent with his actual injuries. Dr. Watson also opined due to some of the inconsistencies between the Employer's records and Claimant's reports, Claimant may not have sustained an industrial injury.

21. At hearing, Cr testified that Claimant could not have injured himself on November 24, 2008, because he did not work that day. He further stated that Claimant could not have injured himself because they did not carry any pipe. The employment records, however, revealed that Claimant worked for 10 hours on November 24, 2008 performing "pipe install." On November 24, 2008, Claimant worked on Jz's crew and not with Cr. Cr lacked firsthand knowledge of Claimant's job duties on November 24, 2008.

22. The Employer's records also reflect that Claimant worked and received wages on November 25, 2008, although the details of the work performed on that date were not developed by the record.

23. Based on the foregoing, Claimant has established that he suffered compensable work related injuries to his left shoulder and left cervical spine on November 24, 2008, after lifting and carrying heavy pipe. The testimony of Claimant is more credible and persuasive than that of Cr. Cr had no first hand knowledge of the incidents of November 24, 2008. Further, Cr believed that Claimant could not have been injured on November 24 because he did not work that day. Employer's timekeeping records rebut Cr's belief about Claimant's attendance on November 24, 2008.

24. The medical care Claimant sought at North Colorado Medical Center on November 25, 2008, is authorized based upon the Employer's failure to refer Claimant to a medical provider

after he reported his injury. Thereafter, Employer referred Claimant to Concentra, Scott Parker, D.C., Dr. Jeffrey Wunder, Momentum Physical Therapy and Dr. Jeffrey Seigel. All such medical treatment was reasonable, necessary and related to Claimant's industrial injury.

25. Claimant was temporarily and totally disabled beginning on November 26, 2008, through May 8, 2009, when the Claimant was placed at MMI with no restrictions.

26. Respondents have failed to establish that Claimant was responsible for the termination of his employment. Respondents offered no credible or persuasive evidence to support the reason for the Claimant's separation from his employment.

CONCLUSIONS OF LAW

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

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

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

- *Compensability*

- 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. 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 determination by the Judge. *Faulkner*, 12 P.3d at 846.

- Claimant has established that on November 24, 2008, he sustained an injury to his left shoulder and left side of his neck while in the course and scope of his employment. Claimant credibly testified that after lifting heavy pipe during his shift, he felt pain and a pulling sensation in his left shoulder and neck. Claimant's testimony is more credible than that of Cr who testified that Claimant did not work on November 24, 2008. In addition, Dr. Watson agreed that if Claimant engaged in the work activities Claimant described, he could have sustained an injury.

- *Authorized provider*

- The employer or insurer has the right to select a physician in the first instance to attend an injured employee. Section 8-43-404(5)(a), C.R.S. However, if an employer is notified of an industrial injury and fails to designate an authorized treating physician, 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).

- Claimant reported his injury to two supervisors on November 25, 2008. When Claimant asked about seeking medical treatment, at least one supervisor told him to do what he wished. Neither supervisor referred Claimant to a physician for treatment so Claimant sought treatment at North Colorado Medical Center. Accordingly, the treatment Claimant underwent at North Colorado Medical Center is authorized. Respondents are responsible for payment of the bills associated with such treatment subject to the fee schedule.

- **Medical Benefits**

- 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).

- Because Claimant sustained an industrial injury, he is entitled to reasonable and necessary medical treatment to cure and relieve him of the effects of such injury. The treatment Claimant has undergone with North Colorado Medical Center, Concentra, and Concentra's referrals was reasonable, necessary and related to Claimant's industrial injury. Respondents shall pay for such medical treatment subject to the fee schedule.

- **Temporary Total Disability**

- 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. §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).

- Claimant has established that he is entitled to TTD commencing on November 26, 2008, through May 8, 2009. The employer records reflect that Claimant worked and received wages on November 25, 2008. As of November 25, 2008, Claimant was under physical work restrictions and then medically restricted from working. The physical restrictions would have precluded Claimant from performing his normal job duties had Employer not terminated Claimant's employment.

- **Responsibility for Termination**

- Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., (termination statutes) provide that, where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury. Respondent shoulders the burden of proving by a preponderance of the evidence that Claimant was responsible for her termination. *See Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 20 P.3d 1209 (Colo. App. 2000).

- An employee is "responsible" if the employee precipitated the employment termination by a volitional act which an employee would reasonably expect to result in the loss of employment. *Patchek v. Colorado Department of Public Safety*, W.C. No. 4-432-301 (September 27, 2001). Thus, the fault determination depends upon whether a claimant performed some volitional act or otherwise exercised a degree of control over the circumstances resulting in termination. *Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1994), *opinion after remand*, 908 P.2d 1185 (Colo. App. 1995). That determination must be based upon an examination of the totality of the circumstances. *Id.*

- As found, Respondents have not established that Claimant was responsible for termination of his employment. Employer apparently terminated Claimant's employment because the management staff determined that Claimant was lying or was insubordinate. No persuasive or credible evidence reflected how the Employer arrived at its determination that Claimant lied or was insubordinate or as to what volitional acts Claimant committed that

constituted insubordination. Based upon the totality of the circumstances, Claimant did not commit a volitional act that led to the termination and did not exercise a sufficient degree of control over the circumstances of his termination. Claimant was not responsible for the termination of his employment. Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., do not bar Claimant from receiving temporary disability benefits.

- **Offsets**

- Pursuant to §8-42-103(1)(c)(I), C.R.S., TTD benefits shall be reduced, but not below zero, by the amount of benefits payable to an individual through Social Security Disability. Here, Claimant began receiving SSDI sometime in May 2009. Claimant was placed at MMI on May 8, 2009, thereby terminating TTD benefits. To the extent that TTD and SSDI payments would overlap, Respondents would be entitled to offset the amount of the SSDI although neither the specific amounts nor the applicable dates were established.

ORDER

It is therefore ordered that:

1. Claimant sustained a compensable injury to his left shoulder and left cervical spine on November 24, 2008.

2. Claimant is entitled to medical benefits to cure and relieve him of the effects of the industrial injury.

3. The Claimant's medical care with North Colorado Medical Center, Concentra Medical Centers, Scott Parker, D.C., Dr. Jeffrey Wunder, Momentum Physical Therapy and Dr. Jeffrey Seigel was reasonable, necessary, related and authorized.

4. The Respondents shall pay the Claimant TTD benefits from November 26, 2008, until May 8, 2009, based upon the Claimant's average weekly wage of $480.00.

5. Respondents shall be entitled to any applicable offset for Social Security Disability income.

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

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

DATED: March 30, 2010

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-790-452

ISSUES

The issues to be determined by this decision are:

1. Whether Claimant sustained a compensable injury at work on April 9, 2009, and whether the need for medical treatment and disability is proximately caused by the incident of April 9, 2009;

2. Whether Claimant is entitled to temporary total disability benefits (TTD) benefits from April 9, 2009, to August 11, 2009; and

3. Whether Claimant is entitled to ongoing medical benefits as a result of the incident on April 9, 2009.

PROCEDURAL MATTERS

The parties reached the following stipulations:

1. Concentra is the authorized treating provider in this claim, if it is found compensable.

2. Claimant's average weekly wage is $250.30, if the claim is found compensable.

FINDINGS OF FACT

1. Claimant has suffered from chronic low back pain since approximately 2005. Claimant sustained a prior back injury while working for another employer.

2. With regard to the prior worker's compensation claim involving his back, claimant had an MRI done in April and May, 2007. Radiology performed of Claimant's lumbar spine in April 2007 suggested that Claimant suffered muscle spasm. The MRI of Claimant's lumbar spine performed on May 21, 2007, revealed disc bulging at L2-3, broad based central disc protrusion at L3-4, resulting in mild spinal stenosis, large central and right paracentral disc herniation at L4-5 resulting in significant spinal stenosis and impinging on the L5-S1 nerve root and mild disc bulges at other levels.

3. Claimant was working for Employer on April 9, 2009. Claimant testified that his

shift was from 11:00 p.m. to 7:00 a.m. At that time, Claimant alleges he was lifting heavy boxes when he felt a strain in his low back. Claimant testified that he was lifting two 12 packs of soda pop at the time of his alleged injury. The incident was not witnessed. Claimant testified that this incident occurred at the end of his shift at 4:30 a.m. Claimant's testimony is neither credible nor persuasive.

4. Claimant also alleges a previous back injury while working for Employer, which occurred on February 13, 2009. Claimant apparently worked through this injury. This incident also involved lifting product to stock shelves. Claimant was placed at maximum medical improvement with no impairment for the February 2009 incident.

5. Ms. Hasty is the adjuster handling Claimant's claims. She testified that a Notice of Contest was filed on the February 2009 claim and the April 2009 claim. The Notices of Contest were filed because Claimant was not forthcoming about a prior back injury while Claimant worked for B. This injury occurred in 2007. Claimant did not reveal the B injury as it is not listed on his application for employment with Employer. Claimant did however list prior employers going back to 1996.

6. Mr. -JN- is a store manager for Employer. He was Claimant's supervisor at the time of the alleged injury. Mr. -JN- testified that packs of pop weigh about 10 pounds. The testimony of Mr. -JN- is credible and persuasive.

7. Claimant received conservative treatment at Concentra Medical Centers for both of Claimant's alleged injuries. An MRI of Claimant's lumbar spine performed on May 16, 2009 was essentially unchanged from the imaging performed two years earlier. The disc bulges remained unchanged. There was no evidence of injury to Claimant's spine as a result of his April 2009 lifting incident.

8. Claimant also testified that he disclosed to his treating providers the fact that he had a prior back injury in 2007. However, this is contradicted by the medical records, which specifically state that, "He denies any prior history of injury other than the injury in February." Also, Dr. Danahey noted in February 2009 with regard to prior medical history, "[n]othing of relevance is noted." Claimant's testimony about his medical history is not credible or persuasive.

9. Claimant was placed on varying restrictions for his alleged work incidents in both February 2009 and April 2009. According to Dr. Danahey, Claimant was released to work with no restrictions for his February 2009 injury on June 2, 2009 and May 5, 2009. Although Claimant was placed on restrictions after these dates, Claimant was not compliant with the restrictions.

10. Claimant testified that he has never had a contractor's license. However, this is in contrast to Claimant's application for employment with Employer where Claimant indicated he had a contractor's license. The application for employment was prepared in Claimant's own

handwriting. However, Claimant testified that the employment application was incorrect and that he had a contractor's license. Claimant's testimony is not credible or persuasive.

11. Following Claimant's departure form the workplace of the Employer, Claimant testified that he worked as a painter and as a painter he is required to lift paint buckets, ladders and heavy items. Claimant admitted that these items are heavier than the cans of pop he had been lifting on April 9, 2009. The medical records also indicate that Claimant had been doing home renovations while he was on work restrictions. Claimant's non-compliance with restrictions constitutes some evidence that he did not suffer an injury as a result of the incident of April 9, 2009.

12. Claimant also testified that he refused to return to work because he did not want to re-injure his back. However, this is contradicted by the fact that he was working as a painter lifting heavy items.

13. Claimant has failed to prove a work related injury as a result of the incident that occurred on April 9, 2009 while lifting cans of soda weighing 10 pounds.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-40-101, 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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979). A 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). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

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

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

4. A claimant is required to prove that an injury arose out of and in the course of the claimant's employment. *Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844 (Colo. Ct. App. 2000). See also, Section 8-41-301(1)(b) & (c), C.R.S. An injury arises out of employment if it is sufficiently related to the conditions and circumstances under which the employee generally performs his job functions such that the activity may reasonably be characterized as an incident of the employment, even if the activity is not a strict obligation of the employment and does not confer a specific benefit on the employer. *Price v. Industrial Claim Appeals Office,* 919 P.2d 207 (Colo. 1996). The essence of the test is whether the conduct originated in the work-related duties or responsibilities so as to be considered part of the service to the employer in connection with the contract of employment. *Popovich v. Irlando,* 811 P.2d 379 (Colo. 1991). This issue is one of fact to be determined by the ALJ based on an examination of the totality of the circumstances. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office,* 907 P.2d 715 (Colo. App. 1995).

5. Arising out of employment requires the claimant to prove "a causal connection between the employment and injuries such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract." *Madden v. Mountain W. Fabricators*, 977 P.2d 861, 863 (Colo. 1999). Course of employment refers to the time, place and circumstances of the claimant's injury. *Wild West Radio, Inc. v. Indus. Claim Appeals Office*, 905 P.2d 6 (Colo. Ct. App. 1995).

6. There is a distinction between the terms "accident" and "injury". The term accident refers to an "unexpected, unusual or undesigned occurrence." Section 8-40-201(1), C.R.S. In contrast, an "injury" refers to the physical trauma caused by the accident. In other words, an "accident" is the cause and an "injury" is the result. *City of Boulder v. Payne*, 426 P.2d 194 (Colo. 1967). No benefits flow to the victim of an industrial accident unless an "accident" results in a compensable "injury." Compensable injuries involve an "injury", which requires medical treatment or causes disability. *H & H Warehouse v. Victory*, 805 P.2d 1167, 1169 (Colo. App. 1990).

7. The claimant is only entitled to benefits if the industrial injury is the proximate cause of the claimant's need for medical treatment. *Merriman v. Indus. Comm'n*, 210 P.2d 448 (Colo. 1949). Additionally, ongoing benefits may be denied if the current and ongoing need for medical treatment or disability is not proximately caused by an injury arising out of and in the course of the employment. *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. App. 1997). Pursuant to *Wherry v. City and County of Denver*, W.C. No. 4-475-818 (ICAO March 7, 2002), if an incident is not a significant event resulting in an injury, the claimant is not entitled to benefits.

8. The totality of the evidence shows that Claimant did not sustain an injury to his low back on April 9, 2009. The medical records reveal MRIs, which do not indicate any change to Claimant's back condition as a result of the incident that occurred on April 9, 2009. Moreover,

Claimant testified that while he was allegedly on restrictions, he was working doing renovations on houses. He admitted that even as a painter, Claimant carried paint, ladders and equipment, all which exceed the weight of the cans of pop Claimant alleges he carried the day of the incident. Therefore, Claimant's testimony that he did not want to return to work for fear that he would re-injure himself is not credible or persuasive.

9. The credible testimony of Ms. Hasty reveals that Claimant failed to inform her of a similar injury to his low back while Claimant was working for another employer. Moreover, Claimant testified he had a history of chronic low back pain. The medical records also indicate that Claimant worked doing house renovations in June 2009. Additionally, Claimant was placed at maximum medical improvement with no impairment for the incident and was only placed on restrictions for a relatively brief period of time. Mr. -JN- credibly testified that Claimant failed to show up for work even after being released to regular duties. Claimant testified that he was concerned about re-injuring himself, however this is in stark contrast to the medical records and Claimant's testimony that he was doing house renovations. Claimant's testimony is not credible or persuasive. Given this, the ALJ finds that Claimant's activities on April 9, 2009, did not cause an injury requiring medical treatment or causing disability. See *Wherry v. City and County of Denver*, W.C. No. 4-475-818 (ICAO March 7, 2002). Alternatively, the ALJ finds that ongoing medical treatment and any disability for the low back is not proximately caused by the activities of April 9, 2009. *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. App. 1997).

ORDER

IT IS, THEREFORE, ORDERED THAT:

1. Claimant failed to prove by a preponderance of the evidence that he sustained a work injury resulting in the need for medical benefits or permanent impairment. Claimant's claim for compensation is denied and dismissed with prejudice.

2. Claimant's claim for TTD from April 9, 2009 to August 11, 2009 is also denied and dismissed with prejudice.

All other issues not expressly ruled on and determined are left for future determination.

DATED: __March 30, 2010

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-765-003

ISSUE

The issue for determination is medical benefits after maximum medical improvement (*Grover* medical benefits).

FINDINGS OF FACT

1. Claimant sustained a compensable injury on July 15, 2008. Claimant reached maximum medical improvement on February 19, 2009.

2. Insurer filed a Final Admission of Liability on November 3, 2009. Where asked to state its position on medical benefits after MMI, Insurer stated, "Carrier will cover maintenance medical benefits as outlined in DIME report by Dr. Jeffrey Jinks, MD 7/1/09 report attached."

3. Jeffrey P. Jenks, M.D., in a report dated July 1, 2009, noted that Claimant had complaints of right hand pain following a significant crush injury and partial amputation of her right fourth digit. He noted that Claimant uses Ibuprofen intermittently. Claimant has a prosthesis. Dr. Jenks stated that, "[Claimant] does not need any maintenance care."

4. Albert Hattem, M.D., examined Claimant on February 19, 2009. He noted her medication was occasional Ibuprofen. He stated that, "[Claimant] will require maintenance care. I recommend that Ibuprofen to be refilled for an additional six months."

5. Thomas Eskestrand, M.D., examined Claimant on April 22, 2009. He prescribed Ibuprofen 800 *tid*, and dispensed a -E- splint.

6. The opinions of Dr. Hattem and Dr. Eskestrand are credible and persuasive. Medical care after MMI is reasonably needed to relieve Claimant from the effects of the industrial injury.

CONCLUSIONS OF LAW

An insurer is liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S. 2000. This liability continues after maximum medical improvement when a claimant shows substantial evidence of the need for such treatment. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The insurer may contest any future claims for medical treatment on the basis that such treatment is unrelated to the industrial injury or occupational disease. An insurer retains the right to file a petition to reopen for the purpose of terminating a claimant's right to receive medical benefits. *See Grover, supra.*

Claimant has shown substantial evidence of a need for treatment after maximum medical improvement. Insurer is liable for treatment after MMI.

ORDER

It is therefore ordered that Insurer is liable for medical treatment after MMI.

All matters not determined herein are reserved for future determination.

This decision of the ALJ does not grant or deny a benefit or a penalty and may not be subject to a Petition to Review. Parties should refer to Section 8-43-301(2), C.R.S., and other applicable law regarding Petitions to Review. If a Petition to Review is filed, see Rule 26, OACRP, for further information regarding the procedure to be followed.

DATED: *March 31, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-793-279

ISSUE

The issue to be determined is medical benefits after maximum medical improvement (*Grover* meds).

FINDINGS OF FACT

1. Claimant injured her back on April 5, 2009. She reached maximum medical improvement on October 1, 2009. Claimant has continued to suffer discomfort as a result of the injury.

2. Michael C. Sparr, M.D., examined Claimant on August 28, 2009. He stated that, "[Claimant] can certainly takes (sic) medications including Amriz and Tramadol, and she uses a PLO with good benefit." Claimant credibly testified that the prescriptions helped.

3. On a "Physician's Report of Worker's Compensation Injury" dated October 1, 2009, from Urgent Care, the provider indicated that maintenance care after MMI was required.

4. When Claimant last saw James Hubbard, M.D., at Emergicare, on October 8, 2009, Dr. Hubbard provided a sample pack of medications. He recommended a home exercise program.

CONCLUSIONS OF LAW

An insurer is liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S. This liability continues after maximum medical improvement when a claimant shows substantial evidence of the need for such treatment. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The insurer may contest any future claims for medical treatment on the basis that such treatment is unrelated to the industrial injury or occupational disease. An insurer retains the right to file a petition to reopen for the purpose of terminating a claimant's right to receive medical benefits. *See Grover, supra.*

Claimant has shown substantial evidence of the need for treatment after maximum medical improvement. Insurer is liable for the costs of such care after maximum medical improvement from authorized providers.

ORDER

It is therefore ordered that Insurer is liable for the costs of reasonably needed medical care related to the compensable injury from authorized providers after maximum medical improvement.

All matters not determined herein are reserved for future determination.

This decision of the ALJ does not grant or deny a benefit or a penalty and may not be subject to a Petition to Review. Parties should refer to Section 8-43-301(2), C.R.S., and other applicable law regarding Petitions to Review. If a Petition to Review is filed, see Rule 26, OACRP, for further information regarding the procedure to be followed.

DATED: *March 31, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-676-547

ISSUE

The sole issue for determination is maximum medical improvement (MMI). (See 12/22/09 Transcript, p. 4, l. 20; Respondent's Proposed Findings of Fact, Conclusions of Law, and Order, p. 2; Application for Hearing, 9/8/09; Respondent's Case Information Sheet, p. 2). Respondent seeks to overcome the opinion of the Division independent medical examiner

(DIME) by clear and convincing evidence.

FINDINGS OF FACT

1. Claimant sustained injuries in a compensable accident on February 6, 2006.

2. During the course of his treatment, Claimant came under the care of Craig Louckes, M.D., an orthopedic surgeon. Dr. Louckes recommended a total hip replacement for Claimant's right hip. After a hearing, Respondent was ordered to pay for temporary disability benefits and for the cost of the right hip replacement. Claimant underwent surgery to have his right hip replaced on November 27, 2007.

3. An authorized treating physician, John Burris, M.D., placed Claimant at MMI on May 28, 2008. A DIME was requested. The DIME was performed on October 29, 2008, by Alan Lichtenberg, M.D. Dr. Lichtenberg stated that Claimant was not at MMI.

4. Claimant continued to treat with his physicians, including Dr. Louckes. Claimant was again placed at MMI. Claimant requested a follow-up DIME. Dr. Lichtenberg performed the follow-up DIME on July 7, 2009. Dr. Lichtenberg again stated that Claimant was not at MMI. In addition to saying that Claimant was not at MMI because he needed treatment for his lower back and for his psychological problems, Dr. Lichtenberg stated that Claimant was not at MMI because he needed the left hip replacement that was being recommended by Dr. Louckes.

5. The problems with Claimant's left hip began after Claimant's right hip replacement in November 2007. Shortly after his right hip surgery, Claimant was walking on crutches when he slipped on some ice. Dr. Louckes, after conservative care, recommended a left hip replacement. The carrier refused to authorize the left hip replacement.

6. Claimant testified that shortly after his right hip replacement, he was walking on two crutches. He was walking across an icy area when one of his crutches slipped out from under him, causing him to fall with force on his left hip.

7. Dr. Lichtenberg testified at his deposition that Claimant told him about his fall on crutches during the first DIME appointment in October 2008. At the follow-up DIME in July 2009, Claimant again described to Dr. Lichtenberg how he fell on the ice while walking on crutches. In both the DIME and the follow-up DIME, Claimant was consistent in describing the mechanism of injury for his left hip.

8. At the time of the right hip replacement in November 2007, there were several diagnostic tests performed on the left hip. In an x-ray which was taken of Claimant's hips on November 21, 2007, shortly before the right hip surgery, it is indicated that there was advanced arthritis in the right hip joint, but that the left hip is normal. Dr. Kawasaki, at his deposition taken on April 19, 2007, stated that Claimant's left hip was normal. Upon further questioning, Dr. Kawasaki was asked if he would recommend a replacement for the left hip, and he said that he would not.

9. Dr. Lichtenberg, in his deposition, said, “If the left hip was x-ray normal on 11 of ’07, we would not expect it to advance to moderate osteoarthritis noted only a year or so later without an injury.” Dr. Lichtenberg was asked to explain how the left hip could go from being normal to needing a replacement within a period of a year, he stated that the most likely explanation would be trauma. He also said that, “it (the need for hip replacement) certainly can’t be due to just normal osteoarthritis degenerative disease. It wouldn’t occur that quickly.”

10. The most likely explanation of the need for a left hip replacement is that Claimant did fall on his crutches while walking on the ice.

CONCLUSIONS OF LAW

1. A DIME physician’s opinion on MMI is binding unless overcome by clear and convincing evidence. Section 8-42-107(8)(b)(III), C.R.S.; *Montoya v. Industrial Claim Appeals Office*, 203 P.3d 620 (Colo.App. 2008); *Rodriguez v. Kane Koncrete*, W.C. No. 4-715-022 (ICAO July 31, 2009). Clear and convincing evidence is evidence that is highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). The party challenging the DIME physician’s finding must produce evidence showing it highly probable the DIME physician is incorrect. *Id.* A mere difference of opinion between physicians fails to constitute error. *Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000). The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo.App. 1998). A DIME physician’s determination of MMI inherently requires the examining physician to determine the cause of the claimant’s condition. Since the DIME physician is required to identify and evaluate all losses and restrictions that 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. *Id.*

2. Alan Lichtenberg, M.D., the DIME physician, examined Claimant on October 29, 2008. In his report, he stated that Claimant suffers from a significant adjustment disorder with major depression and very high pain levels. He recommended additional treatment including referral to an orthopedic surgeon for evaluation and treatment of pain in both his hips, psychological evaluation and treatment, and pain management. He stated that Claimant was not at MMI.

3. Dr. Louckes has recommended a left hip replacement. The left hip replacement is necessary because Claimant slipped when walking on crutches following his right hip surgery. The left hip condition is the result of the compensable injury.

4. Respondent has not overcome the MMI determination of the DIME physician by clear and convincing evidence. Claimant has yet to reach MMI from the effects of this compensable injury.

5. Medical benefits, temporary disability benefits, permanent disability benefits, and other issues not determined by this order are reserved.

6. This order does not grant or deny a benefit or penalty. This order is not subject to review at this time. Section 8-43-301(2), C.R.S.

ORDER

It is therefore determined that Claimant has not reached MMI.

All matters not determined herein are reserved for future determination.

DATED: *March 31, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-676-547

ISSUE

The sole issue for determination is maximum medical improvement (MMI). (See 12/22/09 Transcript, p. 4, l. 20; Respondent's Proposed Findings of Fact, Conclusions of Law, and Order, p. 2; Application for Hearing, 9/8/09; Respondent's Case Information Sheet, p. 2). Respondent seeks to overcome the opinion of the Division independent medical examiner (DIME) by clear and convincing evidence.

FINDINGS OF FACT

Claimant sustained injuries in a compensable accident on February 6, 2006.

During the course of his treatment, Claimant came under the care of Craig Louckes, M.D., an orthopedic surgeon. Dr. Louckes recommended a total hip replacement for Claimant's right hip. After a hearing, Respondent was ordered to pay for temporary disability benefits and for the cost of the right hip replacement. Claimant underwent surgery to have his right hip replaced on November 27, 2007.

An authorized treating physician, John Burris, M.D., placed Claimant at MMI on May 28, 2008. A DIME was requested. The DIME was performed on October 29, 2008, by Alan Lichtenberg, M.D. Dr. Lichtenberg stated that Claimant was not at MMI.

Claimant continued to treat with his physicians, including Dr. Louckes. Claimant was again placed at MMI. Claimant requested a follow-up DIME. Dr. Lichtenberg performed the follow-up DIME on July 7, 2009. Dr. Lichtenberg again stated that Claimant was not at MMI. In addition to saying that Claimant was not at MMI because he needed treatment for his lower back and for his psychological problems, Dr. Lichtenberg stated that Claimant was not at MMI because he needed the left hip replacement that was being recommended by Dr. Louckes.

The problems with Claimant's left hip began after Claimant's right hip replacement in November 2007. Shortly after his right hip surgery, Claimant was walking on crutches when he slipped on some ice. Dr. Louckes, after conservative care, recommended a left hip replacement. The carrier refused to authorize the left hip replacement.

Claimant testified that shortly after his right hip replacement, he was walking on two crutches. He was walking across an icy area when one of his crutches slipped out from under him, causing him to fall with force on his left hip.

Dr. Lichtenberg testified at his deposition that Claimant told him about his fall on crutches during the first DIME appointment in October 2008. At the follow-up DIME in July 2009, Claimant again described to Dr. Lichtenberg how he fell on the ice while walking on crutches. In both the DIME and the follow-up DIME, Claimant was consistent in describing the mechanism of injury for his left hip.

At the time of the right hip replacement in November 2007, there were several diagnostic tests performed on the left hip. In an x-ray which was taken of Claimant's hips on November 21, 2007, shortly before the right hip surgery, it is indicated that there was advanced arthritis in the right hip joint, but that the left hip is normal. Dr. Kawasaki, at his deposition taken on April 19, 2007, stated that Claimant's left hip was normal. Upon further questioning, Dr. Kawasaki was asked if he would recommend a replacement for the left hip, and he said that he would not.

Dr. Lichtenberg, in his deposition, said, "If the left hip was x-ray normal on 11 of '07, we would not expect it to advance to moderate osteoarthritis noted only a year or so later without an injury." Dr. Lichtenberg was asked to explain how the left hip could go from being normal to needing a replacement within a period of a year, he stated that the most likely explanation would be trauma. He also said that, "it (the need for hip replacement) certainly can't be due to just normal osteoarthritis degenerative disease. It wouldn't occur that quickly."

The most likely explanation of the need for a left hip replacement is that Claimant did fall on his crutches while walking on the ice.

CONCLUSIONS OF LAW

A DIME physician's opinion on MMI is binding unless overcome by clear and convincing evidence. Section 8-42-107(8)(b)(III), C.R.S.; *Montoya v. Industrial Claim Appeals Office*, 203 P.3d 620 (Colo.App. 2008); *Rodriguez v. Kane Koncrete*, W.C. No. 4-715-022 (ICAO July 31,

2009). Clear and convincing evidence is evidence that is highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). The party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Id.* A mere difference of opinion between physicians fails to constitute error. *Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000). The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo.App. 1998). A DIME physician's determination of MMI inherently requires the examining physician to determine the cause of the claimant's condition. Since the DIME physician is required to identify and evaluate all losses and restrictions that 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. *Id.*

Alan Lichtenberg, M.D., the DIME physician, examined Claimant on October 29, 2008. In his report, he stated that Claimant suffers from a significant adjustment disorder with major depression and very high pain levels. He recommended additional treatment including referral to an orthopedic surgeon for evaluation and treatment of pain in both his hips, psychological evaluation and treatment, and pain management. He stated that Claimant was not at MMI.

Dr. Louckes has recommended a left hip replacement. The left hip replacement is necessary because Claimant slipped when walking on crutches following his right hip surgery. The left hip condition is the result of the compensable injury.

Respondent has not overcome the MMI determination of the DIME physician by clear and convincing evidence. Claimant has yet to reach MMI from the effects of this compensable injury.

Medical benefits, temporary disability benefits, permanent disability benefits, and other issues not determined by this order are reserved.

This order does not grant or deny a benefit or penalty. This order is not subject to review at this time. Section 8-43-301(2), C.R.S.

ORDER

It is therefore determined that Claimant has not reached MMI.

All matters not determined herein are reserved for future determination.

DATED: *March 31, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-804-091

ISSUES

Ø Did claimant prove by a preponderance of the evidence that his reaction to a quit-smoking medication and development of rhabdomyolysis arose out of and within course of his employment?

Ø Did claimant prove by a preponderance of the evidence that he is entitled to medical and temporary disability benefits?

FINDINGS OF FACT

Employer operates a business fabricating electronic parts. -Y- is president and -Z- is manager of human resources at employer. Claimant worked for employer as a floater, whose duties involved routing, drilling, and, laminating circuit boards. Claimant's date of birth is January 1, 1972; his age at the time of hearing was 38 years. In his Workers' Claim for Compensation filed September 16, 2009, claimant alleges he suffered a work-related injury on February 13, 2009, after taking Chantix – a medication therapy prescribed to help patients quit smoking cigarettes. Employer terminated claimant on June 30, 2009, because he failed to respond to employer's attempts to correspond with him regarding his ability to return to work after exhausting his FML.

Claimant had smoked cigarettes since 1994. Sometime around February 10, 2009, claimant began taking Chantix, which his primary care physician (PCP) prescribed to help him quit smoking cigarettes. Claimant took the Chantix for 3 to 4 days before noticing blood in his urine. Crediting claimant's testimony, his body reacted to the Chantix, and he developed rhabdomyolysis – a condition caused by breakdown of muscle tissue, potentially causing kidney failure.

Employer provides health insurance coverage for employees. Prior to calendar year 2009, employer's health insurance carrier and Mr. -Y- discussed premiums. The carrier suggested that Mr. -Y- institute cost containment measures and start a wellness program to reduce claims and contain premium increases. One of the cost containment measures suggested by the carrier was to encourage employees to stop smoking.

At a meeting with employees in December of 2008, Mr. -Y- discussed the increasing cost of health insurance premiums. Mr. -Y- told employees that employer was looking to implement a

wellness programs for its employees to promote healthy habits. Mr. -Y- announced an incentive to employees to quit smoking where employer would offer those employees a 20% discount on their share of the premium. Employee participation in Mr. -Y-'s offer was voluntary on the part of employees. Employer however was unable to implement the discount offer because of the administrative problems of monitoring and verifying whether employees had quit smoking.

Crediting the testimony of claimant's supervisor, -X-, he and claimant had discussed the merits of quitting smoking months before the company meeting in December of 2008. Mr. -X- had quit smoking some 5 years before that and encouraged claimant to quit. Because employer allows employees to smoke cigarettes, Mr. -X- never ordered claimant to quit smoking or suggested he take Chantix. Mr. -X-'s testimony supports a finding that, before Mr. -Y- suggested it at the December meeting, claimant had the good sense to consider quitting smoking for its own health merits.

Claimant's testimony that he felt employer would terminate him if he did not quit smoking is unpersuasive and unreasonable under the circumstances. Indeed, claimant testified that his job was not in jeopardy because of his smoking habit. While claimant implies that employer showed by past conduct that it might arbitrarily fire him, that assertion is unsupported by the evidence. Employer's records show claimant was a problem employee because of attendance issues. Those records show employer attempting over several years to work with claimant through resolving his attendance problem with progressive discipline. In addition, Mr. -Y- persuasively testified that 80 of the 200 employees continue to smoke cigarettes. There was no persuasive evidence to support claimant's subjective belief that employer would terminate him because of his smoking habit.

Claimant failed to show it more probably true than not that his injury from his decision to take Chantix has its origins in his work-related functions and is sufficiently related to his work to be considered part of the employment contract. Claimant's testimony supports the following findings: Claimant never discussed his smoking habit with Mr. -Y-. Mr. -Y- never told claimant to quit smoking. Claimant decided to quit to take advantage of employer's offer of a 20% premium discount. Claimant's decision to quit was voluntary and represented a way to improve his long-term health. Claimant's decision benefited him personally. No one at employer directed claimant to seek medical attention from his PCP to quit smoking. No one at employer directed claimant to take Chantix. Claimant took the Chantix on his own time while at home, and not on employer's time. Here, claimant failed to show it more probably true than his decision to take Chantix should be considered part of his employment contract. Claimant thus failed to show it more probably true than not that his injury from taking Chantix arose out of and within the course of his employment contract.

CONCLUSIONS OF LAW

Claimant argues he has proven by a preponderance of the evidence that his injurious reaction to Chantix arose out of and within course of his employment. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102 (1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and scope of his 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. X-ray*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

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

Section 8-41-301(1)(c), *supra*, conditions recovery upon claimant showing that his injury is one arising out of and within the course of his employment. The phrases are not synonymous and a claimant must prove both requirements. The "arising out of" and "course of" employment criteria present distinct elements of compensability. The course of employment requirement refers to the time, place and circumstances of employment. The "arising out of" criterion requires the claimant to establish a causal connection between the employment and the injury such that the injury has its origins in the claimant's work related functions and is sufficiently related thereto to be considered part of the employment contract. *Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). An activity arises out of an in the course of employment when it is sufficiently interrelated to the conditions and circumstances under which the employee generally performs his job functions that the activity may reasonably be characterized as an incident of employment. *Price v. ICAP*, 919 P.2d 207 (Colo. 1996). The test for determining if the injury arises out of the course of employment is whether there is a causal connection between the duties of the employment and the injuries*. Irwin v. ICAP*, 695 P.2d 763 (Colo. App. 1984). If a sufficient nexus exists between the activity and the usual circumstances of the job functions so that the activity may be considered an incident of employment, then the activity arises out of and in the course of employment. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985).

Here, the Judge found claimant failed to show it more probably true than not that his injury from taking Chantix arose out of and within the course of his employment contract. Claimant thus failed to prove by a preponderance of the evidence that his injurious reaction to Chantix is

compensable.

As found, claimant took the Chantix medication on his own time at home; his injury from Chantix therapy thus failed to occur within the time and place constraints of his employment. While claimant argues his decision to quit smoking provided a benefit to employer that should be deemed part of his employment contract, such benefit is speculative and theoretical. There was no persuasive evidence otherwise showing what benefit would inure to employer, other than as a possible way to lower premiums if the losses to the carrier decreased because of improved health of the employee risk pool.

In addition, claimant's decision to quit smoking was a voluntary decision he acted upon to benefit himself. Moreover, claimant decided to take Chantix based upon advice of his PCP, and not based upon any implied or express directive or advice of employer. There was no persuasive evidence bringing claimant's decision to take Chantix within the course of his employment. Nor was there persuasive evidence showing claimant's decision to take Chantix arose out of his employment.

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

ORDER

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

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

2. If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, Colorado, 80202. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.*

DATED: _March 31, 2010___

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-649-193

ISSUES

The issue determined herein is claimant's petition to reopen.

FINDINGS OF FACT

1. Claimant is a 74-year-old man who sustained a work-related back injury on April 11, 2005 when he was performing his job as a maintenance worker for the employer. Claimant slipped and fell, twisting his low back.

2. On April 12, 2005, Dr. Daniel Gibertini, M.D. examined claimant, who reported back pain. Dr. Gibertini diagnosed a lumbar strain and recommended physical therapy and medications.

3. Dr. Gibertini reexamined claimant on May 6, 2005. Dr. Gibertini noted that claimant had a difficult time getting up out of a chair onto the examination table.

4. On June 1, 2005, Dr. Daniel Baer, D.O., examined claimant, who was slow moving from sit to stand as well as stand to sit. Claimant used a cane with very slow movement in his gait.

5. On June 8, 2005, claimant had a magnetic resonance image ("MRI"), which showed chronic appearing anterior wedging of the L4, L2, and T12 vertebral bodies and mild to moderate degenerative disc disease of the lumbar spine with relative sparing of the L4-L5 disc.

6. On June 14, 2005, Brian Polvi, D.C., began treatment of claimant. Dr. Polvi was unable to perform numerous examination procedures because of the claimant's pain levels. Additionally, claimant moved from sit to stand and on and off the examination table with severe pain behaviors.

7. On July 15, 2005, Dr. Gibertini reevaluated the claimant, who reported that he had an epidural steroid injection on July 11, 2005, and that he "is in as much pain as he ever was." Claimant still had a difficult time walking as well as rising from the chair.

8. On August 22, 2005, Dr. Bee provided a surgical consultation for claimant. Dr. Bee concluded that claimant's pain was due to his facet joints and that claimant was not a surgical candidate.

9. Darlene Kletter, N.P., examined claimant on September 12, 2005. Claimant was unable to bend his back in any direction because his pain was so intense.

10. On September 28, 2005, Dr. Baer reexamined claimant and noted that claimant underwent physical therapy, chiropractic care, epidural steroid injections, facet injections, and a surgical consultation without any benefit for his low back pain. Dr. Baer determined that claimant was at maximum medical improvement ("MMI") because there were no further treatment options for claimant. Dr. Baer noted that claimant was disappointed.

11. Dr. Albert Hattem, M.D. evaluated claimant on November 10, 2005. Claimant complained of persistent low back pain at 7-8/10. Dr. Hattem diagnosed low back pain, but did not diagnose any hip pain. Dr. Hattem opined that because claimant failed to respond to all conservative measures consisting of physical therapy, chiropractic treatment, facet injection, epidural steroid injections, claimant was at MMI. Dr. Hattem opined that additional conservative measures were not likely to be beneficial and claimant was not a surgical candidate. Dr. Hattem determined 19% whole person impairment rating for the lumbar spine, imposed permanent restrictions, and recommended post-MMI medical maintenance care.

12. Claimant did not return for an appointment with Concentra until January 18, 2007, almost 14 months after being placed at MMI. Claimant complained of persistent and even worsening low back pain during the last six months and that he could not walk more than 50 feet. Claimant also stated that he never settled his case. Claimant rated his low back pain as 7-8/10. Claimant denied any intervening injury. On examination, Dr. Hattem noted that claimant had great difficulty getting on and off the examination table and demonstrated significant pain behaviors. Dr. Hattem recommended a repeat MRI of claimant's lumbar spine.

13. On February 7, 2007, claimant underwent another lumbar spine MRI, which showed no change compared to the prior study on June 8, 2005.

14. On February 21, 2007, the insurer filed a Final Admission of Liability. Claimant filed an objection and a request for a Division Independent Medical Examination ("DIME"). The application requested evaluation of low back pain, psychological, and all other issues related to the industrial injury.

15. On April 26, 2007, Dr. Hattem reexamined claimant, who continued to complain of persistent unchanged low back pain. Dr. Hattem advised claimant that because the lumbar MRI was unchanged, there was no indication for any specific medical interventions.

16. On June 25, 2007, Dr. John Bissell, M.D., performed the DIME. Claimant stated that he could sit for several hours, but could only stand for 15 minutes and walk no more than 75 yards. Claimant reported his pain 7/10 and 9+/10 with activity. Claimant also reported that he thought he had 60% of his pain in his low back and 40% in his left hip. Additionally, claimant reported that he felt that the impairment rating he received from Dr. Hattem was not reflective of

the amount of disability he suffered. Claimant stated that before the injury he was able to do physical activity, but now he could not do much of anything.

17. On examination, Dr. Bissell noted that claimant had 5/5 strength in his left hip. Claimant also had diffuse tenderness throughout the axial lumbar spine, buttocks, and hips. Dr. Bissell diagnosed left L3-4 disk protrusion. Dr. Bissell did not diagnose claimant with any hip injury. Dr. Bissell concluded that claimant's left L3-4 disc protrusion was a likely pain generator for claimant's current complaints. Dr. Bissell agreed that claimant reached MMI on November 10, 2005. Dr. Bissell determined 23% whole person impairment due to the low back condition. Dr. Bissell determined 0% mental impairment because claimant did not meet diagnostic criteria.

18. Respondents filed an Application for Hearing on the issue of permanent partial disability ("PPD") benefits. Claimant did not file a Response to the Application for Hearing. On November 7, 2007, hearing was held. Judge Walsh issued on order determining that no clear and convincing evidence demonstrated that Dr. Bissell's whole person impairment rating of 23% was incorrect.

19. Respondents filed a Final Admission of Liability on December 20, 2007 consistent with the order by Judge Walsh. Claimant filed an Application for Hearing on January 18, 2008, on the issue of permanent total disability ("PTD") benefits.

20. Claimant returned for an evaluation with Dr. Hattem on January 10, 2008, almost eight and half months since his previous examination. Claimant stated that his condition remained unchanged since April 2007. Additionally, claimant stated that he had not yet settled his claim. Claimant denied any new injury. Dr. Hattem recommended medications of Tramadol and Amitriptyline.

21. On February 15, 2008, respondents filed a Motion to Strike Claimant's Application for Hearing alleging that the issue of PTD benefits was ripe at the time respondents filed their Application for Hearing on July 19, 2007. Respondents argued in their motion that when a claimant fails to endorse the issue of PTD within thirty (30) days after a final admission of liability or in response to respondents' application for hearing, as required by C.R.S. § 8-43-203 (2)(b)(II), those issues are closed and cannot be litigated.

22. On February 29, 2008, an Order was granted striking claimant's Application for Hearing.

23. On December 12, 2008, Dr. David Richman, M.D., performed an independent medical examination ("IME") for claimant. Claimant stated that his pain level was 5-8/10, and that he could not do anything but sit in his recliner all day. Additionally, claimant stated that he could only stand or walk for 10 minutes at the most. Dr. Richman thought that claimant was functionally worse since MMI. He diagnosed claimant with some depression and recommended a repeat lumbar MRI, x-rays, and medial branch blocks.

24. On December 28, 2008, claimant filed a petition to reopen based upon a change of condition.

25. On February 19, 2009, Dr. Hattem reevaluated claimant, almost 13 months since his previous evaluation. Claimant denied any intervening injury. Claimant stated that his low back pain radiated to the left hip. On examination, Dr. Hattem noted that claimant had difficulty getting on and off the examination table. Claimant rated his pain at 7/10. Dr. Hattem reviewed Dr. Richman's recommendations and agreed that they were reasonable. Dr. Hattem disagreed with Dr. Richman that claimant was worse. Dr. Hattem concluded that claimant remained at MMI.

26. Claimant then underwent a third MRI of the lumbar spine on March 2, 2009. This March 2, 2009 MRI did not show any change from either the June 8, 2005 or the February 7, 2007 MRI studies.

27. Claimant returned on March 12, 2009 for an evaluation with Dr. Hattem. Claimant rated his pain at 8/10. Dr. Hattem noted that claimant was not in any acute distress. Additionally, claimant denied any new injury or that he had any radiating leg pain. Dr. Hattem noted that claimant's MRI remained unchanged from the previous MRI studies. Dr. Hattem referred claimant to Dr. John Sacha, M.D., for consideration of medial branch blocks.

28. On April 13, 2009, Dr. Sacha examined claimant, who demonstrated pain behaviors and had 4/5 positive Waddell's signs. On examination, Dr. Sacha noted that claimant had negative hip rotation with pain localized to the back. Claimant denied pain anywhere but in his back. Dr. Sacha recommended medial branch blocks. Subsequently, Dr. Sacha opined on May 18, 2009 that the medial branch blocks would be considered medical maintenance care and that claimant remained at MMI.

29. On June 8, 2009, claimant filed an application for hearing, alleging change of condition, medical benefits, and temporary disability benefits. Respondents filed a Response to the Application for Hearing on July 7, 2009.

30. On August 24, 2009, Dr. Sacha took claimant off all prescription medications due to elevated liver enzymes. As a result, claimant had temporary increased low back pain. On September 21, 2009, Dr. Sacha noted that the blood lab results were normal and he prescribed Avinza to treat claimant's ongoing low back pain.

31. On September 30, 2009, hearing was held. On October 30, 2009, Judge Jones issued an order denying the petition to reopen. The order found that claimant had not suffered a change of condition and that his depression was due to stress from the ongoing litigation rather than from chronic pain.

32. On October 5, 2009, claimant was reevaluated by Dr. Sacha. Claimant stated that he was fed up because of a legal argument over whether he deserved PPD versus PTD benefits.

33. On November 9, 2009, Dr. Sacha changed claimant's medication from Avinza to Opana. On November 16, 2009, claimant reported that the Opana helped his pain, but he reported some depression. Dr. Hattem then referred claimant to Dr. Shockney to evaluate the depression.

34. On November 19, 2009, Dr. Peterson examined claimant and noted trochanteric bursitis. He injected claimant's left hip.

35. On November 19, 2009, claimant filed a Petition to Review the October 30, 2009 Order of ALJ Jones. Claimant filed his brief in support of the petition to review on January 28, 2010. Respondents filed their brief in opposition to petition to review on February 27, 2010. An Appeal is pending and a ruling on claimant's appeal has not yet occurred.

36. On November 25, 2009, claimant filed another petition to reopen based on a change of medical condition. Claimant also filed another Application for Hearing on November 25, 2009, which endorsed the issues of petition to reopen, medical benefits, temporary total disability benefits, and PTD benefits. Respondents filed a Response to the Application for Hearing on December 15, 2009, endorsing defenses of claim preclusion, issue preclusion, waiver, and that claimant's case remains closed. This Application and Response was the subject of the February 23, 2010 hearing.

37. On November 30, 2009, Dr. Shockney examined claimant and diagnosed major depression and pain disorder. He recommended psychological treatment. On November 30, 2009, Dr. Sacha noted that claimant was still at MMI. On December 14, 2009, Dr. Shockney reported that claimant was upset because he had pain for five years and because he thought that his medical treatment had not been good.

38. At hearing, claimant admitted that, at the first hearing on September 30, 2009, his pain complaints were 8-9/10. Claimant admitted that he still had the same pain complaints at the second hearing. He also admitted that, at the first hearing, he could not even get out of a chair. Claimant also testified at the second hearing that he still could not get out of a chair and that he had problems getting up out of chair ever since shortly after his injury. At the first hearing, claimant testified that he could walk only from his front porch to his truck and back to his porch. This condition remained unchanged at the second hearing. Claimant admitted testifying at the first hearing that he developed depression due to his chronic pain. Claimant also testified at the second hearing that he developed depression due to chronic pain. Claimant admitted, however, that he also testified at the first hearing that he was frustrated that his case had not settled and was still in litigation four and half years after he sustained his injury. Claimant testified that he wants his case to be over. At the second hearing, claimant provided the same testimony. Moreover, claimant testified that he recalled testifying at the first

hearing that he did not care if he lived, died, or arose from bed in the mornings and that he still did not at the time of the second hearing. Additionally, at the second hearing, claimant testified that his brother and his cousin both committed suicide. Claimant agreed that depression might run in his family. The trier-of-fact also is concerned that claimant might have a genetic suicidal trait. Moreover, claimant recalled testifying at the first hearing that the physicians have not done enough to relieve his pain. At the second hearing, claimant testified that he felt the same way and that he now had hip pain.

39. Dr. Hattem's previous September 18, 2009, deposition testimony was received as evidence. Dr. Hattem testified that claimant's condition remained unchanged. Dr. Hattem disagreed with Dr. Richman that claimant was no longer at MMI. Dr. Hattem credibly and persuasively testified that frustration could lead to depression. Furthermore, Dr. Hattem testified to a reasonable degree of medical probability that claimant did not sustain a worsening of condition and that the medical treatment claimant is receiving should be considered maintenance care. Dr. Hattem's testimony is credible and persuasive.

40. Respondents objected to claimant filing the current petition to reopen on November 25, 2009, while he has a pending petition to review the order denying his December 28, 2008 petition to reopen. Respondents also argued that claimant is not permitted to file successive petitions to reopen. Claimant clarified at hearing that he seeks to reopen based upon a change of condition since the last hearing on September 30, 2009.

41. The preponderance of the evidence does not show that claimant's physical condition from the work injury has changed. He continues to suffer chronic low back pain. His MRI findings are unchanged. His authorized treating physician had to make medication adjustments due to elevated liver enzyme levels, but the resulting changes in pain levels are part and parcel of claimant's post-MMI maintenance treatment. The preponderance of the evidence also fails to demonstrate that claimant suffered a change in his psychological condition since the September 30, 2009, hearing as a natural consequence of the admitted April 11, 2005 work injury. The October 30, 2009, order found that claimant's depression was due to his frustration that his claim had not settled and was not due to his chronic pain. The record evidence shows the same facts for the period after the September 30, 2009, hearing. Indeed, claimant reported increased depressive problems in November 2009, after issuance of the October 30 order denying his first petition to reopen. Dr. Shockney recorded a history that the depression and anger was due to claimant's five years of pain and his belief that his medical treatment had not been optimal. At hearing, claimant again admitted his frustration that his claim had not settled. Claimant also admitted that he had a family history of suicide. Dr. Hattem and Dr. Sacha again determined that claimant remained at MMI while he obtained post-MMI treatment by Dr. Shockney. Dr. Richman's contrary opinion in 2008 is not persuasive that claimant's condition worsened.

CONCLUSIONS OF LAW

1. Respondents objected to claimant filing the current petition to reopen on November 25, 2009, while he has a pending petition to review the order denying his December 28, 2008 petition to reopen. Respondents also argued that claimant is not permitted to file successive petitions to reopen. Claimant clarified at hearing that he seeks to reopen based upon a change of condition since the last hearing on September 30, 2009. Nothing in the statute prohibits claimant from pursuing this separate petition to reopen based upon a change of condition since the last hearing.

2. 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). Reopening is appropriate when the degree of permanent disability has changed, or when additional medical or temporary disability benefits are warranted. *Dorman v. B & W Construction Co.*, 765 P.2d 1033 (Colo. App. 1988). Claimant has the burden of proving these requirements, *see Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). 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 failed to prove by a preponderance of the evidence that he suffered a change of physical or psychological condition as a natural consequence of the work injury.

3. Claimant also alleges that his case should be reopened due to economic circumstances without a showing of a change in his medical condition. *Lucero v. Industrial Commission*, 732 P.2d 642 (Colo. 1987) held that a change in condition means “a change in the claimant’s physical or mental condition resulting from the compensable injury and not a change in economic conditions, even though that change may affect the claimant’s income.” *Id*. at 649. Here, claimant argues that his case should be reopened and that he should be found permanently and totally disabled due to his change in economic condition. *Lucero* precludes this reopening.

ORDER

It is therefore ordered that:

1. Claimant’s petition to reopen based upon a change of medical condition is denied and dismissed.

2. Claimant’s alternative ground that he is entitled to reopen his claim based upon a change of economic condition is denied and dismissed.

DATED: March 31, 2010

Martin D. Stuber
Administrative Law Judge

ORDER GRANTING RESPONDENTS' MOTION FOR SUMMARY JUDGMENT, ORDER VACATING HEARING, AND ORDER GRANTING ATTORNEY FEES

THIS MATTER has come before the undersigned upon Respondents' motion for summary judgment regarding unripe issues and statute of limitations..In this order, "ALJ" refers to Administrative Law Judge, "C.R.S." refers to Colorado Revised Statutes (2009); OACRP refers to the Office of Administrative Courts Rules of Procedure, 1 CCR 104-1., and C.R.C.P. refers to Colorado Rules of Civil Procedure.

On March 16, 2010 the Office of Administrative Courts (OAC) received a letter from the claimant, dated March 10, 2010. The letter is addressed to: “To Whom it Concern or ALJ.” The letter is not entitled a response to the motion for summary judgment but does address the issues. Although it is not timely filed the ALJ will consider this a response to the motion.

On March 22, 2010 the undersigned ALJ issued an interim order granting the Respondents’ relief. That order indicated that a full order would be forthcoming. The full order follows herein.

ISSUES

Whether the issues endorsed in claimant's December 11, 2009 Application for Hearing are ripe for adjudication.

Whether claimant's claim for additional benefits in his Application for Hearing is barred by the statute of limitations.

Whether the Respondents’ are entitled to an award of attorney fees.

FINDINGS OF UNDISPUTED FACT

1. A hearing in this matter is currently scheduled for March 23, 2010.

2. Claimant sustained an admitted work injury on October 16, 2003. A Workers' Claim for Compensation was filed in this case on December 5, 2003. The Claim for Compensation alleged that claimant had sustained a low back strain as a result of moving cases of shoes on October 16, 2003.

3. Respondents filed a Final Admission of Liability on October 14, 2004. The Final Admission of Liability admitted to 15% whole person impairment rating.

4. Claimant filed an Application for Hearing on October 22, 2004. The issues endorsed in the application for hearing included medical benefits, permanent partial disability benefits and

permanent total disability benefits.

5. Initially a hearing was set to take place on February 2, 2005. The hearing did not take place as scheduled.

6. By October 24, 2005, Respondents filed a Motion to Close Due to Non-Prosecution of the case. An Order to Show Cause was issued by the Director on November 17, 2005. Claimant failed to file a response to the Order to Show Cause and his claim closed automatically on December 19, 2005.

7. On July 26, 2006, Claimant's counsel, Mr. W, filed a Motion for Withdrawal of Counsel. This Motion was granted on August 10, 2006.

8. On December 13, 2007, Claimant, through Mr. W as counsel, filed an Application for Hearing endorsing penalties for Respondents alleged failure to exchange medical records on a timely basis. Claimant did not set this matter for hearing. Instead, Claimant filed a second Application for Hearing on March 26, 2008. Claimant endorsed petition to reopen, medical benefits and penalties against Respondents for allegedly failing to designate an authorized provider to provide maintenance care.

9. Respondents filed a Response to Application for Hearing on April 25, 2008. Respondents endorsed the defenses of statute of limitations, cure of the penalty, apportionment, causation, relatedness, attorney fees for endorsing an unripe issue and failure of claimant to state the penalty with specificity. A hearing regarding these issues was scheduled for July 16, 2008, at 1:30 p.m. in Colorado Springs.

10. In order to prepare a defense of the claim, Respondents sent interrogatories to claimant and requested signed releases, along with a list of all medical providers. Claimant failed to answer the interrogatories or provide signed releases and a list of medical providers to allow Respondents to further defend the claim.

11. Respondents filed a Motion to Compel Claimant to Answer Interrogatories and Provide Releases on June 6, 2008. Respondents also filed an opposed Motion to Extend Time to Commence Hearing on June 6, 2008. Respondents' respective motions were granted on June 20, 2008.

12. Even after entry of these Orders, Respondents did not received any executed releases or claimant's responses to Respondents' Interrogatories. On December 17, 2008, Respondents' counsel sent correspondence requesting signed releases and responses to interrogatories. Respondents did not receive answers from claimant or executed releases.

13. Six and one-half months passed from the date ALJ Walsh ordered claimant to execute releases and answer interrogatories. Claimant failed to comply with the order. Respondents then filed a Motion to Dismiss with Prejudice on January 13, 2009 pursuant to C.R.S. §8-43-207 (1)(e) and this was granted on January 27, 2009.

14. Claimant failed to appeal this Order.

15. On December 11, 2009 claimant filed an Application for Hearing which endorsed the issues of medical benefits, authorized provider, and reasonably necessary. This Application for Hearing was filed more than six years from claimant's October 23, 2003 date of injury. Moreover, the Application for Hearing does not endorse petition to reopen as an issue.

16. Respondents then filed a Response to Application for Hearing on January *5,* 2010, endorsing the claim was dismissed with prejudice pursuant to Order dated 1/27/09; collateral estoppel; attorney fees for filing an Application for Hearing on unripe issues; and statute of limitations.

17. Respondents have expended time and fees in-the defense of claimant's unripe claims. Claimant is barred by the statute of limitations from obtaining additional benefits.

CONCLUSIONS OF LAW

1. Summary Judgment is warranted when the moving party demonstrates that it is entitled to judgment as a matter of law. C.R.C.P. 56. Once the moving party establishes no material fact is in dispute, the burden of proving the existence of factual issues shifts to the opposing party. *Gifford v. City of Colorado Springs,* 815 P.2d 1008 (Cob. App. 1991). A failure of the opposing party to satisfy the burden entitles the moving party to summary judgment. *Id.*

2. The doctrine of ripeness refers to the requirement that a claim involve an actual case or controversy between the parties that "is sufficiently immediate and real so as to warrant *adjudication." Jessee v. Farmers Ins. Exchange,* 147 P.3d 56 (Cob. 2006); *Olivas-Soto v. Indus. Claim Appeals Office,* 143 P.3d 1178 (Cob. App. 2006).

3. ALJ Stuber ordered on January 27, 2009 that claimant's claim was dismissed with prejudice as a discovery sanction pursuant to §8-43-207(1)(e), C.R.S (2008) and C.R.C.P. 37 (b)(2). It is undisputed that claimant failed to appeal the Order dismissing his claim. Thereafter, claimant filed an Application for Hearing on the issues of medical benefits, authorized provider, and reasonably necessary. Claimant's December 11, 2009 Application for Hearing should be stricken as a matter of law.

4. Claimant's work injury occurred on October 23, 2003. Claimant's claim was dismissed with prejudice on January 27, 2009. Claimant did not appeal this Order and his claim closed.

5. Claimant's December 11, 2009 Application for Hearing did not endorse the issue of petition to reopen. Even if claimant had endorsed petition to reopen as an issue, claimant's claim is barred by the statute of limitations pursuant to C.R.S. §8-43-303 (2009). This statute provides that "[a]t any time within six years after the date of injury, the director or an administrative law judge may . . . review and reopen any award on the ground of fraud, an

overpayment, an error, a mistake, or a change in condition. . .." More than 6 years have passed since the date of claimant's injury and the filing of the current Application for Hearing. Additionally, claimant did not endorse petition to reopen on his December 11, 2009 Application for Hearing. Claimant's claim is barred by the statute of limitations since he failed to file a petition to reopen within 6 years of the date of his injury.

6. Section 8-43-211(d), C.R.S. (2009) provides for an award of attorney fees and costs in this matter. If a party requests a hearing on an issue that is not ripe for adjudication, the party *"shall* be assessed the reasonable attorney fees and costs of the opposing party in preparing for such hearing." § 8-43-211(d), C.R.S. (2009) (emphasis supplied).

7. Respondents have incurred attorney fees and costs defending claimant's unripe issues. Therefore, claimant *"shall* be assessed the reasonable attorney fees and costs" for Respondents preparing this Motion for Summary Judgment and preparing for hearing on issues that are not ripe for adjudication. § 8-43-211(d), C.R.S. (2009) (emphasis supplied).

8. Counsel for Respondents, C has been a workers' compensation attorney for 5 and 1/2 years Respondents have expended a total of $2,025 in fees and costs in responding to claimant's unripe application for hearing and in filing this motion. These fees and costs are reasonable and necessary and related to unripe hearing issues.

ORDER

1. Respondents' Motion for Summary Judgment is hereby granted.

2. Claimant's December 11, 2009 Application for Hearing is hereby stricken. The hearing on March 23, 2010 at 9:00 a.m. in Colorado Springs is vacated.

3. Respondents are awarded reasonable attorney fees and costs in the amount of $2,025 for preparing this Motion for Summary Judgment and preparing for hearing on issues that are not ripe for adjudication.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, Colorado, 80202. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

DATE: March 31, 2010 /s/ original signed by:

Donald E. Walsh
Administrative Law Judge