Dec 2009 Orders

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-645-139

ISSUE

The issue to be determined is the reasonable and necessary essential services to be provided to Claimant on a daily basis.

FINDINGS OF FACT

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

1. Claimant sustained compensable industrial injuries on March 11, 2005, while working and residing in the State of Colorado. Claimant has a cervical radicular myelopathy with a spinal cord injury that has left her wheelchair bound.

2. While in Colorado, Claimant was under the care of William Shaw, M.D., who had provided a prescription for home healthcare for eight hours per day.

3. Claimant moved to ^ on June 1, 2007. After Claimant's move to ^, she came under the care of Kathryn Borgenicht, M.D., who continued the medications prescribed by Dr. Shaw as well as the home health care prescription. Claimant's home healthcare in ^ was provided to her by her ex-husband, ^ ^, who is paid $15.00 per hour to provide these services.

4. When Claimant moved to ^, Respondents provided and paid for an assisted living facility, ^, at the rate of $35,000.00 per year where Claimant is still residing. Respondents also purchased a van for Claimant in April 2007 so that her home healthcare individual could drive her to and from medical appointments. The van is now being used by Mr. ^.

5. In July 2007, Dr. Borgenicht increased the prescription for home healthcare to twelve hours per day. In February of 2008, Dr. Borgenicht increased the home healthcare prescription to eighteen hours per day. There are no medical records from Dr. Borgenicht giving his basis for the increase in home healthcare hours.

6. After the prescription for home healthcare was increased to eighteen hours per day, Respondents wished to transfer Claimant to a facility that provided twenty-four-hour care by medical professionals. The facility chosen by Respondents would have provided Claimant with a private room as well as all of her meals and twenty-four hours of nursing care.

7. Claimant declined the offer of a nursing facility and requested continuation of private home healthcare and modification of her home. Hearings were held before Administrative Law Judge Barbara Henk and an Order was issued on February 6, 2009, directing Respondents to pay for modifications to Claimant's unfinished basement in the house that she owned in ^ where her ex-husband was residing.

8. Claimant chose to not have the Respondents pay for the home modifications but to have her home modifications preformed in a manner she chose. By Order dated July 9, 2009, a Stipulation was approved wherein Claimant was provided the sum of $200,000.00 to pay for any home modifications she chose to have performed to her home located at ^, ^ or any other home that Claimant chooses to move to in the future.

9. Claimant testified that the home is being modified and that she plans to move to such home at the end of November 2009. In addition, ^ ^ and Claimant's daughter, ^ ^, live in the upper part of the house. According to Claimant, Mr. ^, Ms. ^, and her granddaughter, are personally performing the essential services for 15 hours per day from 6:00 a.m. to 9:00 p.m.

10. After Claimant's prescription for home healthcare was increased to eighteen hours per day, Respondents requested that Mr. ^ provide the exact essential services he was providing to Claimant from 6:00 a.m. to 9:00 p.m. Mr. ^ began turning in forms detailing his duties in order to receive his payment of $1,575.00 per week. The home care hourly reports of Mr. ^ from February 10, 2009 through August 4, 2009 set forth in specific detail all duties for which he was being paid during such period of time.

11. In addition to performing services relative to Claimant's medical care such as assisting her with a catheter, bathing her, and assisting her with dressing and undressing, Mr. ^ was also charging $15.00 per hour for services including taking Claimant for rides in the van, listening to music, talking to Claimant, watching a movie with Claimant and fixing and eating popcorn with her, assisting her with e-mail, driving her to the park and watching children play at the park.

12. Claimant had been seen by Bradley Aylor, M.D., when she first moved to ^. She returned to him on March 25, 2009. Dr. Aylor noticed that since he had seen her in December of 2006, her functional status had declined. He had no explanation for this. He indicated that she had normal tone and reflexes in the lower extremities and he could not explain the findings on clinical examination. Due to her progressive decline in status without medical explanation, he recommended that she be seen at the Mayo Clinic. Dr. Aylor stated that the types of duties that required medical attention could be performed within eight hours per day and that he would recommend eight hours of "home care" per day.

13. Claimant was evaluated at the Mayo Clinic in June 2009. She was seen by a neurologist who indicated that there was no evidence of spinal cord compression at the current time but that her neurological examination was compatible with spinal cord dysfunction. However, he stated that, “the puzzling finding is that her muscle bulk is very preserved for the degree of weakness. She does receive physical therapy twice a week, but she said that it is passive therapy. Usually with passive therapy, there also is progression of muscle atrophy.”

14. Russell Gelfman, M.D., from the Mayo Clinic evaluated Claimant and reviewed all of the diagnostic tests. He indicated that he was unable to confirm the prior diagnosis that had been given to Claimant as ASIA D. He stated that an EMG had been performed which showed activation of voluntary motor unit potentials in right lower extremity muscles. He stated that this finding had clinical significance and that about 40% of individuals with ASIA B injuries recover unassisted walking and up to 90% of people with ASIA C injuries recover unassisted walking with proper encouragement and training. He felt that Claimant’s diagnosis was a spinal cord injury classified as ASIA C. Dr. Gelfman opined that Claimant required eight hours per day of essential home services to help with normal personal care such as caring for her bladder, assisting with transfers in and out of bed, as well as helping with other activities of daily living such as bathing and dressing. He stated that she was able to feed herself and perform upper body grooming.

15. Dr. Gelfman testified that Claimant’s muscle bulk was very well preserved for her degree of weakness and that this was an “unusual finding.” He stated that if Claimant had had no movement and no sensation in her legs then the muscles “typically tend to atrophy”. He indicated this was even seen with aggressive therapy. He stated that this unusual finding could not be explained and that he was “concerned” about such finding. In Dr. Gelfman’s practice he had not seen anybody with a spinal cord injury severe enough to not be able to move their extremities but still have this degree of bulk.

16. Dr. Gelfman stated that Claimant required eight hours per day of assistance. He agreed that someone would need to perform catheterization once or twice per day and help her get in and out of bed, get dressed and bathed. He also felt that she could perform light food preparation on her own and was able to feed herself. Dr. Gelfman did not believe that Claimant required someone to be with her from 6:00 a.m. until 9:00 p.m. on a daily basis.

17. Surveillance was performed on May 14, May 15, May 31, June 1, June 2, July 23, and July twenty-four, 2009. The surveillance film was seen by Claimant and she acknowledged that Mr. ^ was the individual in the surveillance films.

18. After the first hearing was held in this matter, Mr. ^ was requested to advise if all of the home healthcare services were being performed by him and no other individuals. He claimed that all hours that he had turned in since the hearing was held in October 2008 were only performed by him.

19. Mr. ^ indicated that his home healthcare duties changed on a daily basis depending on various activities and medical appointments. Mr. ^ testified that Claimant assisted him in preparing the documents and that he would discuss with her what duties he performed before submitting the documents. Mr. ^ acknowledged that there were times when Ms. ^ and his granddaughter, ^ ^, performed some of the duties. However, he stated this happened "very rarely." Of the $171,000.00 that he had been paid by Insurer up until that point in time, he could not provide any documentation as to what he would have paid these individuals. According to Mr. ^, he is with Claimant from 6:00 a.m. to 9:00 p.m. on a daily basis and it was very "seldom" or very "rare" that his daughter or granddaughter was with Claimant. He also indicated that he would never leave Claimant alone unless he was out having a cigarette or doing her laundry. Later he testified that he might have left her by herself for an hour.

20. Mr. ^ is the sole proprietor of the ^ ^ in ^, ^. He testified that at no time between February 14, 2009, and August 25, 2009, had he been at the ^ between the hours of 6:00 a.m. and 9:00 p.m.

21. Surveillance on May 15, 2009, shows that Mr. ^ arrived at Claimant's residence at 5:45 a.m. but left at 7:32 a.m. and returned to his home. He remained at his home until 10:15 a.m. when he left to perform errands at a hardware store and to go to the ^ ^. He then returned home at 11:30 a.m. and did not return to Claimant's residence at ^ until approximately 12:30 p.m. He then left Claimant's residence at 4:00 p.m. and returned home. The home healthcare sheet for May 15, 2009, submitted by Mr. ^ indicated that he was with Claimant from 6:00 a.m. until 9:00 p.m. On May 31, 2009, Mr. ^ arrived at Claimant's residence at 5:41 a.m. but left at 8:00 a.m. and returned to his home. He remained at his own residence until 10:35 a.m. when he left and went to the ^ ^ until 11:15 a.m. He then returned home at that time. Mr. ^ than returned to Claimant's residence at 1:00 p.m. and on that date took Claimant to a High School graduation in ^. Claimant remained at the High School graduation from 1:30 p.m. until 3:30 p.m. and was then taken to a private residence. She remained there until Mr. ^ drove her home at 6:30 p.m. Mr. ^ then left Claimant's residence at 6:30 p.m. On the home healthcare sheet submitted by Mr. ^ for May 31, 2009, there is no mention of the graduation and Mr. ^ submitted hours from 6:00 a.m. to 9:00 p.m. and did not indicate that they had left the facility other than to go to the park and "stopped to watch the children" as well as watching a movie with Claimant and fixing popcorn. On June 1, 2009, Mr. ^ arrived at Claimant's ^ residence at 5:40 a.m. but left at 7:30 a.m. and traveled to various locations until he returned to his own home at approximately 8:30 a.m. He later left his home at 9:20 a.m. and performed additional errands including going to the ^ ^ for approximately one hour and then returning home.

22. On July 23, 2009, Mr. ^ again arrived at Claimant's residence at 5:45 a.m. but left at 7:30 a.m. and returned to his own home. He again did not leave his own home until approximately 10:30 a.m. and again went to the ^ ^ and returned to his own home again. He did not return to Claimant's residence until 1:00 p.m. when he took her to her physical therapy appointment. While Claimant was in the physical therapy ap-

pointment, Mr. ^ went to the ^. He returned Claimant to her residence at approximately 3:15 p.m. but then left again at 4:00 p.m. and returned to his own home. He did not leave his home between 4:00 p.m. and 9:00 p.m. On July twenty-four, 2009, Mr. ^ arrived at Claimant's residence at 5:50 a.m. but again left at 7:30 a.m. and returned home. He then again went to the ^ ^ at approximately 10:00 a.m. for an hour and then returned to his own residence. He then again returned to Claimant's residence at 1:00 p.m. and stayed with Claimant until 4:00 p.m. He left at that time and went to his own house where he did not leave between the hours of 4:00 p.m. and 9:00 p.m. On the worksheets turned in by Mr. ^ for July 23 and July twenty-four, 2009, he claimed that he was with Claimant from the hours of 6:00 a.m. until 9:00 p.m.

23. According to Claimant, Mr. ^ might leave her alone at the most for one-half hour. She indicates that she does nap anywhere from one to three hours per day. According to Claimant, she was unaware that Mr. ^ was turning in forms that were incorrect until she received the Interrogatories that contained the home care hourly reports from February 10, 2009, through August 4, 2009. Claimant agreed that in her discovery responses she was asked whether any other individuals had provided the home healthcare services set forth in the home healthcare sheets other than Mr. ^. If there were other individuals she was to provide the names and addresses and the dates and hours services were provided. She indicated in her discovery that no other individuals had provided those services. At the hearing she indicated that she might have "interpreted" the question wrong and that Mr. ^ was simply responsible for seeing that her "needs were taken care of".

24. Claimant alleges that when she moves to her own home that if she were not provided with home care services from 6:00 a.m. to 9:00 p.m. that she could be "in trouble" if something occurred. However, she acknowledged that she declined the Respondents' offer to place her in a twenty-four-hour facility with medical professionals. Claimant also testified that she felt that the services provided by Mr. ^ including taking her to the park, watching movies with her and simply spending time with her should be paid for by the Respondents as she considered these "quality of life services." According to Claimant, on the days the surveillance clearly showed that Mr. ^ was not with her that those were "most likely" days that her daughter was there. However, the surveillance does not indicate that anyone arrived at Claimant's facility at the time Mr. ^ left or that anyone was leaving the facility at the time that Mr. ^ arrived.

25. Claimant is able to perform daily activities such as brushing her teeth, brushing her hair and washing her face and the truck of her body. She is able to turn the TV off and on and change channels. She is able to use the phone as well as work on the computer. She is also able to feed herself and use a microwave. She operates her own wheelchair and can go in and out of buildings and to medical appointments by herself as long as she is driven by someone. She also naps anywhere from one to three hours per day. According to Claimant, she also wears Depends in case she has some type of bladder accident.

26. Although surveillance was conducted in this matter on seven separate days and some of these were consecutive days, at no time did the surveillance indicate that Mr. ^ was with Claimant from 6:00 a.m. until 9:00 p.m. On the days of surveillance, Claimant was left anywhere from three to six hours on her own without assistance from Mr. ^.

27. The ALJ finds that Claimant does not require a caregiver to be with her from 6:00 a.m. to 9:00 p.m. on a daily basis and does not find Claimant or Mr. ^'s testimony to be credible in that there has always been someone with Claimant fifteen hours per day since February 10, 2009. The weight of the evidence Indicates that Claimant and Mr. ^ were aware that home healthcare sheets were being turned into the carrier for services that were not being performed. Instead the evidence indicates that Mr. ^ arrives at Claimant's residence in the morning and performs services and then leaves again and returns later in the day to also perform such services. Mr. ^'s testimony that he did not go to the ^ ^ at any time between 6:00 a.m. to 9:00 p.m. is rebutted by the surveillance. Claimant herself acknowledged that Mr. ^ provided incorrect testimony. The ALJ finds that the sheets being turned in for services provided do not correctly indicate what services have been provided to Claimant.

28. Dr. Aylor and Dr. Gelfman have opined that Claimant does require assistance with activities of daily living that relate to her medical condition including assistance with getting in and out of bed, dressing, bathing, and help with catheterization. The ALJ finds Dr. Gelfman and Dr. Aylor's opinions to be credible in that Claimant requires such assistance on an eight-hour per day basis.

29. According to Claimant, when she moves to her own house she will reside in the basement and her ex-husband and daughter will live upstairs. Either one of these individuals will be able to come down in the morning and assist her with her essential services. These individuals can also return at the noon hour and in the evening to assist her with these activities. The services which were allegedly rendered to Claimant by Mr. ^ or other home healthcare providers including taking her for a ride to the park, listening to music with her, talking about positive stuff, helping her with her e-mail, watching children play or watching movies with her do not relate to Claimant's medical condition and do not treat the effects of the injury. The ALJ finds that these services are not incidental to the provision of medical treatment and are not reasonable and necessary essential services.

CONCLUSIONS OF LAW

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

1. The purpose of the Workers' Compensation Act of Colorado (Act), Section 8-40-101, et seq. C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of liti-

gation. Section 8-40-102(1), C.R.S. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and scope of his employment. Section 8-41-301(1), C.R.S.; *See City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of Claimant nor in favor of the rights of Respondents. Section 8-43-201, C.R.S.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice or interests. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936). A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The 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. Respondents are liable for 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. The question of whether Claimant proved treatment is reasonable and necessary is one of fact. *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d, 1192 (Colo. App. 2002).

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

5. The ALJ concludes that Claimant has not been receiving essential services from a home health care provider from 6:00 a.m. until 9:00 p.m. from February 10, 2009, and ongoing despite the sheets being turned in by Claimant and Mr. ^. Although Respondents have paid Mr. ^ approximately $6,825.00 per month for such services, these services have not been performed.

6. The ALJ finds that the home health services were falsely submitted and paid for by Respondents. There has been a misrepresentation by the submission of the

home healthcare sheets to Respondents when the work allegedly being performed and paid for was clearly erroneous. The ALJ finds that Claimant has not been receiving nor does she require home healthcare services from 6:00 a.m. to 9:00 p.m. on a daily basis.

7. Claimant was specifically requested to advise if anyone other than Mr. ^ had provided the services listed on Exhibit A and to provide the names and addresses of any other individuals who had performed the services as well as the dates and times performed. The ALJ does not find Claimant's testimony to be credible in that she "misunderstood" or "misinterpreted" the question. In addition, the ALJ does not find, based upon the surveillance, that anyone else would have been arriving or leaving to take care of Claimant at the times Mr. ^ arrived or left Claimant's residence.

8. The services set forth by Dr. Aylor and Dr. Gelfman which include assistance with catheterization, bathing and getting in and out of bed are found to be a necessary part of treatment of Claimant's condition and are "medical in nature" because they have a direct bearing on Claimant's condition and symptoms. However, the other "services" that were allegedly provided by Mr. ^ and other medical providers such as going to the park with Claimant, watching a movie with Claimant, helping her with her e-mail, or simply sitting around and talking to her, are not medical in nature, do not treat the effects of the injury nor are they incidental to providing treatment. Claimant's allegation that these activities should be paid for by Respondents as they are "quality of life services" is incorrect. Since these services are not medical in nature or incidental to receiving medical services, the expenses incurred while providing them are not compensable. *Kuziel v. Petfair, Inc*, 931 P.2d 521 (Colo. App. 1996).

9. Claimant has also alleged that she would be in trouble at times if she did not have someone with her from 6:00 a.m. to 9:00 p.m. However, Claimant acknowledged that she was offered twenty-four hour nursing care at a nursing facility that she declined. The weight of the evidence would indicate that, at the present time, Claimant is being provided with approximately eight hours per day of essential services based upon the actual hours spent by Mr. ^ with Claimant and not the hours that he claims to have performed. The ALJ therefore accepts the opinions of Dr. Aylor and Dr. Gelfman in that Claimant is entitled to eight hours per day of essential services.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law the ALJ enters the following Order:

1. Claimant's request for home healthcare services from 6:00 a.m. to 9:00 p.m. is denied.

2. Respondents shall be responsible for payment of eight hours per day of essential services and such essential services can be provided on a daily basis for any eight hours to be chosen by Claimant.

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

DATED: *November 30, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-783-809

ISSUES

¬ Did Claimant prove by a preponderance of the evidence that Claimant suffered an injury arising out of and in the course and scope of her employment with employer?
¬ If Claimant did prove a compensable injury, did Respondents prove by a preponderance of the evidence that Claimant was responsible for her termination of employment?
¬ If Claimant did prove a compensable injury, was the treatment provide by Dr. Karli reasonable and necessary to cure and relieve the effects of the injury and was Dr. Karli authorized?
¬ If Claimant did prove a compensable injury, did Respondents prove claimant should be penalized pursuant to Section 8-43-102(2), C.R.S. for one day's compensation for each day she failed to properly report her injury?
¬ The parties stipulated that the issue of average weekly wage ("AWW") and temporary disability benefits would be held in abeyance for future determination either through agreement of the parties or at a future hearing.

FINDINGS OF FACT

1. Claimant was employed with employer as a clinic manager. Claimant began her employment with employer in May, 2007. Claimant's job duties included working at the front desk of employer's veterinary clinic, interacting with clients as they arrive at the clinic and invoicing clients for services rendered. Claimant testified that as part of her compensation agreement, she was provided with veterinary care for her pets at no charge, including dog food.
2. Employer testified that her agreement with her employees was to provide free veterinary services for pets of her employees, but the employees would pay for all medications and lab work relating to the care of those animals. This testimony con-

flicted with the testimony of the Claimant who indicated that the agreement would include all medications and lab work relating to the care of her pets. There was no written agreement setting forth the established standard for the benefit of having the Employer treat the pets of the employees. There was conflicting evidence as to whether the same benefit was provided to each employee. Claimant testified that when Employer hired a new employee, she was told specifically that the new employee was not to receive the same level of free care that Claimant received.

3. Claimant testified that on or about June 26, 2008, she was working at the front desk of the clinic when she went to sit down on her chair, missed the chair and landed on her tail bone on the floor of the clinic. Claimant testified that she felt stunned and had pain in her back up to her head. Claimant testified that she did not immediately get up, but sat on the floor for a few minutes. Claimant testified she eventually got up and told Employer that she had fallen. Claimant testified Employer advised Claimant she had a trade arrangement with an acupuncturist, Dr. Bump, and offered to allow Claimant to see Dr. Bump under her trade agreement. Employer also offered Claimant use of a cold laser therapy devise. Claimant testified she treated with Dr. Bump on one or two occasions, but did not receive relief from the treatment. Claimant also testified she had treated with Dr. Bump prior to the June 26, 2008 incident for her pre-existing back issues. Claimant also attempted to use the cold laser therapy devise but did not obtain much relief from the devise.

4. Employer and Ms. Suazo, a veterinary technician for employer testified at the hearing. The testimony of Employer and Ms. Suazo was consistent with Claimant insofar as they were aware of the incident occurring on June 26, 2008. Employer acknowledged asking Claimant if she was hurt after the incident, and Claimant responded that she would be OK. Employer acknowledged offering the services of the acupuncturist and cold laser therapy devise to Claimant. Employer further acknowledged that she did not refer Claimant for medical treatment with a physician upon being told of the incident, beyond offering the services of the acupuncturist.

5. Claimant has a long history of prior back injuries, including documented degenerative changes in both the low back and upper cervical spine and a history of prior cervical spine surgery consisting of a C6-7 fusion. Claimant was under active care for problems with her right hip with Dr. Feeney prior to her industrial injury. Dr. Feeney noted in March 2008 that Claimant had undergone an MRI of the right hip on February 26, 2008 that revealed a labral tear. Claimant received treatment from a dermatologist in Englewood, Colorado on July 23, 2008 for a cosmetic procedure to address a ruptured epidermal inclusion cyst. Claimant did not report back pain to the dermatologist.

6. Claimant eventually was evaluated by Dr. Karli on October 29, 2008 and reported a recurrence of a chronic complaint of axial low back pain. Claimant reported to Dr. Karli that in June 2008, she was sitting on a chair that had wheels and it slipped, causing a fall into the seated position. Claimant reported an immediate onset of pain across the back that continued all summer and caused Claimant to reduce her activities. Dr. Karli performed x-rays and determined that Claimant's condition was the result of a chronic situation that was aggravated by sudden axial load with the fall. Due to the fact that Claimant had no shock absorptive capacity at L4-L5 and L5-S1, something was flared as a result of the fall. Dr. Karli recommended anti-inflammatories to treat Claimant's condition.

7. Claimant underwent an epidural steroid injection ("ESI") on November 3, 2008 under the auspices of Dr. Karli. Claimant reported significant relief with from the ESI when she returned to Dr. Karli on November 19, 2008. Dr. Karli recommended an additional injection followed by ongoing rehabilitation and prescribed Claimant Darvocet. Dr. Karli performed a facet block injection at the L4-5 and L5-S1 levels on November 25, 2008.

8. Claimant returned to Dr. Karli for complaints of neck pain on December 23, 2008. Dr. Karli noted Claimant had multiplanar limitations in her range of motion with increased pain on extension and clear tenderness in the suboccipital paraspinal soft tissues palpation that reproduced some headache. Dr. Karli provided Claimant with Vicodin and Valium and recommended cryotherapy and stretching techniques that are used to augment trigger point therapies.

9. Claimant was eventually terminated from her employment with employer on January 22, 2009. Claimant was instructed by her employer to take a weeks vacation beginning January 15, 2009. Claimant was terminated from her employment by voice mail. According to the voice mail message, Claimant was terminated because Employer could no longer afford to employ Claimant.

10. Employer testified that in the Summer of 2008 there were concerns raised with regard to the financial impact of Claimant's employment with Employer. Ms. Robbins, Employer's business manager and bookkeeper testified that in 2008 she began asking Claimant for copies of the invoices involving the care provided to Claimant's pets through Employer. Claimant would promise to provide invoices to Ms. Robbins, but never did. In December 2008, Employer requested Ms. Suazo prepare information from a database to determine what care had been provided to Claimant's pets and what care had been invoiced. Ms. Sauzo prepared the requested audit information and presented her results to Ms. Robbins.

11. With regard to the accident, Ms. Robbins testified that she became aware of the Claimant's alleged injury a few days after the occurrence when she had a conversation with the Claimant where the Claimant asked Ms. Robbins if a workers' compensation claim would affect the clinic. Ms. Robbins testified she told the Claimant, "yes" and explained that the clinic would face a higher premium. Claimant then told Ms. Robbins about the incident where she fell off a chair. Ms. Robbins testified she asked Claimant is she needed to see a doctor, and Claimant answered "no".

12. Employer testified that Claimant was consistently tardy during 2008, would spend work time running personal errands and was dealing with emotional issues involving the health of her pet. Claimant's emotional state resulted in Claimant having an emotional meltdown at the front desk in January 2009. Employer testified that during 2008 she would bring up during staff meetings the importance of the employees to invoice themselves for care provided to their pets. However, Employer did not ever confront Claimant specifically for the alleged failure of Claimant to properly invoice the care her pets received from employer.

13. After Claimant was terminated, Claimant contacted employer requesting an exit interview. In response to Claimant's request, Employer wrote to Claimant on January 27, 2009 that rejected Claimant's request for an exit interview and further explained the reasons for termination. Employer advised Claimant that "there were many liberties taken by you that impacted this practice in a way that led to my decision". Later in the

letter, in direct response to Claimant's request for an exit interview, Employer explained that "there are no words that I can use to explain this in a way that will make sense to you. We have different opinions on the details and there will be nothing positive that will come out of further discussion." Later, in response to Claimant's request for reimbursement for a cell phone bill and gas, Employer explained that Claimant had been more than reimbursed "with the liberties taken with regard to time, medications, supplements, and food."

14. Employer testified in this matter that often times what Employer told Claimant and what Claimant heard were completely different. The ALJ finds that this is likely very accurate. The ALJ finds it difficult to believe that Claimant would consider free pet food obtained from the employer as part of her compensation package, but there is no credible evidence that Claimant was made aware that her assumption that the free goods and services, including free pet medications and food, were not a part of her compensation package, and the failure to properly invoice herself for these items would result in her termination of employment. Employer testified at hearing that the voice mail message left for Claimant where Employer stated the reason for termination was the inability to be able to afford Claimant's continued service was an attempt to be sympathetic to Claimant and give Claimant an out. However, Employer also testified that Claimant was terminated because Employer could no longer afford Claimant's emotional burden, could no longer afford the chaos and could no longer afford Claimant using the services of the clinic for free.

15. Following Claimant's termination, Claimant continued to seek care with Dr. Karli. Dr. Karli noted on February 20, 2009 that Claimant had been referred for physical therapy for her cervical spine. Dr. Karli continued Claimant's pain medications and recommended a possible second epidural injection. Claimant returned to Dr. Karli on July 1, 2009 and reported her cervical spine had responded well to the therapy. However, Dr. Karli also noted that Claimant's low back complaints had actually worsened. In response to a phone conversation with Claimant's attorney, Dr. Karli noted that it was his opinion that both the neck and low back complaints were causally related to the work injury in question. Dr. Karli noted that while Claimant had a prior history of both neck and back injuries, she was not under active care for these conditions at the time of the June 26, 2008 incident.

16. At Respondents request, Claimant underwent an Independent Medical Examination with Dr. Bernton ("IME") on July 30, 2009. Dr. Bernton issued a report indicating Claimant reported an injury occurring when she turned to answer a phone and sit down, missed the chair, and sat on her tailbone resulting in a shock that traveled up her spine to the top of her head. Dr. Bernton noted that Claimant had a prior history of a fractured tailbone in May 2005 and cervical surgery in 1989. Dr. Bernton opined in his report that Claimant's treatment that she presented for starting in October 2008 was not due to the reported episode where Claimant missed a chair and fell onto the floor, and that episode did not cause sufficient injury to be reasonably described as a cause for Claimant's symptoms and treatment.

17. Dr. Bernton testified in this matter that Claimant suffers from chronic degenerative changes in both the low back and upper cervical spine. Dr. Bernton opined that Claimant's current complaints are related to the chronic degenerative changes in her spine, and not the incident in which she missed a chair and fell onto the floor. Dr. Bern-

ton based this opinion on the fact that Claimant's injury occurred in June 2008, but Claimant did not receive treatment until October 2008. Dr. Bernton noted that Claimant did not seek treatment for six months and continued her usual job. In this regard, Dr. Bernton opined that if the fall had resulted in a substantial injury, the Claimant would have required care.

18. The ALJ finds the medical opinions of Dr. Karli more credible and persuasive than those from Dr. Bernton. Dr. Bernton relies on the lack of treatment Claimant sought initially after the industrial injury for the basis of his opinion. However, Claimant did receive some acupuncture treatment and cold laser therapy offered by Employer after the injury. Moreover, the ALJ credits the testimony of Ms. Robbins who reported that Claimant inquired as to how the filing of a workers' compensation claim would affect Employer within a few days of the injury. Claimant admittedly had a long history of prior medical treatment to her neck and back. The ALJ finds, however, that the incident of June 26, 2008 aggravated her pre-existing condition and caused Claimant's need for additional treatment from Dr. Karli.

19. The ALJ finds that Employer was aware of an incident involving Claimant missing a chair resulting in symptoms to Claimant's low back as of June 26, 2008. Employer responded by offering Claimant treatment through a trade agreement with an acupuncturist and the use of a cold laser therapy device. The ALJ infers from this evidence that Employer was aware that Claimant was seeking "treatment" for her condition. The ALJ notes that under the Colorado Workers' Compensation Act, the Employer has the right to select the physician who provides medical care in the first instance. The ALJ finds and determines that offering care through a trade agreement with an acupuncturist does not rise to the level of designating a "physician" to treat Claimant following an industrial injury. There is no credible evidence in the record as to the qualifications of the acupuncturist to determine that the acupuncturist is a "physician" as contemplated by the Colorado Workers' Compensation Act. Employer also did not provide Claimant with a choice of physicians for Claimant to choose from when treatment was offered. However, the ALJ finds that the acts of the Employer of offering Claimant acupuncture and use of the cold laser devise demonstrate that Employer was aware of Claimant's need for medical treatment. At that point, it is incumbent upon Employer to provide Claimant with medical treatment, regardless of whether the Claimant specifically says that she wants to go to a physician.

20. Despite Claimant reporting her injury verbally to Employer and Ms. Robbins, Claimant did not report her injury in writing until a workers' claim for compensation was completed by her attorney on January 29, 2009. The ALJ finds Claimant was aware of the compensable nature of her claim within a few days after the accident when she sought treatment with the acupuncturist and inquired with Ms. Robbins as to the financial consequences for the employer for her filing a claim for compensation. The ALJ finds that Claimant failed to make a claim for compensation because she believed she was benefiting the employer by seeking care under her personal insurance. However, the workers' compensation act does not provide an exception to the reporting requirement. As such, the ALJ finds that first time a written notice of the injury was completed was January 29, 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 leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

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

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

4. As found, Claimant suffered an injury when she went to sit down on or about June 26, 2008, missed the chair, and landed on the floor on her buttocks. As found, the ALJ credits Claimant's testimony that she suffered immediate pain, and credits the testimony from the Employer and Ms. Suaza that Claimant appeared to be in pain following the injury. The ALJ credits the medical reports from Dr. Karli insofar as Claimant presented with a consistent accident history to Dr. Karli upon her presentation for treatment in October, 2008. The ALJ discounts the medical records from Ms. Long, the PA-C, Dr. Rees-Jones and Dr. Maurer insofar as Claimant was seeking medical treatment Claimant received from these medical providers was unrelated to her low back complaints for which Claimant sought treatment with Dr. Karli. The ALJ notes that Claimant had a long history or prior low back complaints, but concludes based upon the medical records and opinions of Dr. Karli, that Claimant's accident of June 26, 2008 aggravated her preexisting condition. In support of this finding, the ALJ notes that Claimant had not received treatment for her low back complaints for over a year prior to her industrial injury of June 26, 2008.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Pursuant to Section 8-42-404(5), C.R.S., Respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once Respondents have exercised their right to select the treating physician, Claimant may not change physicians without first obtaining permission from the insurer or an ALJ. *See Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996). The right to select the treating physician, however, passes to Claimant where the employer fails to designate a physician willing to treat Claimant in the first instance. *See Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565 (Colo. App. 1987). Section 8-43-404(5), C.R.S. now requires the employer to provide an injured employee with a list of at least two physicians or medical providers willing to treat Claimant.

6. As found, Employer was aware that Claimant was seeking treatment as of the date of her injury and offered the Claimant treatment through use of a cold laser therapy devise and acupuncture. The ALJ credits the testimony of the Employer that treatment was offered to the Claimant in the form of visits with an acupuncturist, but finds that this treatment does not rise to the level of providing the Claimant with a "physician" to treat her injuries as required by the Act. The ALJ further notes that the Claimant was allowed to use the cold laser therapy devise by the employer as evidence that the Employer knew or reasonably should have known that Claimant was injured in the fall on or about June 26, 2008, and should have been referred for medical treatment pursuant to Section 8-43-404(5), C.R.S.

7. 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).

8. As found, Respondent has failed to prove that Claimant committed a volitional act that led to her termination of employment. Respondent argues that Claimant's belief that she would have free medical treatment for her animals, including the payment of all medications, lab work and food was unrealistic. The ALJ agrees. However, there was no credible evidence presented at the hearing that Claimant was advised that she was abusing the "free pet care" services provided by employer, and no credible evidence that Claimant was warned that her abuse of this policy would lead to her termination of employment. According to the Employer, Claimant was fired because of the emotional issues involving her pet, the fact that these emotional issues were affecting her ability to

perform her job duties, along with the fact that the employer could no long afford to keep Claimant employed. In this case, the ALJ credits the testimony of the Employer that often times there were communication issues between the Claimant and the Employer that led to the Claimant's eventual termination from employment, including Claimant's understanding of the extent to which she was allowed to utilize the services of the Employer for her pets. However, Respondents have not shown that Claimant committed a volitional act that led to her termination of employment. Instead, Claimant was terminated for a litany of issues, including her inability to regulate her emotional state following the illness of her dog.

9. Respondents also allege that Claimant is subject to a penalty of one day's compensation for failure to timely report her injury in writing. The ALJ agrees. Section 8-43-102(1)(a), C.R.S. states in pertinent part:

> Every employee who sustains an injury resulting from an accident shall notify said employee's employer in writing of the injury within four days of the occurrence of the injury…. Otherwise, if said employee fails to report said injury in writing, said employee may lose up to one day's compensation for each day's failure to so report….

10. As found, Claimant reported her injury to her employer verbally, but did not report her injury in writing until January 29, 2009. Claimant is subject to a late reporting penalty pursuant to Section 8-43-102(1)(a) for her failure to timely provide written notice of the injury.

ORDER

It is therefore ordered that:

1. Respondents shall pay all reasonable necessary and related medical benefits provided by Dr. Karli and his referrals to treat Claimant for her compensable injury to her back and neck.
2. Claimant is found not to be responsible for her termination of employment.
3. Claimant is subject to a penalty of one day's compensation for each day that she did not report her injury in writing to her employer for the period of July 1, 2008 through January 29, 2009.

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

All matters not determined herein are reserved for future determination.

DATED: November 20, 2009

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-788-199

ISSUES

¬ Did the Claimant establish by a preponderance of the evidence that he is entitled to temporary total disability ("TTD") benefits?

¬ If Claimant did establish by a preponderance of the evidence that he is entitled to temporary disability benefits, did Respondents establish by a preponderance of the evidence that Claimant is precluded from receiving temporary disability benefits due to the fact that he was responsible for his termination of employment?

¬ Prior to the hearing, the parties stipulated to an average weekly wage ("AWW") of $1,413.23.

FINDINGS OF FACT

1. Claimant was employed as a swamper for employer. Claimant suffered an admitted injury to his right shoulder on March 5, 2009. Claimant reported his injury to Mr. Lawson, his supervisor. Lawson referred claimant to Dr. Mosely. Claimant was evaluated by Dr. Mosely on March 10, 2009. Mr. Lawson accompanied claimant to his appointment with Dr. Mosley. Dr. Mosely noted Claimant had a significant amount of ecchymosis over his right shoulder, but did not believe Claimant had a tendon rupture. Dr. Mosley diagnosed claimant with right shoulder pain and provided claimant with a written release to regular employment. However, claimant and Mr. Lawson testified that Dr. Mosley told them verbally that he wanted claimant on light duty. Mr. Lawson testified that based on Dr. Mosely's verbal work restrictions, Claimant was provided with light duty work, despite the fact that Dr. Mosely's written report indicated Claimant could return to work without restrictions.

2. Based on the testimony of the Claimant, corroborated by the testimony of Mr. Lawson that Dr. Mosely provided different instructions regarding Claimant's work restrictions verbally than he did in writing, the ALJ finds the records of Dr. Mosely completely unpersuasive with regard to work restrictions. The fact that the treating physician would provide verbal work restrictions directly to the employer that are in complete contrast to the written work restrictions completely undermines Dr. Mosely's opinion with regard to Claimant's work restrictions, and the ALJ interprets Dr. Mosely's medical records entirely against Respondents and in favor of Claimant. The written reports from Dr. Mosely can not be credited by this ALJ where they do not reflect the doctor's true opinion of Claimant's ability to perform his work duties. Instead, the facts in this case lead the trier of fact to believe that Dr. Mosely is simply catering to the employer and providing written work restrictions that the physician does not truly believe in, and this written release to return to work without restrictions is rejected.

3. On March 11, 2009, Claimant had an appointment with Dr. Robert Adams, an orthopedist. Dr. Adams diagnosed a possible right rotator cuff tear. Dr. Adam's ordered an MRI and released claimant to return to modified duty with no lifting greater than one half pound with his right arm and avoid any major use of his right arm away from his body. Claimant testified that he advised Mr. Lawson of Dr. Adam's restrictions. The ALJ finds the work restrictions from Dr. Adams more credible than the written work restrictions

from Dr. Mosely. The restrictions from Dr. Adams are consistent with the verbal work restrictions from Dr. Mosely and the ALJ finds that the work restrictions from Dr. Adams properly reflect claimant's ability to perform work duties following his injury.

4. Following his March 5, 2009, injury, Claimant did not return to work at employer until March 16, 2009, due to the pain and symptomatology related to his work injury. Based on the testimony of the Claimant and Mr. Lawson, the ALJ finds that when claimant returned to work, he resumed his duties as a swamper/mentor and was permitted to work without the use of his right arm. After Claimant returned to work on March 16, 2009, he was provided with light duty by the employer as recommended by Dr. Mosely.

5. On March 20, 2009, claimant returned to Dr. Adams for an MRI. Upon review of the MRI, Dr. Adams recommended diagnosed at rotator cuff tear and recommend surgery but permitted claimant to return to modified duty with the a one pound restriction and no overhead reaching or reaching away from the body from March 20, 2009, through April of 2009.

6. While performing light duty work for employer, as a mentor to other swampers, claimant was instructed to proceed to Santa Rosa, New Mexico for a rig move. Mr. Lawson testified that claimant's job duties on the site move was to mentor Mike Workman, a short service employee ("SSE") who was not yet experienced enough to work without a mentor. Lawson testified that the reason for having an SSE work with a mentor was to ensure that the SSE is aware of the jobs they are expected to perform and do not get injured.

7. Claimant arrived in Santa Rosa on the afternoon of Friday, April 3, 2009. That afternoon, the crew went to the rig site to drop off the bed trucks and was advised that the rig move had been postponed until Monday, April 6, 2009, because the rig would not be ready to move on April 5, 2009. Claimant was not expected to be at the rig move until Monday, April 6, 2009.

8. Claimant testified that Saturday, April 4, 2009, was his day off. He and other employees were consuming alcohol on that day. Claimant admitted to getting intoxicated on April 4, 2009.

9. Mr. Lawson testified that he received complaints about claimant, including complaints from the hotel staff that claimant had been running around the lobby in his underwear and "flipping people off." On rebuttal, Claimant denied wearing underwear as a practice. Claimant, admitted he was swimming with Carhart shorts on.

10. On Sunday, April 5, 2009, claimant did not report to the rig site as he was under the impression that the rig move did not begin until Monday, April 6, 2009. Several other employees, but not all of the employees, went to the rig site on Sunday to perform preparatory work for the rig move on Monday. The preparatory work was described as "moving pus" which involves the collection of left over equipment from the previous site and getting it ready to be moved to the new site, but does not involve moving buildings.

One of the employees who went to the rig site was Mr. Workman. Claimant testified that he was unaware that Mr. Workman intended to go to the rig site on April 5, 2009.

11. On the morning of Sunday, April 5, 2009, claimant was no longer intoxicated and he could have gone out to the job site had he been asked by either a pusher or a safety manager. Claimant testified he would have been unable to assist in hauling "pus" because he did not have the use of his right arm due to his March 5, 2009, work related injury. Claimant testified that either a pusher or a safety manager is in charge of telling crew members to go out to the rig on any given day during a rig move. The ALJ finds that no representative of the employer advised Claimant that he should go out to the rig site on Sunday, April 5, 2009.

12. On Monday April 6, 2009, the date Claimant testified the rig move officially began, Claimant reported to the job site. When Claimant arrived at the job site on Monday, April 6, 2009, the derrick was still at the old rig site with power to the rig and no buildings had been moved to the new rig site. Claimant worked at the new rig site during the move. His assignment was to assist Mr. Workman in "setting a building" at the "back yard" of the new rig site.

13. Claimant testified that Mr. Workman already knew how to handle the bridles. Claimant stated that he was never advised by any representative of employer that a mentor and an SSE had to work side by side the entire time they were on a job site. In fact, claimant testified that everyone has a role during a rig move and everyone works independent of one another. While claimant was mentoring Mr. Workman, it was not uncommon for Mr. Workman to work on his own during a rig move.

14. Even though claimant was acting as Mr. Workman's mentor, Mr. Workman did not work by his side throughout the rig move. Mr. Workman traveled back and forth between the old and new location throughout the move. Neither claimant nor Mr. Workman was advised that this was against company policy by any representative of employer at any time during the rig move.

15. The rig move took two full days, April 6 and April 7, 2009. Following the rig move, Claimant returned to Colorado. According to the testimony of the Claimant and Mr. Lawson, there were no additional problems with the rig move after April 5, 2009 and employer at no time prior to Claimant returning to Colorado contacted Claimant with regard to the issues that took place on April 4 and April 5, 2009. At no time prior to Claimant's return to Colorado were any concerns expressed to claimant by employer or the client regarding the client's perception of the progress of the rig move or any safety concerns by the client.

16. After Claimant and the crew returned to Colorado on April 8, 2009 Claimant returned to work on April 10 and again on April 17 at the "yard" in Grand Junction.

17. Mr. Lawson testified that after receiving the complaints about claimant, he performed an investigation into the actions of claimant. However, Mr. Lawson did not order

claimant to return form the Santa Rosa rig move. Instead, Lawson waited until the crew returned from the job site before beginning the investigation. The investigation included gathering information from workers at the rig move and speaking to claimant. After completing the investigation, Mr. Lawson determined that it was appropriate to terminated claimant's employment. Mr. Lawson testified that the reason he decided to terminate claimant's employment was because claimant allowed Mr. Workman, the SSE he was in charge of mentoring on the rig move, to go to the rig site on Sunday without supervision. Claimant was terminated effective April 18, 2009.

18. Mr. Lawson admitted during cross examination that he was unaware of anyone informing the SSE that he should not proceed to the job site on Sunday. Furthermore, on cross-examination, Lawson admitted that the rig move did not start "in full" until Monday, April 6, 2009.

19. The ALJ finds that the act that resulted in claimant's termination of employment was allowing the SSE to proceed to the job site without supervision on Sunday. The ALJ credits claimant's testimony that he was unaware that Mr. Workman intended to proceed to the job site on Sunday, until after Mr. Workman had left. The ALJ finds the Claimant's testimony that he did not believe that the rig move started in full until Monday to be credible. The ALJ further finds that the Claimant was unaware that allowing the SSE to proceed to the job without supervision prior to the rig move beginning was an act that would result in his termination.

20. The ALJ further credits the testimony of the Claimant and Lawson that the rig move was not scheduled to begin in full until Monday. Therefore, any argument was terminated for being too hungover to report to work on Sunday is rejected. The ALJ credits the testimony of the Claimant that some employees, but not all, reported to work on Sunday.

21. While there was a significant amount of testimony regarding claimant's actions on Saturday while in Santa Rosa, the ALJ finds that even if these actions contributed to claimant's termination of employment, claimant was unaware that his consumption of alcohol and socially unacceptable behavior would result in his termination of employment. Moreover, the ALJ credits the testimony of Mr. Lawson that the reason Claimant was terminated from his employment with employer allowing the SSE to proceed to the job site without supervision. As previously indicated, the ALJ finds that Claimant was unaware of the SSE's intention of proceeding to the job site, and therefore, the Claimant did not commit a volitional act that led to his termination of employment.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving

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

2. To prove entitlement to TTD benefits, 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). 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 her 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).

3. Respondents argue that Claimant is precluded from receiving TTD benefits by virtue of the release to return to work without restrictions. The ALJ is unpersuaded. As found, Dr. Mosely's medical records are in direct conflict with the verbal instruction he provided to employer to provide Claimant with light duty work. As found, the work restrictions provided by Dr. Adams are a more accurate reflection of Claimant's ability to perform his work duties after his injury. Therefore, the ALJ finds that Claimant has shown that it is more probably true than not that Claimant has established that he suffered an impairment of earning capacity established by restrictions that impair the Claimant's ability effectively and properly to perform his regular employment.

4. Respondents argue that Claimant is precluded from collecting temporary disability benefits due to the fact that he is responsible for his termination of employment. The ALJ is not persuaded.

5. 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 con-

cept 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).

6. As found, Respondents have failed to establish that Claimant performed a volitional act that resulted in his termination of employment. As found, Claimant was unaware that the SSE was going to go to the job site on Sunday, April 5, 2009. Respondents also failed to establish that Claimant was aware that having the SSE proceed to the job site on April 5, 2009 without his mentor would result in Claimant's termination of employment. The ALJ further finds that while Claimant acted unprofessionally in the motel in New Mexico, this did not result in his termination of employment. Claimant was not reprimanded for his actions while he was in New Mexico, nor was Claimant contacted by his supervisor upon being notified of his actions and advised that such actions would not be tolerated.

ORDER

It is therefore ordered that:

1. Respondents shall pay Claimant temporary disability benefits for the period of March12, 2009 through March 15, 2009, temporary partial disability benefits from March 16, 2009 through April 17, 2009 and temporary total disability benefits from April 18, 2009 until terminated by statute.

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

All matters not determined herein are reserved for future determination.

DATED: November 30, 2009

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-765-203

ISSUES

¬ Whether Claimant has proven by a preponderance of the evidence that her need for right shoulder surgery is a compensable consequence of her admitted industrial injury.

FINDINGS OF FACT

1. Claimant was employed as the Director for Moffat County Housing Authority. Claimant suffered an admitted injury to her right shoulder on May 23, 2008 when she was filling in for a bus driver who had to go home and was pushing a client in a wheelchair up a ramp and the wheelchair began to tip. Claimant grabbed the wheelchair and prevented the wheelchair from tipping. After pushing the client into his house, Claimant noticed pain in her right shoulder as she got back in her bus and was driving back to work.

2. Claimant sought treatment on the date of her injury at the emergency room of Memorial Hospital. Claimant reported an accident history of having a sudden pain in her right shoulder after pushing a wheelchair up a ramp. Claimant was diagnosed with a right shoulder sprain and was subsequently referred to Dr. Wilson. Claimant was examined by Dr. Wilson on May 27, 2008 and was diagnosed with a trapezius and cervical sprain. Claimant was thereafter referred to Dr. Sauerbrey.

3. Claimant was initially examined by Dr. Sauerbrey on July 1, 2008. Physical examination revealed tenderness to palpation over the AC joint and leading edge of the acromion. Provocative testing of the right shoulder showed pain with Hawkin's and impingement testing. Dr. Sauerbrey also noted shoulder apprehension and a positive SLIR test. Dr. Sauerbrey diagnosed a cervical strain, right shoulder Type II SLAP lesion and right shoulder AC arthritis and impingement syndrome. Dr. Sauerbrey recommended an MRI arthrogram of the right shoulder and indicated he believed Claimant had a labral tear.

4. Claimant underwent an MRI with fluoroscopic injection of the right shoulder on July 10, 2008. The MRI revealed a 4 cm multilocular ganglion cyst located at the anterior/inferior margin of the suprascapular notch positioned between the supraspinatus and subscapularis muscle bellies at the medial margin of the coracoid process that appeared to communicate with the joint capsule. The MRI also revealed normal glenohumeral joint ligaments and labral complex with no evidence of a rotator cuff tear. The MRI also revealed AC joint arthropathy with a Type I acromion. Claimant also underwent a cervical MRI on July 10, 2008 that revealed some small disk protrusion at the C5-6 level, a minute central disk protrusion at the C6-7 level with no evidence of compression of the spinal cord or exiting roots.

5. Claimant returned to Dr. Sauerbrey on July 15, 2008 and discussed the findings of her right shoulder MRI. Dr. Sauerbrey opined his belief that based on the shoulder and neck MRI's, Claimant's symptoms were likely coming from the shoulder joint. Dr. Sauerbrey recommended surgical management of the shoulder and noted that the only other option was to attempt an injection to try to get the shoulder symptoms to settle down. Claimant returned to Dr. Sauerbrey on August 5, 2008. Dr. Sauerbrey reiterated his opinion that Claimant needed to undergo surgery for a decompression of the cyst and labral tear. Dr. Sauerbrey requested preauthorization for the surgery, but the request for preauthorization was denied by Insurer.

6. Claimant was referred for an IME with Dr. Scott on September 29, 2008. Dr. Scott performed a physical examination that revealed no swelling of the right shoulder, but did note crepitance with forward flexion. Dr. Scott noted Claimant had negative drop arm sign and negative apprehension sign. Dr. Scott reviewed Claimant's medical records, including the MRI reports from Dr. Jones dated July 10, 2008. Dr. Scott opined that the Claimant suffered a strain to the posterior superior right shoulder in the May 23,

2008 incident. Dr. Scott further opined that the ganglion cyst and the AC joint arthropathy were degenerative in nature and more likely than not pre-existed Claimant's May 23, 2008 injury. Dr. Scott recommended Claimant continue with an exercise program for her neck and right shoulder and consider a steroid injection if her shoulder continued to remain symptomatic, or alternatively, spray and stretch therapy to the right lateral neck and trapezius area.

7. Claimant continued to treat with Dr. Sauerbrey on October 23, 2008 with continued complaints of pain in her right shoulder. Dr. Sauerbreay provided Claimant with an injection to the shoulder and noted his opinion that Claimant was a surgical candidate as a result of her May 23, 2008 injury. Claimant returned to Dr. Sauerbrey on November 25, 2008 with continued complaints of shoulder pain. Dr. Sauerbrey noted Claimant had swelling in the shoulder. Dr. Sauerbrey provided Claimant with a prescription for Vicodin for the pain.

8. Dr. Sauerbrey referred the Claimant to Dr. Tobey for a second opinion on December 5, 2008. Dr. Tobey noted Claimant injured her right shoulder when she was pushing a wheelchair and the wheelchair began to tip over and Claimant reacted by grabbing the wheelchair and pulling it over towards the right. Dr. Tobey diagnosed claimant with probable rotator cuff teninosis and symptomatic right supracular notch cyst. Dr. Tobey noted that he did not have a complete copy of Claimant's medical records, but based upon his review of the available medical records, Dr. Tobey opined that Claimant's cyst was pre-existing, but asymptomatic. Therefore, Dr. Tobey opined that the proposed surgery was reasonable and related to the work injury of May 23, 2008.

9. Claimant has a history of prior injuries to her right shoulder, including surgery consisting of a subacromial decompression of the shoulder on April 9, 1998. Claimant had another aggravation of her right shoulder in November, 2005 when she was lifting a box at work. Claimant underwent a course of treatment with Dr. McLaughlin that was completed by October 2007.

10. Respondents obtained the testimony of Dr. Sauerbrey in conjunction with this hearing. Dr. Sauerbrey testified that on his examination on July 1, 2008, Claimant presented with a positive shoulder apprehension test and a positive sideline internal rotation ("SLIR") test. Dr. Sauerbrey testified that the SLIR test is one that he uses in his own practice to test for a possible labral tear. Dr. Sauerbrey also testified that the apprehension test is also used to test for a labral tear. The results of these tests led him to believe Claimant had a torn labrum and that Claimant's complaints were resulting from her symptoms in her shoulder radiating into her neck.

11. Dr. Sauerbrey testified that he reviewed the MRI film and MRI report. According to Dr. Sauerbrey's interpretation of the MRI film, he opined that the MRI revealed a torn labrum that Dr. Sauerbrey believed was related to Claimant's industrial injury. Dr. Sauerbrey admitted on cross examination that the radiologist report did not indicate that Claimant had a torn labrum, but explained that the report shows that there is a communication between the joint and the cyst, and that communication is through a tear.

12. Respondents presented the testimony of Dr. Scott at hearing. Dr. Scott testified that the arthrogram performed on July 10, 2008 did not show a labral tear. Dr. Scott also testified that labral tears are typically throwing injuries, and Claimant's mechanism of injury was not probable to lead to a labrum tear. Dr. Scott opined that he believed a work injury did occur, but thought that the injury was limited to a muscular strain. Dr.

Scott further testified that he believed the ganglion cyst in Claimant's shoulder pre-existed the industrial injury and was not caused or aggravated by the industrial injury. Dr. Scott opined that he believed Claimant's condition could reasonably be treated with surgery, but that the surgery was not related to the industrial injury.

13. This case involves somewhat diverse medical opinions from the various treating and examining physicians. The ALJ finds the opinion of Dr. Sauerbrey most persuasive with regard to the cause of Claimant's current complaints. Dr. Sauerbrey's explanation with regard to what is shown in the MRI film is the most credible and persuasive testimony explaining Claimant's symptoms. The ALJ credits this testimony over the testimony of Dr. Scott and finds that Claimant's industrial injury caused the need for surgery.

14. The ALJ finds that the evidence shows that Claimant was asymptomatic with regard to her right shoulder complaints for at least seven (7) months prior to her industrial injury. Claimant has consistently complained of symptoms to her right shoulder following the industrial injury. Moreover, the positive SLIR test and positive apprehension test as noted by Dr. Sauerbrey, combined with the MRI findings demonstrate that it is more probably true than not that Claimant needs shoulder surgery to cure and relieve the effects of the industrial injury. The ALJ also notes that Dr. Scott found a negative apprehension test on his examination in September 2008. However, the ALJ resolves this conflict in the evidence in favor of Claimant and determines that the surgery recommended by Dr. Sauerbrey is reasonable, necessary and related to Claimant's May 23, 2008 injury.

CONCLUSIONS OF LAW

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

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

3. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385

(Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

4. As found, the ALJ concludes that Claimant has shown that the industrial injury on May 23, 2008 caused, aggravated or accelerated her need for shoulder surgery recommended by Dr. Sauerbrey.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the shoulder surgery recommended by Dr. Sauerbrey pursuant to the Colorado Medical Fee Schedule.

All matters not determined herein are reserved for future determination.

DATED: November 24, 2009

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-785-388

ISSUES

¬ Whether Claimant proved by a preponderance of the evidence that she suffered a compensable injury arising out of and in the course and scope of her employment with employer?

¬ If Claimant did suffer a compensable injury, whether Claimant proved by a preponderance of the evidence that the medical treatment she received was reasonable, necessary and related to her industrial injury and was provided by an authorized provider?

¬ Whether Claimant's claim for compensation is barred by the applicable statute of limitations?

FINDINGS OF FACT

1. Claimant was employed as a paraprofessional for employer from 1997 through 2008 working with special needs children. Claimant was hired to work with a wheelchair bound student who was a quadriplegic and her job duties included Claimant getting the student fully included in a classroom. Claimant would get the student off the school bus at 7:50 a.m. and would transport the student to the classroom. Claimant would follow the student during the school day and would put the student back on the school bus at

2:45 p.m. Due to the student's condition, Claimant was responsible for changing the student's diaper approximately twice per day. When Claimant began working with employer in 1997, the student was in fifth grade and weighed approximately fifty (50) pounds. In order to change the student, Claimant would need to take the student into the bathroom where a table was located, lift the student onto the table and change the student's diapers. Claimant continued to care for this student until the student graduated in 2005. By the time the student graduated, Claimant testified the student weighed approximately ninety (90) pounds.

2. Claimant developed back pain beginning during the 2004-2005 school year. Claimant testified that during 2005, she would notice the back pain in the evening when she was finished for the day, and also in the morning when she would wake up. Claimant reported this back pain to her physicians, but believed the back pain was related to her arthritic process.

3. Claimant had a history of non-work related psoriatic arthritis for which Claimant sought treatment with National Jewish Medical Center ("National Jewish) and her personal physician, Dr. Scheuer. Claimant's psoriatic arthritis caused other symptoms in Claimant to develop, including splitting fingernails and extreme fatigue. Claimant began receiving treatment for her other symptoms with National Jewish in April 2005. Claimant did not, however, report complaints of back pain to her physicians at National Jewish.

4. Claimant had taken a leave of absence from her position as a paraprofessional with employer beginning in the 2005-2006 school year. Claimant submitted a letter indicating of resignation indicating her intention to not return for the 2006-2007 school year on January 30, 2006 after her leave of absence. However, Claimant did return to the school district as a paraprofessional during the 2007-2008 school year. Claimant then resigned her position with the school district on March 10, 2008 indicating that she was unable to fulfill her duties in her role as a paraprofessional apparently because of her non-work related infections. Claimant continued to work for employer part time in the role as a bus driver after resigning her position as a paraprofessional in 2006.

5. Claimant apparently first sought treatment for her low back pain with Dr. Niebur in May 2008. Claimant acknowledged that she did not report her back pain as being work related upon seeking treatment with Dr. Niebur. Claimant was referred from Dr. Niebur to Dr. Hahn. Dr. Hahn noted on May 28, 2008 that Claimant had experienced low back pain for approximately five (5) years now and had recently undergone a Magnetic Resonance Image ("MRI") that revealed a small annular tear and L4-5 with a small disc bulge at the L5-S1 level. Claimant was diagnosed with low back pain, possibly due to the annular tear and disc bulge and provided with and epidural steroid injection ("ESI"). Claimant returned to Dr. Hahn on August 11, 2008 and noted that she had better than 50% improvement following a second ESI, before her pain slowly returned after a camping weekend.

6. Claimant was subsequently referred to Dr. Corenman on November 4, 2008. Claimant reported to Dr. Corenman that she developed a gradual onset of low back pain in approximately 2005 to 2006. Claimant reported her back pain initially improved with stretching, but eventually became more chronic and referred somewhat into the bilateral hip regions. Dr. Corenman noted that Claimant's low back pain was likely caused by her degenerative disk disease at L5-S1 and mild degenerative changes at L4-L5. Dr. Corenman recommended facet blocks at L3 through S1 and, if that were to be success-

ful, Claimant would be a candidate for rhizotomies and if the Claimant's symptoms were facetogenic pain, then her symptoms would not be related to her work. Dr. Corenman further opined that he believed Claimant had typical advancement of degenerative disc disease based upon his review of the MRI and x-rays, but noted he could not discount that there was some chronic aggravation from her job.

7. After undergoing facet block injections that provided Claimant with no relief, Dr. Corenman recommended Claimant undergo discograms at the L3-4, L4-5 and L5-S1 levels. Claimant was found to have severe pain at the L5-S1 level and L4-L5 level with a normal disc without pain at the L3-L4 level. On December 26, 2008, Dr. Corenman noted Claimant was a possible surgical candidate for a 2-level fusion based upon the results of the discograms. Dr. Corenman testified in this matter that the positive results at the L4-L5 and L5-S1 level with a normal result at the L3-L4 level indicated that Claimant's pain generators were her discs and she didn't have a thalamic pain processing issue. Dr. Corenman opined that Claimant's degenerative disc disease was aggravated by her work activities as a paraprofessional with employer and that her need for surgery was causally related to her work exposure. Dr. Corenman opined that Claimant's work activities aggravated her underlying degenerative disc disease based upon Claimant's history that she began to develop low back pain during the 2005-2006 time frame after working with students. Dr. Corenman opined that Claimant's degenerative disc disease was asymptomatic until the lifting episodes at work, involving prolonged lifting, bending and twisting, aggravated Claimant's condition.

8. Claimant underwent an Independent Medical Examination ("IME") with Dr. Paz on May 27, 2009. Dr. Paz reviewed Claimant's medical records in conjunction with the IME and noted Claimant's job duties as a paraprofessional, including Claimant's gradual onset of low back pain over time without any specific date of occurrence. Dr. Paz noted that Claimant reported her low back pain would be aggravated with hunting during September and October each year for over the past ten (10) years. Dr. Paz provided a report that set forth his opinion that Claimant's degenerative disc disease was not causally related to her work related exposures between 1997 and 2008. Dr. Paz opined that the etiology of Claimant's lumbar degenerative disc disease is a combination of advancing age, a genetic predisposition to development of lumbar degenerative disc disease and possibly recreational activities.

9. Dr. Paz testified in this matter and elaborated on his opinion in this matter. Dr. Paz testified that he was familiar with the employment activities performed by paraprofessionals based upon his experience providing medical care for employees of a different school district. Dr. Paz noted that Claimant was experiencing symptoms prior to 2006, but her symptoms were ultimately diagnosed as psoriatic arthritis. Dr. Paz opined that he did not believe that Claimant's employment activities as a paraprofessional aggravated her degenerative disc disease because there was no medical records establishing the extent of degree of her symptoms, other than prior to 2006. Dr. Paz noted that according to Claimant's testimony, she recovered from any symptoms that would develop during the day, just as Claimant would recover from any exacerbation of her back pain she developed while hunting during the months of September and October.

10. Respondents introduced employment records, including an undated note from Ms. Haberman establishing Claimant's timeline for employment. According to Ms. Haberman, Claimant complained of back problems to her supervisor during the 2005-

2005 school year, but did not report the problems as stemming from any particular incident. The ALJ finds Respondents were unaware Claimant was alleging a workers' compensation injury until her attorney filed a Workers' Claim for Compensation on February 6, 2009.

11. The ALJ finds the testimony of Claimant credible and finds that Claimant began to develop low back pain while at work during the 2004-2005 school year. The ALJ credits Claimant's testimony that lifting the special needs student who weighed nearly ninety (90) pounds aggravated her back pain and developed the onset of her symptoms. The ALJ notes that Claimant's testimony in this regard is consistent with the reports to her medical providers and the employer records. The ALJ finds Claimant's testimony credible that the symptoms continued to develop even after she resigned her position as a paraprofessional until May 2008 when she eventually sought medical treatment. Despite resigning her position for health reasons unrelated to this claim, Claimant's symptoms never returned to her baseline level. The ALJ finds the testimony of Claimant credible that she did not initially understand the compensable nature of her symptoms. Regardless, however, Claimant did not seek medical treatment for her symptoms until 2008. Therefore, Claimant's back condition did not become a compensable injury until she sought medical treatment for her back pain.

12. The ALJ further finds that Claimant did not know the compensable nature of her claim for workers compensation benefits until Dr. Corenman's December 26, 2008 report opined that Claimant's pain was caused by an aggravation for the degenerative disc disease, and not by Claimant's psoriatic arthritis.

13. The ALJ credits the testimony of Dr. Corenman over the conflicting testimony of Dr. Paz. The ALJ finds the testimony of Dr. Corenman consistent with Claimant's testimony and supported by the records of other physicians. The ALJ finds Claimant has shown that it is more probably true than not that her job as a paraprofessional aggravated or accelerated her degenerative disc disease and caused her current need for treatment.

14. The ALJ finds that Claimant did not report the injury to her employer in writing until February 6, 2009. Therefore, the treatment received by Claimant prior to February 6, 2009 is deemed to be unauthorized. After reporting her injury, Employer did not refer Claimant for medical treatment. Therefore, the choice of treating physician was transferred to Claimant. The ALJ finds the treatment from Dr. Corenman, and his referrals, obtained after February 6, 2009 to be authorized. The ALJ further finds the treatment from Dr. Corenman and his referrals after February 6, 2009 to be reasonable, necessary and related to her occupational exposure.

CONCLUSIONS OF LAW

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

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

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

3. Claimant must show that the injury was sustained in the course and scope of his employment and that the injury arose out of her employment. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 579. A work-related injury is compensable if it "aggravates, accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.* Whether there is a sufficient "nexus" or relationship between the Claimant's employment and his injury is one of fact for resolution by the ALJ based on the totality of the circumstances. *In re Question Submitted by the United States Court of Appeals*, 759 P.2d 17 (Colo. 1988). The question of whether a claimant has proven that a particular disease, or aggravation of a particular disease, was caused by a work-related hazard is one of fact for determination by the ALJ. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999).

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

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

5. This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

6. As found, the ALJ determines that Claimant's job duties as a paraprofessional aggravated her degenerative disc disease and eventually resulted in her need for treatment. The ALJ finds that Respondents are liable for the reasonable, and authorized medical treatment necessary to cure and relieve the Claimant from the effects of her industrial injury.

7. Section 8-43-404(5)(a), C.R.S. provides, as relevant here:

> 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 injury, the employee shall have the right to select a physician or chiropractor.

8. Treatment is compensable under the Colorado Workers' Compensation Act ("the Act") where it is provided by an "authorized treating physician." *Bunch v. Industrial Claim Appeals Office*, 148 P.3d 381 (Colo. App. 2006); *see also* Sections 8-42-101(1)(b), 3.6(b), 8-42-107(8)(b)(I), 8-43-404(7), 8-43-501(3)(e)(III), 8-43-502(2), C.R.S. (all referring to "authorized treating physician"). "Authorization" as that term is used in workers' compensation proceedings, refers to a physician's status as the health care provider legally authorized to treat an injured employee. *Mason Jar Restaurant v. Industrial Claim Appeals Office*, 862 P.2d 1026 (Colo. App. 1993). Section 8-43-404(5)(a) givers employers or insurers the right to choose the treating physicians in the first instance in order to protect their interest in being apprised of the course of treatment for which they could ultimately be held liable. *Bunch v. Industrial Claim Appeals Office, supra.* (emphasis added). That initial right of selection passes to the employee only if medical services are not timely tendered by the employer or insurer. *Id.*

9. An employer has the obligation to designate a treating physician forthwith upon notice of the injury, or else the right of selection passes to the employee. *Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565 (Colo. App. 1987). If the employee obtains unauthorized medical treatment, the employer or its insurer is not required to pay for it. *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 2006). An employer is deemed notified of an injury when it 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 (Colo. App. 1984) (quoting 3 A. Larson, *Workman's Compensation Law* § 78.31(a) at 15-105 (1983)).

10. As found, Respondents were unaware Claimant was alleging a work related injury until Claimant filed a workers' claim for compensation on February 6, 2009. Therefore, Respondents' obligation to designate a physician did not arise until Claimant reported her injury as being compensable. Respondents are therefore not responsible for the medical treatment Claimant received prior to February 6, 2009 as this treatment is not considered emergency treatment and was not authorized by Respondents.

11. As found, after Claimant reported her injury to her employer on February 6, 2009, Respondents failed to designate a medical provider to treat Claimant for her work related injury. Therefore, Dr. Corenman became authorized by virtue of Section 8-43-404(5)(a) after February 6, 2009.

12. Respondent also alleges that Claimant's claim for compensation is barred by the statute of limitations. The ALJ is not persuaded.

13. Section 8-43-103(2) provides in pertinent part:

> [T]he right to compensation and benefits provided by said articles shall be barred unless, within two years after the injury or after death resulting there from a notice claiming compensation is filed with the division.

14. In determining when the statute of limitations begins to run, Colorado courts follow the "discovery" rule. Under that rule, the statute of limitations for filing a workers' compensation claim commences when "the claimant, as a reasonable [person], should recognize the nature, seriousness, and probable compensable character of his injury." *City of Boulder v. Payne*, 426 P.2d 194 (1967). The "onset of disability" refers to the date the disease impaired claimant's ability to efficiently and effectively perform the duties of her regular employment. *Ricks v. Industrial Claim Appeals Office*, 809 P.2d 1118 (Colo. App. 1991); *Jefferson County Schools v. Headrick*, 734 P.2d 659 (Colo. App. 1986).

15. As found, despite having symptoms of low back pain related to her occupational disease, Claimant did not seek medical treatment for her back symptoms until May 2008. When Claimant initially sought treatment for her low back complaints, her physicians did not relate her symptoms to her work until Dr. Corenman opined that her work as a paraprofessional aggravated her underlying asymptomatic degenerative disc disease after the discogram studies. Therefore, the ALJ finds that the statute of limitations on Claimant's claim for benefits did not begin to run until December 2008 and Claimant's claim is not barred by the statute of limitations.

ORDER

It is therefore ordered that:

1. Respondents are to pay for the reasonable, necessary and related medical treatment obtained by Claimant from authorized providers after February 6, 2009.

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.

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: November 25, 2009

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-733-532

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUES

The issues to be determined by this decision concern average weekly wage (AWW); temporary total (TTD) and/or temporary partial (TPD) disability benefits; and, whether child care expenses under the specific circumstances of this case may be awarded as ancillary to medical care. Claimant disputes Respondents' calculation of TTD benefits for using an improper AWW, and Claimant seeks TPD and TTD benefits. Claimant also seeks recovery of child-care costs for child-care allegedly incidental to her medical treatment. Respondents allege that Claimant's child care is not compensable, that Claimant is not entitled to temporary benefits pursuant to the applicable law, and that Respondents' calculation of Claimant's AWW without health benefits paid by the Employer at the time of her termination is proper. Claimant bears the burden of proof, by a preponderance of the evidence, on all issues heard.

FINDINGS OF FACT

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

Preliminary Findings

1. The Claimant is a dental hygienist and teacher who was injured by a fall in the parking lot of the Employer in October 2006. A program of conservative care failed to improve her back injury from the October 2006 fall and as a consequence, she has been unable to work as often as she had prior to the injury, and she underwent surgery in August 2009. Claimant did not receive indemnity benefits from Respondents until August 2009. She is a 43 year-old female .

2. On October 27, 2006, the Claimant slipped and fell on ice in the parking lot of the Employer, sustaining injuries to her left leg, lower back, shoulders, and neck.

3. The Claimant received treatment for her injuries at Concentra Clinic.

4. After the injury, Claimant's injuries to her neck, shoulders, and legs improved following a course of physical therapy, trigger point injections, steroid injections, and bio- feedback. Nonetheless, the Claimant continued to suffer pain in her back and an associated limited range of motion.

5. The Claimant received care through the Concentra Health System and its doctors throughout her recovery process, including physical examinations, physical therapy, as well as physical medicine consultations.

6. Eric Tentori, D.O., at the Concentra Clinic issued unqualified full duty return to work releases for the Claimant on November 28, 2006, and December 5, 2006.

7. Robert Kawasaki, M.D., issued a full duty return to work release for Petitioner on May 17, 2007.

8. John Burris, M.D., issued a full duty return to work release for the Claimant on January 15, 2008.

9. On October 15, 2008, Edwin Healy, M.D., conducted an independent medical examination (IME) of the Claimant, recommending more aggressive treatment. Dr. Healy issued a return to work release with limits on Claimant: no lifting over 10 pounds and no twisting at the waist.

10. Claimant underwent back surgery on August 17, 2009, in order to treat her continuing back pain.

11. The Claimant had two jobs at the time of her injury. She worked as a teacher with the Employer, and as a dental assistant with H_, where she cared for patients in various nursing homes.

12. The Claimant has had a variable employment history since her back injury. She left the Employer herein on September 6, 2007, and undertook subsequent employment at K_.

13. On March 11, 2008, Kids in Need of Dentistry terminated the Claimant as a result of her inability to focus and her fatigue.

14. The Claimant secured employment in the dental practice of W_, beginning April 1, 2008. _ terminated Claimant's employment on August 21, 2008, due to the fatigue and pain associated with her injury and medications.

15. The Claimant presently works at P_ teaching dental assistants in four, four-hour shifts per week. She also continues to work on a limited, contractual basis with H_.

Average Weekly Wage and Temporary Disability Benefits

16. Upon her termination on March 11, 2008, from her job with K, the Claimant was eligible for COBRA benefits at a cost of $509.01 per month, or $117.46 per week.

17. On August 17, 2009, Respondents began paying the Claimant TTD benefits following her back operation.

18. To calculate TTD benefits, Respondents set an AWW of $660.71 based on the Claimant's employment with the Employer herein in October 2006. Neither Respondents nor Claimant contest that the $660.71 figure represents $593.95 earned by the Claimant in her primary job as a teacher for the Employer, and $66.76 earned in her secondary job as a dental assistant at Home Care Dental Services

19. In addition to earning $593.95 in income each week from the Employer, and $66.76 per week at H, the Employer paid health care benefits for the Claimant in the amount of $42.00 per week, as reflected in a Statement of Weekly Earnings issued by the Employer on August 2, 2007.

20. Respondents' AWW calculation does not include the $42.00 in Employer paid health care benefits.

21. The Claimant alleges that a proper AWW calculation would either include the $42.00 in health care benefits for a total AWW of $702.71, or it should reflect the COBRA benefits available upon her termination from Kids In Need of Dentistry.

22. The cost for Claimant to maintain group health coverage following her injury has been $117.46 weekly, which is her cost of COBRA coverage following termination from K in March 2008. Accordingly, the ALJ finds that the AWW should be $778.17, which represents the sum total of $593.95 for Claimant's salary with the Employer at the time of injury, $66.76 for her weekly income from H at the time of injury, and $117.46 for the costs to maintain group health coverage available from a subsequent employer whereby her employment ended because of the compensable injury herein.

Child Care Services

23. While receiving care from Concentra Clinic, the Claimant had to find childcare for her three children for whom she otherwise provides continuous supervision.

24. The Claimant brought her children to one medical appointment at the Concentra Clinic, resulting in an atmosphere that the attending doctor, Dr. Kawasaki, described as "very chaotic."

25. The Claimant incurred $2,310.00 in child-care expenses to place her children in supervised care while she attended medical appointments.

26. There is no persuasive evidence that any physician prescribed child-care services as part and parcel of her medical treatment.

27. Claimant requests: (1) an AWW that reflects either $42.00 in weekly health care benefits provided by the Employer at the time of her injury, or an AWW that reflects COBRA coverage available to her upon her termination from K on March 11, 2008; (2) two periods of TTD, the first period covering three weeks following her termination from K in March 2008, and the second covering a one-week period after her termination from the office of Dr. _ in August 2008; (3) a payment of $9.53 per day for 1,022 days, less $954.50 earned in 2007 and 2008; (4) a TPD award of $10,781.96 for a period from August 28, 2008, to August 17, 2009; and, (5) reimbursement of $2,310.00 for child care services while Petitioner received medical care from Concentra Clinic.

28. Respondents deny that Claimant should receive any temporary disability benefits pursuant to § 8-40-105(3)(c), C.R.S. (2009), because her authorized treating doctors released her to return to work at full duty. Moreover, Respondents claim that the $42.00 to be added to the Claimant's AWW represents a fringe benefit not contemplated by § 8-40-201(19)(b), C.R.S. (2009). Respondents also assert that child- care during medical treatment is not a compensable benefit.

Ultimate Findings

29. Claimant has proven, by a preponderance of the evidence, that her AWW includes the cost of replacing her Employer-financed health insurance benefits, thus, her AWW at present is $778.17, inclusive of the cost to her of maintaining group health care benefits following her termination from K. The cost for Claimant to maintain group health coverage following her injury has been $117.46 weekly, which is her cost of COBRA coverage following termination from K in March 2008.

30. Claimant failed to prove, by preponderant evidence, that she was temporarily disabled at any time prior to her surgery of August 17, 2009. Respondents have admitted TTD from August 17, 2009 and continuing, pursuant to a General Admission of Liability, filed on August 26, 2009. The admitted AWW and TTD rate is what is disputed.

31. Claimant has failed to prove, by preponderant evidence, that the costs of child-care amount to medically prescribed medical care and treatment.

CONCLUSIONS OF LAW

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

Average Weekly Wage

a. Respondents admitted an AWW of $660.91 and TTD benefits of $440.47 per week from August 17, 2009 and continuing (General Admission, filed August 26, 2009). Whether or not Claimant actually purchased that health coverage at the time of her separation from employment, proximately caused by the original compensable injury, should not preclude the cost thereof as a factor in calculating AWW to reflect the cost of continuation of heath coverage. *Sears Roebuck & Co. v. Indus. Claim Appeals Office*, 140 P.3d 336 (Colo. App. 2006); *Ray v. Indus. Claim Appeals Office*, 124 P.3d 891 (Colo. App. 2005). Moreover, the Colorado Supreme Court has held that an ALJ may properly consider the cost to an employee of purchasing a subsequent employer's COBRA insurance in the calculation of a claimant's AWW. *Avalanche Indus., Inc. v. Clark*, 198 P.3d 589 (Colo. 2008). Accordingly, as found the Claimant's AWW is $778.17, which represents the sum total of $593.95 of her salary with the Employer at the time of injury, $66.76 for her weekly income from H at the time of injury, and $117.46 for the costs of maintaining group health coverage available from a subsequent employer, whereby her separation from employment with the subsequent employer was proximately caused by the effects of her original compensable injury. The differential between the admitted TTD rate and the re-established TTD rate is $78.30 per week.

Temporary Disability Benefits

b. § 8-42-105(3)(c), C.R.S. (2009), provides that "[t]emporary total disability benefits shall continue until the first occurrence of any one of the following: . . . (c) [t]he attending physician gives the employee a written release to return to regular employment." As found, the Claimant received unqualified return to work releases from her authorized treating physicians on November 26, 2006, December 5, 2006, May 17, 2007, and January 15, 2008. Until she underwent back surgery in August 2009, she had not received work-related restrictions by a doctor. Moreover, as Respondents note, Dr. Healy's IME on October 15, 2008, is without legal standing on the issue of a release to return to work. *See Dejoy v. The Shaw Group*, W.C. No. 4-741-382 [Industrial Claim Appeals Office (ICAO), May 14, 2009]. Despite Claimant's prolonged recovery, the ALJ cannot find pursuant to § 8-42-105, that Claimant is entitled to temporary benefits prior to her August 2009 surgery. Her variable employment during this time negates the idea of temporary disability prior to the August 2009 surgery.

Child Care

c. Medical benefits in the child-care context are compensable, only if the service requested is medical in nature or "incidental to obtaining such medical . . . treatment." *Country Squire Kennels v. Tarshis*, 899 P.2d 362 (Colo. App. 1995), citing *Indus. Comm'n v. Pacific Employers Ins. Co.*, 120 Colo. 373, 209 P.2d 908 (1949).

Services that are "medical in nature" include home health services in the nature of "attendant care" if reasonably needed to cure or relieve the effects of the industrial injury. *Atencio v. Quality Care, Inc*., 791 P.2d 7 (Colo. App. 1990). In *Kuziel v. Pet Fair, Inc.*, 931 P.2d 521, 522-23 (Colo. App. 1996), the court held that a claimant's $300 expenditure on a plane ticket for a family member to fly to Colorado to provide child care while the claimant underwent treatment for a work-related injury was **not** compensable because the services "did not relieve the symptoms or effects of the injury and were not directly associated with the claimant's physical needs." One year later, the court held in *Bellone v. Indus. Claims Appeals Office*, 940 P.2d 1116, 1118 (Colo. App. 1997), that child care services were compensable following medical testimony from a claimant's neuropsychologist affirming the need for child care so that the claimant could rest while recovering from a work-related injury. The court distinguished *Kuziel* on the basis that there was no medical testimony in *Kuziel* as in *Bellone* that suggested the child care services were essential to the claimant's course of recovery. *Id*. The ALJ concludes that *Bellone* controls in this case. As found, Claimant presented no medical testimony that child care services were essential to the course of her recovery. Dr. Kawasaki noted that the presence of Claimant's children in the attending room created a "very chaotic" atmosphere," but he was nonetheless able to complete his examination.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Claimant's average weekly wage is hereby re-established at $778.17, which yields a temporary total disability benefit rate of $518.77 per week.

B. In addition to temporary disability benefits paid pursuant to the recent general Admission of Liability, Respondents shall pay Claimant the differential of $78.30 per week from August 17, 2009 through October 22, 2009. from October 23, 2009, Respondents shall pay the Claimant temporary total disability benefits of $518.77 per week continuing until termination thereof is warranted by law.

C. Any and all claims for child-care services are hereby denied and dismissed.

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

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

DATED this_____day of November 2009.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-746-390

ISSUES

Whether the Third Party Doctor is owed any monies for the preparation of a report on October 23, 2008 in response to Claimant's question as to where the ratings were.

FINDINGS OF FACT

1. At the commencement of the hearing there was preliminary discussion concerning the matters before the ALJ. Claimant's counsel, while arguing his position provided the ALJ with a packet of exhibits and referred to them.
2. Claimant's counsel had not offered the exhibits. At the end of Claimant's counsel's argument Claimant's counsel indicated that he rested.
3. Since at that time the exhibits provided to the ALJ were not in evidence, Claimant's counsel was provided an opportunity to reopen his case in chief. Claimant's counsel declined to do so.
4. Thus, there are no facts found by the ALJ.

CONCLUSIONS OF LAW

Based upon there being no facts before the ALJ upon which to make a decision in the matter, the ALJ directed a verdict, denying and dismissing the Claimant's Application for Hearing. This written order memorializes the directed verdict.

ORDER

It is therefore ordered that:

1. Claimant's request for a determination of whether the Third Party Doctor is owed any monies for the preparation of a report on October 23, 2008 in response to Claimant's question as to where the ratings were, is denied and dismissed.
2. All matters not determined herein are reserved for future determination.

DATE: December 1, 2009
/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 3-500-834

ISSUES

1. Whether Insurer has demonstrated by a preponderance of the evidence that it has directly expended $20,000 for the medical treatment of Claimant's Barylliosis and thus should be admitted into the Major Medical Insurance Fund (MMIF).

2. Whether the MMIF has established the affirmative defense of laches by a preponderance of the evidence.

FINDINGS OF FACT

1. Berylliosis or Chronic Beryllium Disease (CBD) is a progressive lung disease caused by the inhalation of Beryllium dust or fumes. The inflammation and scarring caused by Beryllium in the lungs eventually leads to severely compromised lung function and death. There is no cure for CBD and treatment generally requires numerous doctor visits, regularly scheduled lung function testing and radiographic studies. Individuals who suffer from CBD also require the use of oxygen, steroids including Prednisone and bronchodilators including Albuterol.

2. Claimant was exposed to Beryllium from 1966 to approximately 1968 through his work as a grinder for Employer. Insurer was Employer's Workers' Compensation carrier during the time period. When Claimant was 37 years old in 1977 he underwent an abnormal chest x-ray. He subsequently proceeded through a comprehensive evaluation that included lung function tests, a lung biopsy and blood analysis at the Cleveland Clinic. On April 1, 1977 C. Edward Creagh, Jr., M.D. confirmed a diagnosis of CBD and started Claimant on Prednisone. On September 19, 1977 Dr. Creagh estimated that Claimant had a 30% disability based on pulmonary function studies. He remarked that Claimant suffered from "significant lung disease."

3. Claimant's First Report of Injury form was filed on October 24, 1977. The form revealed that the date of the "Injury or initial diagnosis of illness" was 1966-1968 and that Employer first knew of the injury on March 21, 1977. However, according to a "First Report Inquiry" form from the Division of Workers' Compensation the First Report of Injury form noted the date of injury as February 28, 1970. Claimant filed a Worker's Claim for Compensation on December 15, 1977. Based on Dr. Creagh's definitive diagnosis of CBD the Worker's Claim for Compensation listed the date of injury as April 1, 1977.

4. From the period 1978 to 1981 a number of filings, hearings and appeals occurred regarding Claimant's request for compensation. On June 12, 1981 the Industrial Commission issued a Final Order in this matter. The Order provided: "It is concluded that the evidence supports the finding that the claimant has suffered a permanent disability rated at 15% as a working unit as a result of the occupational disease . . .

It is FURTHER ORDERED that the claimant has suffered a permanent disability rated at 15% as a working unit effective July 8, 1977."

5. In October 1993 Insurer applied for admission into the MMIF. The MMIF is one of the funds managed by the Special Funds Unit (SFU) of the Division of Workers' Compensation (DOWC). There are three requirements for admission into the MMIF: (1) the employee must suffer a compensable injury; (2) the injury must have occurred between July 1, 1971 and July 1, 1981; and (3) the employer or its insurer must have paid at least $20,000 in medical or vocational rehabilitation benefits directly related to the injury.

6. Insurer's 1993 Application to the MMIF reflected an injury date of February 28, 1970. On October 15, 1993 SFU Claims Adjuster James Keown asked Insurer to clarify Claimant's injury date and provide additional documentation regarding the medical benefits it had paid. Because Mr. Keown recognized a conflict between Insurer's date of injury and the date on the Employer's First Report of Injury, he remarked that the claim might be a candidate for the Medical Disaster Insurance Fund (MDIF). The MDIF is another fund within the SFU that applied to injuries incurred prior to July 1, 1971.

7. On December 10, 1994 Mr. Keown wrote a second letter to Insurer. Mr. Keown referenced a phone conversation from a day earlier with Mr. Fairchild from Insurer. Mr. Keown noted that Insurer's medical bills and application documented that it had spent $23,313.05 as of that date.

8. The SFU did not issue a written administrative order denying Insurer's 1993 Application to the MMIF. On April 8, 1999 Insurer's employee Francine Bushore contacted SFU claims adjuster Sue Sobolik. Ms. Bushore inquired about the status of Insurer's 1993 Application for admission into the MMIF. Ms. Bushore recounted the phone conversation in a May 5, 1999 letter to Director Mary Ann Whiteside. Ms. Sobolik told Ms. Bushore that the application had been denied in November 1994 due to "insufficient documentation." Ms. Bushore noted that Insurer had never been notified of a denial and "re-submitted copies of all medical documents and computer print-outs on the bills." Ms. Sobolik also told Ms. Bushore that the MDIF was the proper fund for the claim based on the injury date in Insurer's application.

9. On April 26, 1999 Ms. Bushore received a letter from SFU program administrator Barbara Carter. The letter explained that Claimant's claim was governed by the MDIF because of a 1970 injury date. However, Ms. Carter also commented that, based on Insurer's representations, Insurer did not qualify for the MDIF because its payments had now exceeded the $55,000.00 statutory maximum. In a May 11, 1999 letter to Insurer Ms. Whiteside clarified and confirmed Ms. Carter's determination. Ms. Whiteside also offered additional information if Insurer had any further questions.

10. Insurer did not again contact the SFU regarding Claimant's claim until it filed a renewed application for admission to the MMIF on December 1, 2008. Insurer noted that it had paid medical benefits in the amount of $527,485.68 for the treatment of Claimant's CBD. The Application also specified an injury date of April 1, 1977.

11. On March 9, 2009 the DOWC denied Insurer's December 1, 2008 Application for admission to the MMIF. The denial was based on the following: (1) confusion regarding Claimant's date of injury; (2) Insurer's failure to demonstrate that it had spent $20,000 in authorized medical payments; and (3) unconscionable delay.

12. On July 9, 2009 Annyce Mayer, M.D. conducted an independent records review of Claimant's claim. She determined that Claimant's only medical treatment for his CBD prior to July 1, 1981 was Prednisone. Dr. Mayer defined "progression" as "any change in the original condition that would occur in its normal course of development." She defined "sequelae as "separate conditions caused by treatment of, or other external influences upon, the original condition." Dr. Mayer explained that many of Claimant's conditions were more likely than not sequelae of his treatment for CBD. She noted that Claimant's long-term use of immune-suppressing medications caused many of the sequelae. The sequelae included cor pulmonale or right-sided heart failure as a result of lung disease, anemia and a number of infections that resulted from his compromised immune system. Dr. Mayer also remarked that Claimant suffered from a number of conditions that were unrelated to his CBD.

13. Insurer's Senior Claims Adjuster from 2008 Margaret Malone testified at the hearing in this matter. She explained that Insurer's Medical Cost Summary Spreadsheet (Spreadsheet) contained all medical payments for Claimant's claim. The Spreadsheet revealed that Insurer paid $527,485.68 for the period May 1980 through October 1, 2008. Ms. Malone commented that Insurer had pain $183,168.75 on Claimant's claim for drugs, tests and procedures required to monitor Claimant's CBD.

14. Lawrence Repsher, M.D. testified at the hearing in this matter. He was one of Claimant's treating physicians from approximately 1977 to 1984. In a September 24, 2009 report Dr. Repsher estimated that the costs directly related to the diagnosis and treatment of Claimant's CBD probably exceeded $200,000. At the hearing Dr. Repsher reviewed Insurer's compilation of drugs, tests, and procedures listed in its Spreadsheet. He testified that the total payments listed in the Spreadsheet were $183,168.75 and that each payment was directly related to Claimant's compensable disease. Dr. Repsher also remarked that he agreed with Dr. Mayer's opinions with the exception that cor pulmonale represents a progression, rather than a sequelae, of CBD.

15. The SFU's Manager of Claims Adjusters Lucinda Ridley testified at the hearing in this matter. She explained that Insurer's 1993 request for admission into the MMIF was not denied but the SFU simply sought clarification of Claimant's date of injury. The SFU subsequently requested information from Insurer about Claimant's date of injury but Insurer failed to respond. Ms. Ridley noted that the 1999 letters from the SFU were based on a 1970 date of injury and the SFU was not apprised of a 1977 injury date until Insurer's 2008 Application for entry into the MMIF. Ms. Ridley also explained that there are a number of problems associated with attempting to review Insurer's medical bills to determine whether direct payments for treatment of Claimant's CBD have exceeded $20,000. She specifically noted that it is unknown whether medical bills have been paid according to the fee schedule. Ms. Ridley also commented that

Insurer has not performed an analysis of whether the medical bills were directly related to Claimant's CBD or constituted sequelae of Claimant's condition.

16. Insurer has failed to demonstrate that it is more probably true than not that it has directly expended $20,000 for the medical treatment of Claimant's CBD. Dr. Mayer persuasively explained that many of Claimant's conditions were more likely than not sequelae of his treatment for CBD. She noted that Claimant's long-term use of immune-suppressing medications caused many of the sequelae. The sequelae included cor pulmonale or right-sided heart failure as a result of lung disease, anemia and a number of infections that resulted from his compromised immune system. Dr. Mayer also remarked that Claimant suffered from a number of conditions that were unrelated to his CBD. In contrast, Dr. Repsher testified that the total payments listed in Insurer's Spreadsheet were $183,168.75 and that each payment was directly related to Claimant's compensable disease. However, Dr. Repsher agreed with Dr. Mayer's opinions regarding progression and sequelae except that cor pulmonale constituted a progression of CBD.

17. Dr. Repsher only provided an opinion regarding the total combined cost of direct treatment, its sequelae and its progression. Insurer has not produced evidence as to whether it expended $20,000 exclusive of sequelae. Insurer has only offered a total dollar figure with no breakdown. With the profusion of sequelae acknowledged by both doctors, Insurer was required to present evidence as to how much of the total was spent exclusive of treatment of sequelae that occurred after the MMIF closed. Although medical benefits for the sequelae stemming from Claimant's use of Prednisone may be compensable as a natural consequence of Claimant's CBD, the sequelae constitute a new and distinct injury for purposes of admission into the MMIF. Any sequelae that occurred after July 1, 1981 constitute separate injuries for which the cost of treatment cannot be applied toward the $20,000 threshold. In the absence of persuasive evidence regarding the $20,000 limit, Insurer has failed to carry its burden of proof.

18. The MMIF has established that it is more probably true than not that it justifiably relied on Insurer's representations regarding Claimant's date of injury. Insurer thus caused an unconscionable delay that prejudiced the MMIF's defenses. Based on Insurer's 1993 Application the MMIF proceeded under the impression that Claimant had been injured in 1970 even though Insurer was aware that Claimant's injury occurred on July 8, 1977. Insurer did not correct the injury date until after it had amassed significant medical expenses in 2008. Insurer's delay denied the Director of the DOWC his statutory opportunity to review Claimant's case when total medical expenditures reached $15,000 and at subsequent $10,000 increments to determine continuation or cessation of further payments from the MMIF. The SFU was unable to examine Claimant as various treatments were suggested to determine whether the treatments were necessary to promote recovery, alleviate pain or reduce disability. The Director has been deprived of the preceding opportunities by Insurer's failure to promptly file an application for admission to the MMIF containing correct information as to the date of the injury and proof of $20,000 in direct medical payments for Claimant's CBD.

19. Ms. Ridley credibly testified that the SFU sought information from Insurer about Claimant's date of injury but Insurer failed to respond. She explained that there are a number of problems associated with attempting to review Insurer's medical bills to determine whether direct payments for treatment of Claimant's CBD have exceeded $20,000. Ms. Ridley noted that it is unknown whether medical bills have been paid according to the fee schedule and Insurer has not performed an analysis of whether the medical bills were directly related to Claimant's CBD or constituted sequelae of Claimant's condition. The MMIF has thus established the affirmative defense of laches.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

$20,000 Threshold for Admission into MMIF

4. The MMIF was established in 1971 to pay "medical, surgical, dental, hospital, nursing, and drug expenses and expenses for medical, hospital, and surgical supplies, crutches, apparatus, and vocational rehabilitation" in excess of an insurer's limited liability under the Workers' Compensation Act. *See* §§ 8-46-202, -212, C.R.S. The General Assembly subsequently amended the MMIF statutes to provide that no further cases could be accepted into the MMIF for injuries occurring after July 1, 1981. *See* Ch. 82, sec. 4, § 8-66-112, 1981 Colo. Sess. Laws 466, 468; *Grover v. Industrial Comm'n*, 759 P.2d 705, 710, n.3 (Colo. 1988).

5. The following three requirements are necessary for admission to the MMIF: (1) the employee must suffer a compensable injury; (2) the injury must occur between July 1, 1971 and July 1, 1981; and (3) the employer or its insurer must have paid at least $20,000 in medical or vocational rehabilitation benefits directly related to the injury. §8-46-208 C.R.S.; *White v. State Comp. Ins. Fund*, 700 P.2d 923, 924-25 (Colo. App. 1985). The MMIF does not now dispute that the first two requirements have been satisfied. On June 12, 1981 the Industrial Commission determined that Claimant suffered a compensable injury effective July 8, 1977. Furthermore, the MMIF has acknowledged that Claimant's injury occurred between July 1, 1971 and July 1, 1981 for purposes of MMIF liability. Therefore, the only admission requirement contested by the MMIF is whether Insurer has paid at least $20,000 in medical benefits that are directly related to Claimant's CBD.

6. Under DOWC Rule 14-1(A) applicants to the MMIF must provide "copies of the payment history, orders, medical records and all available relevant documents that support the application for admission." The Rule specifies that the Director of the DOWC shall examine the claim file "to determine whether the insurer has exhausted its $20,000 limit of liability for medical benefits." Applications that fail to meet the preceding $20,000 requirement "shall be dismissed."

7. The payments comprising the $20,000 liability limit must be "directly related" to the compensable injury. *In Re Claim of Green*, 789 P.2d 481, 482 (Colo. App. 1990) (concluding that expenses for the claimant's heart attack could not be used to meet the $20,000 limit because they were not directly related to the claimant's compensable shoulder injury, even though the heart attack was considered a natural consequence of the shoulder injury). In *Green* the court of appeals specifically reasoned:

> We agree with the Panel that the intent of the General Assembly in adopting §8-66-112 was to phase out the MMIF and to make insurance carriers and employers fully liable for medical benefits for injuries incurred after July 1, 1981. In establishing the cut-off date of July 1, 1981, the General Assembly employed broad and comprehensive language admitting of no exceptions. The petitioners argue, however, that an exception must be made for injuries that are the direct sequelae of compensable injuries incurred prior to July 1, 1981. We do not agree. . . . Accordingly, we agree with the Panel that claimant's 1982 heart attack was a separate injury for purposes of admission to the MMIF, and that the Director properly denied the petitioners' application.

Id. at 482-83.

8. As found, Insurer has failed to demonstrate by a preponderance of the evidence that it has directly expended $20,000 for the medical treatment of Claimant's CBD. Dr. Mayer persuasively explained that many of Claimant's conditions were more likely than not sequelae of his treatment for CBD. She noted that Claimant's long-term use of immune-suppressing medications caused many of the sequelae. The sequelae included cor pulmonale or right-sided heart failure as a result of lung disease, anemia

and a number of infections that resulted from his compromised immune system. Dr. Mayer also remarked that Claimant suffered from a number of conditions that were unrelated to his CBD. In contrast, Dr. Repsher testified that the total payments listed in Insurer's Spreadsheet were $183,168.75 and that each payment was directly related to Claimant's compensable disease. However, Dr. Repsher agreed with Dr. Mayer's opinions regarding progression and sequelae except that cor pulmonale constituted a progression of CBD.

9. As found, Dr. Repsher only provided an opinion regarding the total combined cost of direct treatment, its sequelae and its progression. Insurer has not produced evidence as to whether it expended $20,000 exclusive of sequelae. Insurer has only offered a total dollar figure with no breakdown. With the profusion of sequelae acknowledged by both doctors, Insurer was required to present evidence as to how much of the total was spent exclusive of treatment of sequelae that occurred after the MMIF closed. Although medical benefits for the sequelae stemming from Claimant's use of Prednisone may be compensable as a natural consequence of Claimant's CBD, the sequelae constitute a new and distinct injury for purposes of admission into the MMIF. Any sequelae that occurred after July 1, 1981 constitute separate injuries for which the cost of treatment cannot be applied toward the $20,000 threshold. In the absence of persuasive evidence regarding the $20,000 limit, Insurer has failed to carry its burden of proof.

Affirmative Defense of Laches

10. The doctrine of laches is an equitable defense that may be raised when a "party's unconscionable delay in asserting its legal rights prejudices the opposing party's defenses or causes the opposing party to detrimentally change its position. *In Re Azar,* W.C. No. 4–354-936 (ICAP, June 9, 2005). The prejudice "must necessarily result from reliance which is justifiable under the circumstances." *Id.*

11. Section 8-46-208(2), C.R.S., governing awards made under the MMIF, provides in relevant part:

> The director, in every case in which an award is made from this fund, shall review said case at such time as the total medical expenditures, including those expended under section 8-42-101, shall reach fifteen thousand dollars and at each ten thousand dollar increment thereafter to determine and enter an order regarding continuation or cessation of further payments from said fund.

12. As found, the MMIF has established by a preponderance of the evidence that it justifiably relied on Insurer's representations regarding Claimant's date of injury. Insurer thus caused an unconscionable delay that prejudiced the MMIF's defenses. Based on Insurer's 1993 Application the MMIF proceeded under the impression that Claimant had been injured in 1970 even though Insurer was aware that Claimant's injury occurred on July 8, 1977. Insurer did not correct the injury date until after it had

amassed significant medical expenses in 2008. Insurer's delay denied the Director of the DOWC his statutory opportunity to review Claimant's case when total medical expenditures reached $15,000 and at subsequent $10,000 increments to determine continuation or cessation of further payments from the MMIF. The SFU was unable to examine Claimant as various treatments were suggested to determine whether the treatments were necessary to promote recovery, alleviate pain or reduce disability. The Director has been deprived of the preceding opportunities by Insurer's failure to promptly file an application for admission to the MMIF containing correct information as to the date of the injury and proof of $20,000 in direct medical payments for Claimant's CBD.

13. As found, Ms. Ridley credibly testified that the SFU sought information from Insurer about Claimant's date of injury but Insurer failed to respond. She explained that there are a number of problems associated with attempting to review Insurer's medical bills to determine whether direct payments for treatment of Claimant's CBD have exceeded $20,000. Ms. Ridley noted that it is unknown whether medical bills have been paid according to the fee schedule and Insurer has not performed an analysis of whether the medical bills were directly related to Claimant's CBD or constituted sequelae of Claimant's condition. The MMIF has thus established the affirmative defense of laches.

ORDER

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

1. Insurer's request for admission into the MMIF is denied and dismissed. Insurer has failed to demonstrate that it directly expended $20,000 for treatment of Claimant's CBD and the MMIF has established the affirmative defense of laches.

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

DATED: December 1, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-793-319

ISSUES

The issues determined herein are compensability, authorization of medical benefits, average weekly wage, and temporary total disability ("TTD") benefits. The parties stipulated that the employer was uninsured for workers' compensation liability on the date of injury.

FINDINGS OF FACT

1. On approximately February 6, 2009, claimant began work for the employer, performing tire, wheel, and light mechanical work on motor vehicles. Claimant had previous experience performing tire work and oil changes, but had no other experience as a mechanic.

2. Claimant was paid $15 per "flat hour" of time that industry standards recognized for each type of labor on vehicles. Claimant's average weekly wage was $250. The parties did not dispute that claimant actually earned $250 per week at the time of his injury on April 17, 2009. Claimant expected to increase his wages over time as he became more efficient. The employer made no statements to claimant that he would be earning $1,000 per week at any point. The employer merely stated that it was "possible" for claimant to earn more in the future. Claimant had no agreement for higher wages and had no reasonable expectancy of earning $1,000 per week in the reasonably foreseeable future. He had only a hope that he would gain experience, become faster at his work, and eventually start performing the "flat rate" work in less time than the "book" provided.

3. Claimant has proven by a preponderance of the evidence that he suffered an accidental injury to his left ring finger arising out of and in the course of his employment on April 17, 2009. Claimant's testimony is credible and persuasive that he rested the rear of the pickup truck drive shaft on the rear axle while he attempted to align the center support and start the bolts. The drive shaft slipped off the rear axle and the U-joint crushed and severely lacerated claimant's left ring finger. "Mark" testified that the drive shaft would not reach the rear axle and that the mechanic should use a jack stand to support the rear of the drive shaft until it is reattached. The drive shaft only reaches TO the rear differential, where it attaches. One may rest the drive shaft on the rear axle, but it is unstable and will likely fall when the center support is bolted. The fact that Mark found the drive shaft in the same position after the accident is not surprising or informative. The nature of the circumferential laceration to the left ring finger as well as the fracture indicates that the left ring finger probably was caught in the U-joint. Claimant did not self-inflict a wound by striking the transmission housing in anger. Mark's testimony that claimant admitted to such a wound is not credible. It is highly unlikely that the employer would take no action against claimant's employment if he had, in fact, admitted to attempting to file a fraudulent report of a workers' compensation injury.

4. Claimant has proven by a preponderance of the evidence that all of the treatment by St. Anthony Summit Medical Center, Howard Head Sports Medicine Centers, and Heart of the Rockies Regional Medical Center and their referrals was authorized and reasonably necessary to cure or relieve the effects of the work injury. The employer transported claimant to the Buena Vista Medical Center, where he was referred to St. Anthony Summit Medical Center.

5. On April 17, 2009, claimant traveled to St. Anthony Summit Medical Center. Physician's Assistant Fedel examined claimant, who reported a history of the work injury. Physical Examination revealed the circumferential laceration of the finger and obvious deformity of the finger. X-rays revealed a transverse, slightly comminuted fracture of the mid diaphysis of the fourth middle phalanx. Dr. Viola performed surgery for open reduction and internal fixation of the fracture and repair of the ring finger extensor tendon. Dr. Viola referred claimant to Howard Head Sports Medicine Centers and also instructed claimant that he could have the sutures removed at a local clinic.

6. Claimant chose Heart of the Rockies Regional Medical Center for that suture removal on May 16, 2009.

7. Claimant was unable to return to the usual job due to the effects of the work injury, but he returned to modified duty work with no wage loss from April 20 to May 9, 2009. Claimant could engage in no pushing or pulling with the left hand and just did "what he could."

8. The employer has failed to prove that claimant was responsible for his termination of employment. Claimant alleged that he had been fired after work on May 9, 2009. The employer alleged that claimant's employment was never terminated and that claimant simply left work. Claimant probably left work at noon on May 9 without permission from Mark or Dawn even though he was scheduled to work until 2:00 p.m. Mark then called claimant and asked why he left work early. Claimant falsely stated that he had permission from Dawn. Claimant stated that he would see the employer on Monday. Mark stated that he would not. Claimant reasonably understood that his employment was terminated. The employer did not allege, and has not demonstrated, that the employment was terminated on May 9 due to claimant's early departure from work. Consequently, the employer has failed to prove that claimant was responsible for his termination of employment.

9. Claimant filed his workers' claim for compensation on May 14, 2009.

10. Claimant subsequently returned to work at "odd jobs," but the record evidence does not demonstrate his earnings for any relevant time periods.

CONCLUSIONS OF LAW

1. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Claimant must prove that an injury directly and proximately caused the condition for which bene-

fits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

In determining credibility, the ALJ should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or unreasonableness of testimony and actions, the probability or improbability of testimony and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or evidence, and any bias, prejudice or interest in the outcome of the case. *Colorado Jury Instructions, Civil*, 3:16. As found, claimant has proven by a preponderance of the evidence that he suffered an accidental injury on April 17, 2009, arising out of and in the course of his employment.

2. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The respondents are only liable for authorized or emergency medical treatment. See § 8-42-101(1), C.R.S.; *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). Under § 8-43-404(5), C.R.S., the respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once the respondents have exercised their right to select the treating physician the claimant may not change physicians without permission from the insurer or an ALJ. *See Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Respondents are liable only for treatment from authorized providers. A physician may become authorized to treat the claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). If the employer fails to authorize a physician upon claimant's report of need for treatment, claimant is impliedly authorized to choose her own authorized treating physician. *Greager, supra*. As found, all of the treatment by St. Anthony Summit Medical Center, Howard Head Sports Medicine Centers, and Heart of the Rockies Regional Medical Center and their referrals was authorized and reasonably necessary to cure or relieve the effects of the work injury.

3. Section 8-42-102(2), C.R.S., sets forth certain methods of calculating the average weekly wage. Section 8-42-102(3), C.R.S., permits the ALJ discretion in the method of calculating the average weekly wage if the nature of the employment or the fact that the injured employee has not worked a sufficient length of time, has been ill or self-employed, or for any other reason, the specific methods do not fairly compute the average weekly wage. *Avalanche Industries, Inc. v. Clark*, 198 P.3d 589 (Colo. 2008). *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993) required recalculation of the av-

erage weekly wage in an occupational disease case involving a new period of TTD long after the initial onset of the disease when claimant had received significant average weekly wage increases in the meantime. *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867 (Colo.App. 2001) upheld application of the *Campbell* holding to allow calculation of disability benefits based upon subsequent employment at a much higher wage than the claimant earned as a pizza delivery driver. As found, claimant's average weekly wage was $250. Claimant has not proven by a preponderance of the evidence that he should have his average weekly wage calculated as $1,000 pursuant to the *Pizza Hut* case.

4. Claimant was unable to return to the usual job due to the effects of the work injury, but he returned to modified duty work with no wage loss. Consequently, claimant 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. 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). One of the terminating events is actual return to modified work. Claimant's claim for TTD benefits from April 20 to May 9 is denied and dismissed. Claimant returned to work at modified duty during this period and earned $250 per week, his preinjury average weekly wage.

5. Claimant has proven by a preponderance of the evidence that he was temporarily and totally disabled commencing May 11, 2009. He was unable to perform his regular occupation. Because claimant's injury was after July 1, 1999, sections 8-42-105(4) and 8-42-103(1)(g), C.R.S. apply. Those identical provisions state, "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." Sections 105(4) and 103(1)(g) bar reinstatement of TTD benefits when, after the work injury, claimant causes his wage loss through his own responsibility for the loss of employment. *Colorado Springs Disposal d/b/a Bestway Disposal v. Industrial Claim Appeals Office*, 58 P.3d 1061 (Colo.App. 2002). An employee is "responsible" if the employee precipitated the employment termination by a volitional act that an employee would reasonably expect to result in the loss of employment. *Patchek v. Colorado Department of Public Safety*, W.C. No. 4-432-301 (September 27, 2001). Thus, the fault determination depends upon whether claimant performed some volitional act or otherwise exercised a degree of control over the circumstances resulting in termination. *See Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1994), *opinion after remand*, 908 P.2d 1185 (Colo. App. 1995). As found, the employer has failed to prove that claimant was responsible for his termination of employment.

6. Section 8-43-408, C.R.S., provides an additional 50% liability for all indemnity benefits if the employer fails to carry workers' compensation insurance. Consequently, claimant's TTD rate is $250 per week.

7. Section 8-43-408(2), C.R.S., requires that an uninsured employer post a bond or certificate of deposit for the present value of all of the unpaid compensation and benefits. WCRP 9-5 provides that the trustee is to be the Subsequent Injury Fund in the Division of Workers' Compensation. Pursuant to WCRP 9-5, the ALJ has calculated a total of $5,892.86 for past-due TTD benefits. There is no present value discount for these past-due amounts. The record evidence did not indicate the amount of the medical bills. The appropriate amount for the bond or deposit is $6,000.

ORDER

It is therefore ordered that:

1. Pinnacol Assurance is dismissed as a party.

2. Thomas M. Stern, Esq., is permitted to withdraw as attorney for Pinnacol Assurance.

3. The employer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers for the work injury, including St. Anthony Summit Medical Center, Howard Head Sports Medicine Centers, and Heart of the Rockies Regional Medical Center.

4. Claimant's claim for TTD benefits from April 20 to May 9, 2009, is denied and dismissed.

5. The employer shall pay to claimant TTD benefits, including the additional liability for failure to insure, at the rate of $250 per week commencing May 11, 2009, and continuing thereafter until modified or terminated according to law.

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

7. The employer shall:

a. Within 10 days, deposit the sum of $6,000 with the trustee, Subsequent Injury Fund Unit of the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: Sue Sobolik, to secure the payment of all unpaid compensation and benefits awarded, or in lieu thereof,

b. File a bond in the sum of $6,000 with the Division of Workers' Compensation within ten (10) days of the date of this order:

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

(2) Issued by a surety company authorized to do business in Colorado.

The bond shall guarantee payment of the compensation and benefits awarded.

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

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

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

DATED: December 2, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-171-138

ISSUES

The issue determined herein is CIGA's petition to reopen based upon an error or mistake in the admitted average weekly wage.

FINDINGS OF FACT

1. Claimant suffered an admitted work injury on April 19, 1993.

2. On May 6, 1993, Home filed a general admission of liability ("GAL") for temporary total disability ("TTD") benefits based upon an average weekly wage of $397.20.

3. On November 17, 1993, claimant was determined to be at maximum medical improvement ("MMI"). On December 28, 1993, Home filed a final admission of liability ("FAL") based upon the same average weekly wage of $397.20.

4. Claimant continued to be employed by the employer until April 1994, although he did not work after his injury.

5. When claimant was employed by the Employer, he had family health and dental insurance coverage for his wife, his daughter, and himself under the employer's group health insurance. While employed, claimant paid his monthly share of the premium for the group health insurance coverage. Claimant's group health insurance discontinued on April 22, 1994.

6. On April 4, 1994, the employer wrote to Home to indicate that claimant had been paying his employee portion of the group health insurance premiums and that his insurance coverage had continued.

7. On April 14, 1994, the employer sent a COBRA letter indicating that claimant's cost to continue the group health insurance for the family was $359.14 per month and the cost to continue dental insurance was $94.52 per month. The total COBRA premium for continuation of the health and dental insurance was $453.66 per month, or $104.69 per week. Claimant could not afford to continue any of the health insurance or dental insurance and he received no health insurance benefits after April 22, 1994.

8. On May 17, 1995, claimant began to receive social security disability insurance ("SSDI") benefits. On June 7, 1995, Home filed an amended GAL to assert an offset of $95.78 due to the SSDI benefits.

9. Claimant's attorney and the adjuster for Home negotiated an increase in the admitted average weekly wage to $531.41, which included $426.72 for the base wage and $104.69 for the COBRA continuation cost for claimant's health and dental insurance. On July 27, 1995, Home filed an amended GAL for the negotiated average weekly wage, but did not change the admitted TTD rates.

10. Claimant became eligible for Medicare coverage on October 1, 1995. His Medicare premium varied each year from $510 per year ($42.50 per month) in 1996 to $964 per year ($80.33 per month) in 2009.

11. On November 6, 1995, hearing was held on the issues of permanent total disability ("PTD") and medical benefits. Neither party raised the issue of average weekly wage as an issue for the hearing. By order dated November 17, 1995, claimant was awarded PTD benefits.

12. On January 16, 1996, claimant obtained a lump sum award for $37,560 of the PTD benefits, which caused the weekly PTD benefit to be reduced by $35.45.

13. On June 11, 2003, Home was declared insolvent. On June 25, 2003, CIGA received Home's file on this claim, although the file was incomplete.

143. On October 8, 2007, the Division of Workers Compensation wrote to CIGA to notify them that the annual 2% cost-of-living (COLA) adjustments had never been made to claimant's average weekly wage and that CIGA had 30 days to admit and pay the COLA increases since November 17, 1993.

15. On March 18, 2008, CIGA filed an FAL for COLA increases since July 30, 2003, resulting in an average weekly wage of $591.45 effective July 1, 2007. CIGA relied upon an initial average weekly wage of $397.20 rather than the negotiated $531.41.

16. On July 24, 2008, CIGA filed another FAL for the COLA increases due July 1, 2008, resulting in an average weekly wage of $603.28.

17. On February 20, 2009, claimant provided interrogatory answers to CIGA, indicating that he had received Medicare insurance.

18. On July 2, 2009, CIGA filed its petition to reopen alleging an error or mistake regarding claimant's health insurance fringe benefit.

19. On August 11, 2009, a prehearing administrative law judge ordered that CIGA's duty to admit for additional COLA increases was stayed pending determination of its petition to reopen.

20. Ms. Renegar, the CIGA adjuster, testified that she realized that COLA increases had never been paid, and that she merely applied the COLA increases to the originally admitted average weekly wage. However, she admitted in testimony that she could not determine how Home determined the admitted average weekly wage, although she admitted that Home had negotiated the admitted wage with claimant. Ms. Renegar testified that she believed that Home should never have included the cost of health insurance and dental insurance in the average weekly wage because she had seen insufficient evidence that claimant even received health and dental insurance benefits. Her testimony is contradicted by the pay stubs that unmistakably show that claimant paid monthly premiums for health and dental insurance coverage and by the COBRA letter from the employer.

21. CIGA has failed to prove by a preponderance of the evidence that the claim should be reopened due to an error or mistake. Claimant is correct that the wage admitted by Home Insurance in the July 27, 1995, GAL reflected a negotiated agreement between claimant and the insurer. Furthermore, the record evidence supports the admission of the $531.41 average weekly wage. The base wage portion of $426.72 is amply supported by the wage records and testimony. Claimant did not elect COBRA insurance coverage, but the employer did not continue to provide the insurance benefits. Consequently, the $104.69 per week in COBRA continuation premiums is appropriately included in the agreed-upon average weekly wage. On October 1, 1995, claimant enrolled in Medicare. At that point, the parties could have agreed or litigated the "conversion" amount of the health insurance benefits, but they did not. On November 17, 1995, claimant was awarded PTD benefits commencing on November 17, 1993, the date of MMI. At that point, the case was closed and the average weekly wage was fixed for PTD benefits, subject only to Home's duty to file annual final admissions of liability for the 2% annual COLA increase in the average weekly wage.

CONCLUSIONS OF LAW

1. CIGA stipulated that the 1997 amendments to section 8-43-303(2)(a), C.R.S., do not apply to this April 19, 1993 injury claim. Consequently, the provisions for reopening for an "overpayment" do not apply. CIGA must prove by a preponderance of the evidence that Home made an error or mistake by admitting for an average weekly wage of $531.41.

2. CIGA has failed to make any showing of error or mistake warranting reopening of the claim. Claimant is correct that the wage admitted by Home Insurance in the July 27, 1995, GAL reflected a negotiated agreement between claimant and the insurer. CIGA, as guarantor for the insolvent insurer, steps into the shoes of Home. CIGA cannot prevail in its petition to reopen by showing merely that CIGA adjusters would not have made the agreement that Home adjusters made. Furthermore, the record evidence supports the admission of the $531.41 average weekly wage. The base wage portion of $426.72 is amply supported by the wage records and testimony. Claimant did not elect COBRA insurance coverage, but the employer did not continue to provide the insurance benefits. Consequently, the $104.69 per week in COBRA continuation premiums is appropriately included in the agreed-upon average weekly wage. Claimant was awarded SSDI benefits on May 17, 1995. On October 1, 1995, claimant enrolled in Medicare. At that point, the parties could have agreed or litigated the "conversion" amount of the health insurance benefits, but they did not. Claimant's Medicare premiums change every year. While the case is open, the annual changes in Medicare premiums can easily be handled on TTD benefits. After permanent disability is determined and the case is closed, there is no apparent obligation to change the admitted wage to reflect annual changes in the Medicare premiums. Finality of determinations is still an important part of the workers' compensation process. On November 6, 1995, hearing was held on the issue of PTD benefits. The average weekly wage was not an issue at that hearing. On November 17, 1995, claimant was awarded PTD benefits commencing on November 17, 1993, the date of MMI. At that point, the case was closed and the average weekly wage was fixed for PTD benefits, subject only to Home Insurance's duty to file annual final admissions of liability for the 2% annual COLA increase in the average weekly wage. CIGA has not demonstrated that an error or mistake exists that warrants reopening.

ORDER

It is therefore ordered that:

1. CIGA's petition to reopen based upon error or mistake in the admitted average weekly wage is denied and dismissed.

2. The prehearing order staying the duty to admit for COLA increases annually since July 1, 1994, is set aside. CIGA shall comply with the statute and with the requests by DOWC to file admissions correcting the PTD rate since the first COLA increase due on July 1, 1994.

DATED: December 2, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-486-659

ISSUES

The issue presented for determination is whether Respondents are entitled to an award of attorney fees.

FINDINGS OF FACT

Having reviewed the file, the following Findings of Fact are entered.

1. Following proper notice to the parties, a hearing was scheduled in Colorado Springs, CO before the undersigned Judge on September 30, 2009, for consideration of Claimant's April 14, 2009, application for hearing in which the issue of medical benefits is raised. Respondents appeared at the hearing through counsel prepared to proceed. Claimant did not appear at hearing in person or through counsel.

2. On October 20, 2009, an Order to Show Cause was entered directing Claimant to show cause why the claim should not be dismissed for lack of prosecution. The Order to Show Cause also requested that Claimant respond to Respondents' Motion for Attorney Fees because of cost incurred by Respondents' counsel to prepare for and appear at the September 30, 2009, hearing. Respondents asserts in its Response to Application for Hearing that it is entitled to an award of attorney fees and cost because Claimant set issues for hearing which were not ripe for determination. Claimant was directed to respond to the Order to Show Cause and Motion for Attorney Fees by November 20, 2009. Claimant did not file a response to the Order to Show Cause and Motion for Attorney Fees.

3. Under Section 8-43-201(d), C.R.S., a person requesting a hearing on issues, which are not ripe for adjudication at the time the request for hearing is filed shall be assessed reasonable attorney fees and costs of the opposing party in preparing for hearing. Claimant has not responded to the Motion for Attorney Fees, therefore, it is found that the Motion for Attorney Fees is granted.

4. Pursuant to the provision of Section 8-43-201(d), Claimant shall be liable for Respondents' reasonable attorney fees and costs associated with Claimant's actions in raising an issue for hearing which is not ripe for determination.

CONCLUSION OF LAW

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

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

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

3. Respondents move for an award of attorney fees and cost because Claimant filed an application for hearing on an issue, which was not ripe for determination. Claimant filed no response to Respondents' Motion for Attorney Fees and Cost and did not respond to the Court's Order to Show Cause. Accordingly, it is concluded that, under Section 8-43-201(d), Respondents shall be award attorney fees and cost in connection with Claimant's claim, which raises issues, which are not ripe for determination.

ORDER

It is therefore ordered that:

1. Claimant shall be liable to Respondents for reasonable attorney fees and costs under Section 8-43-201(d), for Claimant's action in raising issues, which were not ripe for determination.

All matters not determined herein are reserved for future determination.

DATED: December 2, 2009

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-799-803

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she suffered a mental impairment during the course and scope of her employment with Employer.

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

FINDINGS OF FACT

1. Claimant worked for Employer as a corporate trust relationship specialist. Her duties involved supporting managers who maintained corporate trust accounts. Claimant specifically performed transactional work, initiated money movements and communicated with clients.

2. Beginning in 2006 Ethel Vic became Claimant's supervisor. Ms. Vic testified at the hearing in this matter. She explained that Claimant's job duties evolved to require additional client contact. Ms. Vic remarked that Claimant's position required her to communicate effectively and efficiently in the English language.

3. Ms. Vick commented that Claimant's lack of English skills became more problematic over time because of increased client contact. She explained that she received customer complaints about Claimant's language skills. Ms. Vic also noted that Claimant had communication difficulties with coworkers that caused misunderstandings.

4. Claimant's 2006 performance review from Employer reveals that, although she had demonstrated improved understanding in her assignments from managers, she continued to experience issues with communication skills. The communication difficulties impacted Claimant's accuracy and efficiency. The review also stated that Claimant was making a greater effort in interacting with clients and that client interaction was "part of the ongoing project of improving her communication skills."

5. Claimant's 2007 performance review reveals that she continued to exhibit difficulties in communicating with customers and managers. In terms of Claimant's personal development, the review noted "the communication barrier that [Claimant] has experienced over the last several years has caused her considerable problems in this area." The performance review also provided that Claimant had a "development need" of improving proficiency with the English language. However, because she had been unsuccessful in meeting the development need Employer implemented a Performance Improvement Plan on August 7, 2007.

6. Ms. Vic explained that Claimant did not complete her Performance Improvement Plan. She remarked that Claimant took a leave of absence based on a disability resulting from anxiety and depression. Claimant did not subsequently return to work for Employer.

7. On October 5, 2009 Kathy McCranie, M.D. conducted a records review of Claimant's claim and issued a report. She concluded that "it is medically probable that [Claimant] developed depression, as well as a panic disorder, and these psychological symptoms affected her work rather than the other way around." In reviewing Claimant's medical history, Dr. McCranie remarked that Claimant had been treated by several physicians for major depression. She specifically noted that Jill R. Levy, M.D. had determined that Claimant's work environment had triggered her depression and that Claimant's condition prevented her from working. Dr. McCranie also remarked that a social worker had concluded that Claimant's depression and panic disorder occurred as a result of employment issues.

8. Dr. McCranie recounted that Claimant began "treatment for symptoms of insomnia, frequent crying spells, low self esteem, and mood feelings of worthlessness" on June 22, 2007. She commented that Claimant's poor work review did not occur until August 1, 2007 and Claimant did not cease working until September 10, 2007. Dr. McCranie thus remarked that Claimant's symptoms of insomnia, crying, low self-esteem and worthlessness preceded both her employment review and termination. Moreover, Dr. McCranie noted that Claimant's medical providers failed to explain how Claimant's employment caused her symptoms.

9. Claimant has failed to establish that it is more probably true than not that she suffered a permanent mental impairment from an accidental injury arising out of and in the course and scope of her employment. Furthermore, Claimant has not demonstrated that she suffered from a permanent mental impairment as a result of a psychologically traumatic event that was outside of a similarly situated worker's experience. Ms. Vick credibly testified that Claimant's lack of improvement in her communication skills negatively impacted her job performance. She specifically explained that Claimant received customer complaints and Claimant's communication difficulties with coworkers caused misunderstandings. A review of Claimant's performance evaluations reveals that Claimant consistently exhibited communication difficulties that ultimately resulted in a Performance Improvement Plan. Claimant did not complete her Performance Improvement Plan because she took a leave of absence based on a disability resulting from anxiety and depression. Dr. McCranie explained that Claimant's poor work review did not occur until August 1, 2007 and Claimant did not cease working until September 10, 2007. She thus remarked that Claimant's symptoms of insomnia, crying, low self-esteem and worthlessness preceded both her employment review and termination. Dr. McCranie thus persuasively concluded that Claimant's "psychological symptoms affected her work rather than the other way around." Therefore, any negative impact on Claimant's psychological condition did not arise out of and in the course of her employment because it resulted from a disciplinary action or work evaluation that was taken in good faith by Employer.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. 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). An injury occurs "in the course of" employment when a claimant demonstrates that the injury occurred within the time and place limits of her employment. *Popovich v. Irlando,* 811 P.2d 379, 383 (Colo. App. 1991). The "arising out of" requirement is narrower and requires the claimant to demonstrate that the injury has its "origin in an employee's work-related functions and is sufficiently related thereto to be considered part of the employee's service to the employer." *Id*. 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. Section 8-41-301(2)(a), C.R.S. imposes additional evidentiary requirements regarding mental impairment claims. The section provides, in relevant part:

> A claim of mental impairment must be proven by evidence supported by the testimony of a licensed physician or psychologist. For purposes of this subsection (2), "mental impairment" means a recognized, permanent disability arising from an accidental injury arising out of and in the course of employment when the 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 disciplinary action, work evaluation, job transfer, lay-off, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer.

The definition of "mental impairment" consists of two clauses that each contains three elements. The first clause requires a claimant to prove the injury consists of: "1) a recognized, permanent disability that, 2) arises from an accidental injury involving no physical injury, and 3) arises out of the course and scope of employment. *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023, 1030 (Colo. 2004). The second clause requires the claimant to prove the injury is: "1) a psychologically traumatic event, 2) generally outside a worker's usual experience, and 3) that would evoke significant symptoms of distress in a similarly situated worker." *Id.*

6. As found, Claimant has failed to establish by a preponderance of the evidence that she suffered a permanent mental impairment from an accidental injury arising out of and in the course and scope of her employment. Furthermore, Claimant has not demonstrated that she suffered from a permanent mental impairment as a result of a psychologically traumatic event that was outside of a similarly situated worker's experience. Ms. Vick credibly testified that Claimant's lack of improvement in her communication skills negatively impacted her job performance. She specifically explained that Claimant received customer complaints and Claimant's communication difficulties with coworkers caused misunderstandings. A review of Claimant's performance evaluations reveals that Claimant consistently exhibited communication difficulties that ultimately resulted in a Performance Improvement Plan. Claimant did not complete her Performance Improvement Plan because she took a leave of absence based on a disability resulting from anxiety and depression. Dr. McCranie explained that Claimant's poor work review did not occur until August 1, 2007 and Claimant did not cease working until September 10, 2007. She thus remarked that Claimant's symptoms of insomnia, crying, low self-esteem and worthlessness preceded both her employment review and termination. Dr. McCranie thus persuasively concluded that Claimant's "psychological symptoms affected her work rather than the other way around." Therefore, any negative impact on Claimant's psychological condition did not arise out of and in the course of her employment because it resulted from a disciplinary action or work evaluation that was taken in good faith by Employer.

ORDER

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

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

DATED: December 2, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-701-864

ISSUES

The issue for hearing was reopening in connection with a recommendation for left foot arthrodesis.

FINDINGS OF FACT

1. On October 15, 2006, Claimant sustained an admitted industrial left foot crush injury and a right ankle fracture when a piece of machinery ran over his legs. Claimant underwent surgeries on October 15, 2006, October 16, 2006, November 6, 2006, and January 11, 2007.
2. On March 20, 2007, in a letter to the claims adjuster for Insurer, Dr. Shank noted that Claimant had a very severe injury to his lateral column, which might lead to eventual arthritis and arthrosis of his lateral column.
3. Claimant underwent additional surgeries on April 19, 2007, and November 28, 2007.
4. On December 14, 2007, Dr. Shank determined that Claimant was at maximum medical improvement (MMI). Dr. Shank did not anticipate any future treatment with regard to Claimant's right ankle, other than the yearly office visits and radiographs to assess his progress. Dr. Shank indicated that possible future anticipated care to the left foot included left arthrodesis with realignment, and yearly office visits and radiographs to assess his progress.
5. On December 18, 2007, Dr. Shank noted that radiographs showed "significant degenerative changes" about the left foot and early arthritic changes about the right ankle.
6. On January 14, 2008, Claimant was seen by Dr. Quick and was placed at MMI, with 5% right lower extremity impairment and 4% left lower extremity impairment. Dr. Quick recommended post-MMI medical treatment in accordance with Dr. Shank's recommendations, including surgical aftercare, annual x-rays, and possible left foot fusion

in the future. Dr. Quick ordered a Functional Capacity Evaluation ("FCE") to clarify permanent work restrictions.

7. On February 15, 2008, Dr. Shank reexamined Claimant and noted that he had healed completely with no new complaints and was doing well. Dr. Shank released Claimant to activity as tolerated and to follow up in October 2008 for radiographs of his right ankle and left foot.

8. On May 22, 2008, Claimant underwent a Division Independent Medical Examination ("DIME") with Dr. Linda Mitchell. Claimant's chief complaint was left foot pain and right ankle pain. On physical examination, his right ankle was without effusion, tenderness, or crepitus with no lateral or medial instability. Claimant's left foot was without tenderness or crepitus and had trace edema present. There was no lateral or medial hindfoot instability. There was negative drawer sign and Claimant had no tenderness or deformity of the MTP joints bilaterally. Claimant's stance revealed flattening of the medial arches, right greater than left. His gait was slightly broad-based, but not antalgic. He was able to do a deep squat to the floor. His heel walking, toe walking and tandem gait were normal. Romberg was negative.

9. Dr. Mitchell diagnosed right distal tibia/fibula fracture and left second and third metatarsal fractures, third, fourth and fifth tarsometatarsal dislocations and cuboid fracture. Dr. Mitchell found Claimant to be at MMI as of February 11, 2008, for his right ankle and left foot fractures, finding a 9% right lower extremity impairment and a 12% left lower extremity impairment. Dr. Mitchell agreed with Dr. Shank that Claimant's development of arthritis/arthrosis would require arthrodesis at some point in the future. Dr. Mitchell recommended that Claimant be able to see Dr. Shank as needed for follow up. No other maintenance care was indicated.

10. On June 19, 2008, Insurer filed a Final Admission of Liability for the permanent disability benefits and for post-MMI medical benefits.

11. Claimant did not seek treatment for his right ankle and left foot fractures again until October 7, 2008. Claimant was seen in follow up with Dr. Shank for repeat evaluation of his left Lisfranc fracture, dislocation of lateral column injury. Dr. Shank noted that Claimant continued to have global pain mostly localized to the third, fourth and fifth tarsal metatarsal joints and a component of second tarsal metatarsal joint pain as well. Radiographs taken that day demonstrated significant end-stage arthritic changes about the second, third, fourth and fifth tarsal metatarsal joint. Dr. Shank diagnosed Claimant with end-stage posttraumatic Lisfranc arthritic changes with gastroc equines, and offered Claimant the option to undergo arthrodesis to relieve the pain symptoms of his arthritic condition.

12. On October 13, 2008, Dr. Shank requested authorization for left foot gastroc slide Lisfranc arthrodesis, possible tibial/calcaneal autograft, and fourth and fifth tarsal metatarsal steroid injection for end-stage posttraumatic Lisfranc arthritic changes.

13. On December 17, 2008, Administrative Law Judge Martin L. Stuber ordered Insurer to pay for the left foot arthrodesis requested by Dr. Shank.

14. On January 15, 2009, Claimant filed a Petition to Reopen, alleging a change of medical condition based upon an Independent Medical Examination by Dr. Timothy Hall on January 7, 2009.

15. Dr. Hall testified by deposition on June 25, 2009. It was Dr. Hall's opinion that the left foot arthrodesis may improve Claimant's degree of pain and his ambulation. Dr. Hall

believed that the Claimant's left foot had worsened since the February 11, 2008, maximum medical improvement date because he was having more pain. It was also his opinion that Claimant's employment with the United States Post Office, which required standing and walking two and one-half to five hours per day, had made Claimant's ankle and knee complaints worse.

CONCLUSIONS OF LAW

1. Section 8-43-303 (1), C.R.S., permits the reopening of a claim at any time within six years after the date of injury, based upon a change of condition. The power to reopen is discretionary with the Judge. Cordova v. Industrial Claim Appeals Office, 55 P.3d 186 (Colo.App. 2002).

2. Section 8-42-101 (1)(a), C.R.S., requires an employer to provide an injured employee with medical, surgical, dental, nursing and hospital treatment as reasonably needed during the disability to cure and relieve the employee from the effects of the injury. Treatment after maximum medical improvement that does not effect a cure of the condition, but which is necessary to relieve the claimant from the effects of the industrial injury, is maintenance care. Grover v. Industrial Commission, 757 P.2d 705 (Colo. 1988).

3. In Hayward v. Unisys Corporation, W.C. 4-230-686 (ICAO, 2002), surgery was found not to be curative treatment but was considered Grover maintenance medical care, when it was designed to maintain the claimant in his current condition to prevent it from worsening and to provide some symptomatic relief.

4. Both of Claimant's treating physicians, Dr. Quick and Dr. Shank, as well as the DIME physician, Dr. Sue Mitchell, opined that Claimant may need arthrodesis of the foot as part of his maintenance care.

5. The Judge concludes that the opinions of the above three physicians are more credible than Dr. Hall's opinion. The arthrodesis is required as part of his maintenance care. Claimant has not shown such a worsening of condition to justify a reopening.

6. If Claimant should elect to undergo the surgery, the surgery could result in restrictions for a period of time that temporarily disables Claimant. Claimant could at that time file a petition to reopen for a worsened condition. If Claimant shows that the worsening at the time of the surgery is the natural and proximate consequence of this compensable injury (and not his subsequent employment as suggested by Dr. Hall), the claim could be reopened and temporary disability benefits awarded (as well as additional permanent partial disability benefits if, contrary to the expectation of Dr. Hall, the surgery results in increased impairment).

7. Claimant does not seek additional disability benefits in this order. Insurer has already been determined to be liable for the surgery and this order does not alter that liability. 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) and (6), C.R.S., and other applicable law regarding petitions to review.

ORDER

It is therefore ordered that Claimant's petition to reopen is denied. Matters not determined herein are reserved for future determination.

DATED: *December 3, 2009*

Bruce C. Friend, Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-632-269

ISSUES

Whether Claimant is permanently totally disabled and entitled to an award of PTD benefits beginning on the date of MMI.

At hearing, Respondents raised the affirmative defense that Claimant's injury was not a significant contributing factor to his inability to earn a wage on account of Claimant's lack of legal work status in the United States.

FINDINGS OF FACT

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

1. Claimant was injured on November 17, 2004. Claimant sustained a head injury when a loader backed into a gate at the dairy farm where claimant worked. Claimant was struck in the head by the gate and knocked to the ground.

2. Claimant's date of birth is January 11, 1982. Claimant does not have documentation allowing him to legally work in the U.S. When he did apply for a job after the injury Claimant used a Social Security number he had used when he obtained employment with Employer. Claimant was assisted in applying for jobs after his injury by his sister, Gloria Perez, who admitted that if she was asked by a prospective employer she would have told the employer that this Social Security number is false.

3. Claimant underwent a craniotomy and received therapy for a head injury, including cognitive therapy, visual therapy and physical therapy for low back pain. Claimant has had some post-concussive seizures, but he has not had a seizure since June 2007. Claimant was placed at MMI by his treating physician, Dr. Reichhardt, on July 9, 2008. Dr. Reichhardt outlined maintenance medical recommendations that included physician visits, medications and necessary lab tests for the medication prescriptions. He also

recommended four visits with a physical therapist over the next three years as part of the maintenance treatment to maintain Claimant's condition after MMI.

4. Dr. Reichhardt assigned work restrictions of limited lifting, pushing, pulling and carrying to 30 pounds occasionally, 15 pounds frequently, limited bending and twisting at the waist to an occasional basis; no climbing at unprotected heights and no driving. Dr. Reichhardt stated that the driving restriction was due to Claimant's seizures, and this could be lifted if the seizures were controlled. Claimant does not possess a valid driver's license in the State of Colorado.

5. Dr. Navarette, claimant's treating neuropsychologist, performed extensive testing on claimant and found he exhibited poor performance on various malingering tests. She suspected some degree of symptom magnification. She identified claimant giving sub-maximal effort on testing. Though she considered it was reasonable to believe that claimant may be experiencing some degree of cognitive problems, it was difficult to determine the extent of this problem since he seemed to purposely perform poorly on some tests. Dr. LaFosse also performed a neuropsychological evaluation of Claimant. Dr. LaFosse found that Claimant's posture, gait and general motor activity were unremarkable and appeared normal. Dr. LaFosse noted that Claimant's visual learning and memory were within normal limits. Dr. LaFosse further found that while Claimant's executive functioning fell in the mild to moderately impaired range, this was likely attributable to his limited education and reading experience. Dr. LaFosse opined, and it is found, that Claimant's cognitive abilities are in the low average range or better.

6. Claimant testified that spends his average day at home, going to church, listening to church music, watching television and reading the Bible. He tries to help out at home. He picks up his room, does the dishes on occasion, but does not vacuum because he cannot push the vacuum. He testified that he no longer plays basketball because he can't run, can't lift his arms and gets dizzy. Claimant further testified he can only walk ten minutes before he can no longer continue.

7. Claimant testified that he can be up during the day for a while, but after about one hour, he is forced to lie down or sit for 40-50 minutes. He testified feels dizzy and weak if he is up for more than an hour. He testified has problems walking, he gets dizzy and he feels as if he is going to fall and that it is difficult for him to change positions. He testified has trouble getting in and out of cars and up and down from a sitting position. In order to avoid increasing his headaches, Claimant stated he looks for shade and must wear sunglasses as he was instructed by Dr. Politzer. Claimant testified he does not own a cell phone and he does not know how to use a cell phone.

8. Claimant identified himself on the surveillance videos admitted into evidence a Respondents' Exhibits p and Q that were shown at hearing. These videos depicts Claimant outside in the sun without sunglasses on more that one occasion. Claimant is seen to converses and laugh with friends and his nephews in his driveway. Claimant was shown to easily retrieve two gallon jugs from the back of a vehicle, transferring them both to one arm and reaching overhead to close the tailgate. Claimant is

shown sitting on the front porch and bending forward conversing on a cell phone. Claimant is frequently depicted using, answering and checking messages on a cell phone that he would retrieve from his pocket. Claimant is seen to walk comfortably down a sidewalk while looking down at the cell phone. Claimant is shown while he sweeps the front porch area on more than one occasion, bending over on numerous occasions to pick up a rug or mat and beat it against the ground to remove dirt. Claimant exhibited no observable signs of dizziness upon arising from this bent over position. Claimant did not grab onto any object or railing for support. At one point, claimant sits on the grass in front of his house. Though he testified this position made his back hurt, he easily transitioned from sitting to standing.

9. Additional surveillance depicted claimant in Greeley, Colorado a 45 minute drive from Claimant's place of residence. During this video, Claimant is depicted arriving at a medical office, shopping various stores along a sidewalk area, walking around the Greeley Mall and entering and exiting a vehicle. The video demonstrates the family arrived in Greeley shortly before 2:00 p.m. After a medical appointment was completed, Claimant and members of his family went out to eat and then shopped in a strip mall including an ACE Hardware and miscellaneous clothing stores. Claimant entered and exited the vehicle without difficulty. Claimant walked outside in the sun without sunglasses or a hat. Claimant walked down the sidewalk looking at the cell phone without difficulty. Claimant and his family members were in Greeley from the arrival at the doctor's appointment until they left the mall around 7:30. They returned home at that time.

10. The ALJ finds that claimant's testimony, along with the testimony of his two sisters, Gloria and Vicki Perez, regarding Claimant's functional abilities is not credible or persuasive. Claimant's testimony and that of Gloria and Vicki Perez are contradicted by the activities depicted on the surveillance videos taken of Claimant.

11. Dr. Healey testified on behalf of claimant. Dr. Healey's opinions were primarily based on the findings of the functional capacity evaluation performed by Pat McKenna and Dr. Healey's observations of the claimant on one occasion. Dr. Healey agreed that a physician must rely heavily on what a patient tells them.

12. Dr. Healey agreed that clamant could go back to work lifting 10-15 pounds frequently with simple tasks working three to four hours per day. Dr. Healey acknowledged that it was the job of the vocational experts to determine whether claimant could return to work.

13. Pat McKenna performed functional capacity evaluation ("FCE") at the request of the Claimant. The FCE was performed over three sessions that were completed on June 29, June 30 and July 1, 2009. Ms. McKenna testified that based upon her evaluation, Claimant would have difficulty walking after a while because once he fatigues, his double vision kicks in and his feet do not know which eye to believe, and trying to walk for him is like "…walking through a fun house 24/7." Ms. McKenna testified that Claimant has a problem with dizziness evidenced by his starting to fall while standing, losing balance while performing a standing task and having to grab onto the table

for support to keep from falling and that this was seen when claimant was getting up and down. Ms. McKenna's testimony regarding Claimant's dizziness and balance problems is inconsistent with claimant's activities as depicted on the surveillance video just days prior to Ms. McKenna's evaluation that depicted him easily rising from very low seated positions without any evidence of dizziness, and his ability to walk and check the cell phone at the same time. Ms. McKenna further testified that claimant cannot walk or step backward without experiencing balance problems. She described an incident where he was washing dishes in her office and stepped backward away from the sink, losing his balance. Ms. McKenna stated Claimant would try to step backwards and would lose his balance and have to grab hold of something for support. The ALJ finds this is also inconsistent with the surveillance video that depicts claimant stepping backward off his stoop while sweeping with no apparent difficulty. The ALJ finds that the testimony and opinions of Ms. McKenna regarding the results of her FCE and her observations of Claimant's function to be not credible or persuasive.

14. Claimant presented testimony from Mr. Robert Schmidt, a vocational expert. Mr. Schmidt did not present labor market research or any specific investigation he had performed to evaluate employability to support his opinion concerning Claimant's employability. Mr. Schmidt relied on the opinions of Dr. Healey and Ms. McKenna in reaching his conclusions and opinion regarding Claimant's employability. Mr. Schmidt opined that Claimant's chronic pain, attention deficits and cognitive difficulties prevent him from being able to perform any work from which he could earn a wage.

15. Respondents presented testimony from Patrick Renfro, a vocational expert. Mr. Renfro conducted specific labor market research for this case. Specific job descriptions, along with information from the Dictionary of Occupational Titles and information to assist the doctors in analyzing the jobs, were presented to Dr. Reichhardt and Dr. Navarette for consideration. Based on the research he performed and the input of the treating physicians, Mr. Renfro opined that claimant, to a reasonable degree of vocational probability, is capable of earning wages in his commutable labor market.

16. Dr. Reichhardt authored a specific report discussing his review of the jobs presented to him by Mr. Renfro and approved the jobs of kitchen food assembler, Mexican food maker, fast food worker, customer service clerk, garment sorter, folder, housekeeper and companion as being within Claimant's physical capabilities. Dr. Reichhardt's opinions as stated in his report of July 26, 2009 regarding the Claimant's physical ability to perform the jobs presented to him is found to be credible and persuasive.

17. Dr. Navarette to approved the jobs of kitchen food assembler, Mexican food maker, kitchen helper, garment sorter, folder, housekeeper and companion without limitation. She approved the jobs of fast food worker with limitations of no drive through service, customer service clerk without performing "high attentional skills," and sandwich maker if not in a fast paced environment. She notes under the sandwich maker position that claimant "could do well with a repetitive task." Dr. Navarette's opinions are found to be credible and persuasive.

18. The ALJ finds the testimony of Mr. Renfro to be more credible and persuasive regarding Claimant's likely ability to earn any wages than that of Mr. Schmidt. The ALJ finds that, based on the totality of evidence, it is more probable than not that claimant is capable of earning a wage based upon Claimant's physical and cognitive abilities and the availability of suitable jobs within Claimant's geographic area.

19. Mr. Renfro testified that claimant's lack of legal work status in the United States could negatively impact his ability to obtain employment. Mr. Schmidt opined that unless Claimant were to misrepresent himself as a worker with legal status to work in the United States, Claimant would not be able to actually obtain employment. In his opinion, claimant's immigration status presents a significant hurdle in his ability to earn wages. The ALJ finds these opinions of Mr. Renfro to be credible and persuasive. Claimant retains the ability to earn a wage subsequent to his work injury, however, Claimant's ability to actually obtain employment in the United States is more significantly impaired by Claimant's lack of legal work status in the United States than by the effects of Claimant's work injury. The ALJ finds that the effects of Claimant's work related injury are not a significant contributing factor to any inability of Claimant to obtain or maintain employment and earn a wage.

20. The ALJ finds that Claimant has failed to prove, by a preponderance of the evidence, that he is permanently and totally disabled.

CONCLUSIONS OF LAW

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

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

23. Permanent total disability, as defined in § 8-40-201(16.5), C.R.S., means an employee is unable to earn any wage in the same or other employment. As amended in 1991, this statute established a strict definition of permanent total disability.

The phrase, "to earn any wages in the same or other employment, provides a real and nonillusory bright line rule for the determination whether a claimant has been rendered permanently totally disabled." *Lobb v. Indus. Claim Appeals Off.*, 948 P.2d 115 (Colo. App. 1997) The burden of proof in establishing permanent total disability is on the employee to prove that he is unable to earn any wages in the same or other employment. In order to meet the burden of proof established by this statute, claimant must prove permanent total disability by a preponderance of the evidence. The question of whether claimant has carried this burden is one of fact for resolution by the administrative law judge. See *Eisnach v. Indus. Comm'n*, 633 P.2d 502 (Colo. App. 1981).

24. For purposes of permanent total disability, "any wages" means more than zero. *McKinney v. Indus. Claim Appeals Off.*, 894 P.2d 42 (Colo. App. 1995). In *McKinney* the Court held that the ability to earn wages in "any" amount is sufficient to disqualify a claimant from receiving permanent total disability benefits. *See also Christie v. Coors Transportation*, 933 P.2d 1330 (Colo. 1997). In determining whether a claimant is permanently totally disabled, the ALJ may consider his age, education, prior work experience, vocational training, overall physical condition, mental capabilities, and the availability of the work claimant can perform. *See Sandoval v. Sam & Ray's Frozen Foods*, W.C. No. 4-125-205 (ICAO Nov. 30, 1993). The critical test is whether employment exists that is reasonably available to claimant under his particular circumstances. *Weld County School Dist. RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). the claimant fails to prove permanent total disability if the evidence establishes that it is more probable than not that the claimant is capable of earning wages. *Duran v. MG Concrete Inc.,* W.C. No. 4-222-069 (September 17, 1998).

25. There is no requirement that respondents must locate a specific job for claimant to overcome a prima facie showing of permanent total disability. *Hennenberg v. Value-Rite Drugs, Inc.,* W.C. 4-148-050 (September 26, 1995); *Rencehausen v. City and County of Denver*, W.C. No. 4-110-764 (November 23, 1993); *Black v. City of La Junta Housing Authority*, W.C. No. 4-210-925 (December 1998); *Beavers v. Liberty Mutual Fire Ins. Co.*, W.C. No. 4-163-718 (January 13, 1996), *aff'd., Beavers v. Liberty Mutual Fire Ins. Co.,* (Colo. App. No. 96 CA0275, September 5, 1996) (not selected for publication); *Gomez v. Mei Regis*, W.C. No. 4-199-007 (September 21, 1998). Claimant fails to prove permanent total disability if the evidence establishes that it is more probable than not that claimant is capable of earning wages. *Duran v. MG Concrete Inc.*, W.C. No. 4-222-069 (September 17, 1998). As long as claimant can perform any job, even part time, he is not permanently totally disabled. *Vigil v. Chet's Market*, W.C. No. 4110565 (February 9, 1995).

26. In order for a claimant to receive PTD benefits, his work injury must be a significant causative factor in his disability. *Seifried v. Industrial Commission*, 736 P.2d 1262 (Colo. App. 1986).

27. In deciding whether claimant has met his burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the

evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness' testimony and actions; the reasonableness or unreasonableness of the testimony; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936).

28. As found, Claimant has failed to prove by a preponderance of the evidence that he is permanently and totally disabled. Claimant's treating medical providers, Dr. Reichhardt and Dr. Navarette, have credibly opined that from a physical and a neuropsychological standpoint, claimant is capable of performing employment and therefore of earning wages. Both of these providers have evaluated and treated claimant on multiple occasions and are in the best position to evaluate his ability to perform various work tasks. Patrick Renfro credibly testified based on their medical opinions that jobs exist in Claimant's available labor market that are within claimant's restrictions. Mr. Renfro supported his opinions by performing specific labor market research in this case. Mr. Renfro submitted his suggested employment opportunities to the treating physicians for their input. Mr. Schmidt did not communicate with the treating physicians regarding their opinions of claimant's restrictions and rejected their opinions in his analysis. Mr. Schmidt relied upon the opinions and evaluations of Dr. Healey and Ms. McKenna regarding the Claimant's physical and cognitive abilities, evaluations that are not credible or persuasive considering the inconsistencies between those evaluations and the Claimant's demonstrated activities shown on the surveillance videos. The testimony and evidence from the treating physicians in the form of their specific approval of jobs which claimant could perform is more credible and persuasive than the opinions and assessments of Dr. Healey and Ms. McKenna. The opinions of Mr. Renfro regarding Claimant's employability are therefore more credible and persuasive than those of Mr. Schmidt. Claimant has not established by a preponderance of the evidence that he is unable to earn any wages as the result of the effects of his work related injury.

29. Respondents do not argue that claimant's immigration status prevents him from collecting benefits as a matter of law. c.f. *Champion Auto Body v. Indus. Claim Appeals Office,* 950 P.2d 671 (Colo. App. 1997). Respondents argue that this is an unrelated impairment of his ability to find work that should be considered along with other factors. The ALJ agrees. Under the federal Immigration Reform Control Act of 1986, it is illegal and a crime for an unauthorized alien to subvert the employer verification system by tendering false documentation to obtain employment. 8 U.S.C. Section 1324c(a). The Act thus prohibits aliens from using or attempting to use "any forged, counterfeit, altered, or falsely made document" or "any document lawfully issued to or with respect to a person other than the possessor: for purposes of obtaining employment in the United States. Sections 1324c(a)(1)-(3). Similarly, if an employer unknowingly hires an unauthorized alien, or if the alien becomes unauthorized while employed, the employer is compelled to discharge the worker upon discovery of the worker's undocumented status. Section 1324a(a)(2). Thus, if claimant is not hired due to his immigration status, or if he is terminated because his immigration status is discovered, then this is a factor that relates solely to a worker's legal work status and that is independent from the

effects of any work injury. As such, Claimant's ability to obtain and maintain employment is directly adversely affected by the fact that Claimant lacks legal work status in the United States.

30. Legal work authorization is a necessary qualification because employers may not continue to employ workers whom they know to be unauthorized. *Enriquez v. Oglebay Norton Co.*, W.C. No. 4-603-526 (January 21, 2005). The Panel noted in its decision in *Enriquez* that their result was not contrary to the holding in *Champion Auto Body* because, the holding in *Champion* in no way "holds or implies that a claimant's 'work status' may not be considered when evaluating the cause of post-injury wage loss." The United States Supreme Court in *Hoffman v. NLRB*, 535 U.S. 137 (2002) noted that employees are deemed "unavailable" for work during any period when they were not "lawfully entitled to be present and employed in the United States." Here, because Claimant does not possess legal authorization to work in the United States and is therefore "unavailable" for work it follows that Claimant's lack of legal authorization to work in the United States is a more significant contributing factor to his was loss subsequent to his work injury than the effects of the work injury. As found, the effects of Claimant's work injury would not preclude him from obtaining and maintaining employment within his restrictions and within his geographic area of residence. Claimant's work injury is not a significant causative factor in his disability. Claimant is not permanently and totally disabled.

ORDER

It is therefore ordered that:

Claimant's claim for permanent total disability benefits is denied and dismissed.

DATED: December 3, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-777-646

ISSUES

¬ Did respondents overcome by clear and convincing evidence the determination of Dr. Lichtenberg that claimant has not reached maximum medical improvement?

FINDINGS OF FACT

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

1. Employer operates a business that manufactures computer parts. Claimant's date of birth is April 16, 1958; his age at the time of hearing was 51 years. Claimant moved to the United States in 1980. Claimant's primary language is Hmong; however, he speaks and understands sufficient English to function. Claimant began working for employer on the assembly line on September 10, 1981. Claimant complained of right forearm and wrist pain arising out of his assembly work on October 1, 2008. Insurer admitted liability for claimant's claim. Employer terminated claimant on December 13, 2008, when employer was unable accommodate permanent restrictions involving his bilateral upper extremities. Claimant has not returned to work since employer terminated him.

2. Claimant has a preexisting history of left arm problems caused by tendinitis and gout. Claimant was last treated for tendinitis and gout in 1999. However, at the time of the admitted injury, claimant was working without restrictions and had not received treatment since 1999.

3. Employer referred claimant to Arbor Occupational Medicine, where Jade Dillon, M.D., Sander Orent, M.D., and Bruce B. Cazden, M.D., treated him. Dr. Dillon first examined claimant on October 17, 2008. During her physical examination of claimant's right wrist, Dr. Dillon noted claimant showed significant guarding of movement with complaints of pain with any motion. Dr. Dillon diagnosed tendinitis of the right wrist and forearm, recommended physical therapy, and imposed physical activity restrictions limiting bilateral repetitive gripping and grasping.

4. Claimant stated that he never had a translator when he went to Arbor and that he complained of tingling in his fingers and wrists. The physical therapist at Alpha Physical Therapy recorded on October 21, 2008, that claimant complained of numbness and tingling radiating from his right forearm into all fingers. The lack of a translator failed to prevent the physical therapist from understanding the symptoms claimant was communicating.

5. Dr. Cazden initially examined claimant on October 24, 2008. Claimant reported to Dr. Cazden that, although employer had place him in a light-duty position inspecting pouches, he had developed left wrist pain as well. According to Dr. Cazden, claimant denied symptoms of numbness in his hands or symptoms in his bilateral elbows or shoulders at that time.

6. Dr. Orent reevaluated claimant on November 5, 2008, when claimant reported performing light duty at employer, spending 4 hours per day inspecting pouches and alternating his time with a reading assignment. Dr. Cazden persuasively testified that, as of November 5th, there was no medically probable basis to refer claimant for a surgical evaluation. Dr. Cazden explained:

> [Claimant] had no complaints of nerve-related injury, meaning no numbness, no tingling into the hand.

****

> He didn't have any radiating-type complaints at all. So this is why we would not send him to a surgeon and why we probably did not feel that an EMG would be warranted, because **he was not having symptoms that suggested nerve problem**.

(Emphasis added). Dr. Cazden's testimony however overlooks the October 21, 2008, report of the physical therapist at Alpha Physical Therapy, who recorded that claimant complained of numbness and tingling radiating from his right forearm into all fingers.

7. Dr. Cazden reevaluated claimant on November 14, 2008, when he reported some improvement from wearing wrist splints. Dr. Cazden was surprised by claimant's report that his left wrist symptoms were worse than his right. Claimant told Dr. Cazden he was not interested in pursuing any further physical therapy. Dr. Cazden focused upon a neurological evaluation at that visit. Dr. Cazden found claimant's physical examination benign. Dr. Cazden testified that he would have expected claimant's tendinitis to improve as a result of his decreased activity at work. Dr. Cazden placed claimant at maximum medical improvement (MMI) on November 14th, he explained:

> I placed [claimant] at [MMI] because he … did not seem to have any real physical findings that would be suggestive of any significant underlying pathology.
>
> ****
>
> I think that the benign type of exam that he was having suggested to us that there was no need for further intervention or testing.
>
> ****
>
> [W]e didn't seem to make much progress with [claimant] no matter what we did; and that … may have been the reason why acupuncture wasn't suggested.
>
> ****
>
> [T]here [was] no evidence of neck problems, shoulder problems, elbow problems, neurological problems; that's why I put him at MMI.

As of November 14th, Dr. Cazden no longer believed claimant's diagnosis should include tendinitis, and he changed claimant's diagnosis to bilateral wrist pain.

8. Dr. Cazden imposed permanent restrictions on November 14th; he explained:

> Because [claimant] had symptomatic complaints without any objective findings, I could have put him back on just totally regular work; but he felt like he was unable to do it, and so I put him on permanent work restrictions, very light activity … but I didn't feel it was related specifically to his activities at work.

9. Insurer filed a Final Admission of Liability on February 17, 2009. Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation (DOWC).

10. The division appointed Alan B. Lichtenberg, M.D., the DIME physician. Dr. Lichtenberg evaluated claimant on June 3, 2009. Claimant's daughter translated for him. Claimant told Dr. Lichtenberg that he developed bilateral hand, wrist, and arm symptoms in October of 2008. Claimant explained that his assembly duties entailed many repetitive motions twisting and flipping his hands while using screwdrivers, nose pliers, cutters, and needles. Claimant reported that, even after hours of resting his hands, he experiences pain in his bilateral wrists extending up both arms into his shoulders and neck.

11. Dr. Lichtenberg diagnosed preexisting left wrist tendinitis and gouty arthritis; bilateral wrist tendinitis secondary to repetitive motion at work with permanent aggravation of preexisting left wrist complaints; and referred pain from bilateral wrist tendonitis to the elbows, shoulders, and neck. Dr. Lichtenberg reported his opinion that claimant's treatment had been reasonably necessary, but inadequate and inconsistent with recommendations contained in DOWC's treatment guidelines. Dr. Lichtenberg wrote:

> I respectfully disagree with the treating providers, and state that [claimant] is not at MMI as of the date of this exam. [Claimant] continues at high levels of pain, and has never been referred to a specialist for evaluation and treatment, nor had any diagnostic testing other than plain x-rays.

Dr. Lichtenberg recommended referral of claimant to an orthopedic surgeon and to a physiatrist for rehabilitation. Dr. Lichtenberg's determination that claimant had not reached MMI is presumptively correct unless overcome by clear and convincing evidence.

12. Dr. Cazden later became aware of claimant's preexisting history of gout in his left upper extremity. Dr. Cazden testified:

> Gout is a type of arthritis that causes … pain and oftentimes swelling in the distal aspects of the extremities …. [I]t's caused by a genetic defect that allows the accumulation of excess uric acid, which forms crystals in joints.
>
> ****
>
> [Gout is] a lifelong condition. If he had gouty arthritis in his wrist in 1999, certainly there may have been periods where it was less problematic, and there may be periods in his life where it's more problematic, and it may not have anything to do with the repetitive motion-type problem

13. Dr. Cazden believes Dr. Lichtenberg is incorrect; he explained:

> So [Dr. Lichtenberg's] opinion of what may have been taking place with [claimant] in June of 2009, where he's complaining of all of these other body parts that are bothering him, I can't see the relationship between … the person he was interviewing and the person we were interviewing in October and November of 2008.

14. At respondents's request, Physiatrist Gretchen Brunworth, M.D., performed an independent medical examination of claimant on September 3, 2009. Dr. Brunworth agreed with Dr. Cazden's determination that claimant reached MMI on November 14, 2008.

15. Dr. Brunworth testified to the following: Claimant's complaints in September 2009 were inconsistent with his complaints in October and November 2008. Dr. Cazden's records in 2008 reflect that claimant denied experiencing symptoms of numbness or tingling in his upper extremities up through the time that Dr. Cazden placed him at MMI. In September of 2009, Dr. Brunworth noted upon physical examination that claimant had diffuse pain, without objective physiological findings to account for his complaints of pain. Dr. Brunworth also noted that the first record evidence of claimant complaining of neck, shoulder and elbow pain occurred in June 2009 during to Dr. Lichtenberg's examination. Only Dr. Lichtenberg diagnosed claimant with referred pain into the elbows, shoulders, and neck from wrist tendonitis. Dr. Brunworth stated that claimant's diffuse complaints of pain, numbness, and tingling were unrelated to his modified work activities in October, November and December.

16. Neither Dr. Cazden nor Dr. Brunworth could objectively explain the apparent worsening of claimant's condition after November 14, 2008. Dr. Brunworth and Dr. Cazden alike opined that they would expect claimant's symptoms to improve after he was no longer performing his assembly duties. Dr. Brunworth noted claimant complained to his physical therapist that he was experiencing the same pain he had from a bout with gout in 1994. Claimant also has a history of diabetes. Dr. Brunworth testified that gout can cause tingling, numbness, and nerve compression, while diabetes can cause peripheral neuropathies resulting in complaints of numbness and tingling.

17. Dr. Brunworth recommended that claimant undergo an EMG/nerve conduction study of his bilateral upper extremities to determine whether there is any objective basis for claimant's neurological complaints. Dr. Brunworth however testified that the EMG/nerve conduction study she recommends is unrelated to claimant's injury at employer because he had no neurological symptoms in 2008. Dr. Brunworth testified that claimant did not complain of elbow, shoulder or neck pain at the time he was discharged at MMI. Dr. Brunworth opined, and claimant's medical records reflect, that claimant began complaining of elbow, shoulder, and neck symptoms after he left his employment with the employer. Dr. Brunworth opined that claimant's elbow, shoulder, and neck complaints are unrelated to claimant's work injury.

18. Dr. Brunworth was unable to find any objective corroboration of claimant's complaints of pain with any kind of movement of the elbow, neck, or shoulder. Dr. Brunworth testified there likely is a psychological component to claimant's complaints.

19. Before testifying, Dr. Lichtenberg reviewed the report of Dr. Brunworth, the transcript of her testimony at hearing, and the deposition transcript of Dr. Cazden. Dr. Lichtenberg testified that the opinions of Dr. Brunworth and Dr. Cazden had not changed his opinion that claimant has not reached MMI. Dr. Lichtenberg noted that, as of November 14, 2008, Dr. Cazden continued to recommend that claimant use his wrist splints, which help with symptoms of tendinitis but which are not used for symptoms of diabetes or gout; Dr. Lichtenberg testified:

> [W]hat I find interesting about [Dr. Cazden's recommendation to use wrist splints] is that he states the diagnosis of bilateral wrist tendinitis. He re-

> leases [claimant] with four treatments of therapy, no permanent impairment rating.
>
> And, yet, he assigns permanent restrictions of no lifting over 10 pounds, use of splints, and no repetitive motion.
>
> That is not consistent with any reasonable treatment plain or recommendations. **How can you tell somebody there is nothing wrong with them, no rating, yet, give them significant restrictions that cause them to lose their job?**
>
> It just doesn't make any sense. It's not consistent with anything.
>
> And I believe Dr. Brunworth … agrees with me that a rating for both wrists is reasonable ….
>
> So, in my opinion, Dr. Cazden's reports … don't carry a lot of weight with me.

(Emphasis added). Dr. Lichtenberg's testimony here was persuasive in pointing out inherent contradictions in Dr. Cazden's medical opinion.

20. Dr. Lichtenberg opined that claimant sustained bilateral wrist tendinitis caused by 25 years of repetitive work. Dr. Lichtenberg stated that the DOWC treatment guidelines for cumulative trauma disorder acknowledge that 10% of patients diagnosed with tendinitis fail to recover with rest. Claimant's symptoms thus place him in this group. Dr. Lichtenberg offered an additional recommendation for a psychological evaluation. Dr. Lichtenberg stated that this recommendation is consistent with the DOWC treatment guidelines for patients with delayed recovery. Dr. Lichtenberg responded to the fact that claimant complained of inconsistent symptoms without objective findings, indicating this supports a diagnosis of chronic pain warranting a psychological evaluation.

21. There was no persuasive evidence otherwise showing that claimant's limited ability to converse in English presented a language barrier to Dr. Cazden's ability to understand, diagnose, and treat claimant. Claimant's assertion he was unable to effectively communicate with his physicians is unpersuasive. Claimant is able to speak and understand some English. Claimant learned to speak and understand English while working at employer and from practicing with friends. Claimant also speaks English with his personal physicians, who treat him for non work-related conditions.

22. Respondents failed to show it highly probable that Dr. Lichtenberg is incorrect in determining that claimant has not reached MMI. While Dr. Cazden and Dr. Brunworth disagree with Dr. Lichtenberg's determination that claimant needs additional medical treatment, such disagreement fails to show it highly probable that Dr. Lichtenberg's medical opinion is incorrect. As found, Dr. Cazden apparently overlooked the October 21, 2008, report of the physical therapist at Alpha Physical Therapy when he testified claimant's symptoms in November of 2008 failed to indicate nerve involvement. Contrary to Dr. Cazden's testimony, claimant in fact complained of numbness and tingling radiating from his right forearm into all fingers. This finding supports Dr. Lichtenberg's

recommendation for electrodiagnostic studies and for referral of claimant for a surgical evaluation. In addition, Dr. Brunworth agrees with Dr. Lichtenberg's recommendation for electrodiagnostic studies of claimant's upper extremities, while disagreeing that the need for such studies is related to claimant's injury. However, there is medical record evidence from Dr. Cazden indicating his opinion that claimant suffered an injury and that the mechanism of injury was consistent with the objective findings. In addition, Dr. Lichtenberg does not disagree with Dr. Brunworth's assessment that claimant's subjective complaints are nonphysiologic; however, Dr. Lichtenberg interprets that assessment differently. Dr. Lichtenberg interprets claimant's nonphysiologic complaints as indicating chronic pain. Dr. Lichtenberg persuasively testified that the DOWC treatment guidelines recommend a psychological evaluation for chronic pain patients. Dr. Brunworth initially recommended claimant undergo a psychological evaluation, and Dr. Lichtenberg testified that he agrees. Dr. Cazden agreed that Dr. Lichtenberg's recommendation for acupuncture treatment might help claimant, although he was unsure if it would make a huge difference in claimant's ultimate outcome. On balance, the disagreement between Dr. Cazden and Dr. Brunworth on the one hand and Dr. Lichtenberg on the other merely shows a reasonable disagreement of medical opinion. Such disagreement fails to show it highly probable and free from serious doubt that Dr. Lichtenberg is incorrect.

CONCLUSIONS OF LAW

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

Respondents argue they have overcome the determination of Dr. Lichtenberg that claimant has not reached MMI by clear and convincing evidence. 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. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

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

evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Sections 8-42-107(8)(b)(III) and (c), *supra*, provide that the determination of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

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

Here, the Judge found respondents failed to show it highly probable that Dr. Lichtenberg was incorrect in determining that claimant has not reached MMI. Respondents thus failed to overcome by clear and convincing evidence the determination of Dr. Lichtenberg that claimant has not reached MMI.

The Judge found that, on balance, the disagreement between Dr. Cazden and Dr. Brunworth on the one hand and Dr. Lichtenberg on the other merely shows a reasonable disagreement of medical opinion. Such disagreement fails to show it highly probable and free from serious doubt that Dr. Lichtenberg is incorrect.

The Judge concludes that respondents's request for a determination that claimant has reached MMI should be denied and dismissed.

ORDER

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

1. Respondents's request for a determination that claimant has reached MMI is denied and dismissed.

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

DATED: _December 2, 2009__

_____
Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-801-077 and WC 4-800-790

ISSUES

The issues presented for hearing are compensability of each of the two claims which had been previously consolidated by Order dated September 11, 2009, and medical benefits including the passing of the right of selection of an authorized treating physician.

FINDINGS OF FACT

1. The Respondent-Employer employed Claimant as a treatment supervisor in its juvenile treatment facility.

2. On July 24, 2009 Claimant was in her office when she responded to a call for assistance. Upon entering the room to assist, Claimant observed a youth who was being destructive by punching a wall locker. The youth then came at Claimant and Claimant responded by putting the youth in a restraint by restraining the youth's left arm. Other staff members locked hands with the Claimant and they put the youth onto the floor. During this action Claimant also went to the floor. The youth was aggressive and strong and attempting to break free from the restraint. Two additional staff members also came to help. During this altercation, Claimant felt a stabbing pain in the left leg at the top of the thigh. Claimant at the time felt that she had pulled a muscle but did not leave the restraint at that time. The area of injury was the left thigh right below the hip. Claimant experienced a burning shooting pain that extended down to the knee.

3. Claimant did not request medical care on this date because she felt it was just a strain that would go away.

4. Claimant finished her shift on July 24, 2009 and returned to work on July 25, 2009, completing a normal shift. On July 26, 2009 Claimant had minor limping but felt all right.

5. On July 26, 2009 Claimant responded to a call for assistance in another building. While she was running on a rocky area she felt an intense pain in her left leg in the same area as she had injured on July 24, 2009. She was able to continue to respond to the call for assistance and assisted in restraining the subject youth. Claimant reported her symptoms to a supervisor, Mr. William Powers. At this time Claimant completed the paperwork for both the July 24, 2009 incident and the July 26, 2009 incident.

6. Some documentation refers to Claimant's right leg as having been injured. The Administrative Law Judge concludes that there were inadvertent errors in the paperwork and the leg injured was only the left leg.

7. Claimant was referred to St. Thomas More Hospital. After treatment Claimant returned to her home.

8. On Monday, July 27, 2009 Claimant's left leg was in extreme pain and her back was sore. Claimant did go to work this day. She spoke with Dena McCrackin about her condition and she was sent to CCOM that morning. Claimant advised the personnel of her leg and back conditions.

9. The Respondent-Employer did not provide the Claimant with a list of two physicians or corporate medical providers.

10. On July 27, 2009 Steve Quakenbush, P.A, examined the Claimant at CCOM. Mr. Quakenbush assessed a left parascapular strain and left upper leg strain. Mr. Quakenbush recommended restrictions of lift/carry five pounds, no repetitive lifting, pushing or pulling. Walking/standing limited as tolerated. No crawling, kneeling, squatting, climbing, and to avoid youth restraint. Mr. Quakenbush opined that the conditions were work-related by history.

11. Mr. Quakenbush saw the Claimant in follow-up on July 29, 2009. He noted that the Claimant was having increased pain in her upper back. The previously recommended physical therapy had not been approved as of that date. Mr. Quakenbush released the Claimant from work that day and recommended that she return to work with the previously noted restrictions. Mr. Quakenbush provided trigger point injections.

12. The following day, July 30, 2009, Dr. Julian Venegas saw the Claimant at CCOM. Dr. Venegas recommended that the Claimant return to her employment to modify her Worker's Claims. Treatment was not provided. The providers at CCOM would not treat beyond the left thigh according to the medical records because the other conditions were deemed not work-related.

13. The Claimant sought treatment from her family physician, Dr. Gary Mohr. Dr. Mohr saw the Claimant initially on August 6, 2009. Dr. Mohr's assessment was a sprained thoracic region and injury to her shoulder. He recommended an MRI of the thoracic spine. The treatment with Dr. Mohr has not been authorized. Dr. Mohr recommended that the Claimant be off work until released to return to work by her treating

doctor. Dr. Mohr has not yet released the Claimant to return to work. On September 22, 2009 Dr. Mohr became concerned with reflex sympathetic dystrophy of the Claimant's upper extremity and referred her to a neurologist for evaluation. The neurologist is Dr. Foltz. Dr. Mohr also referred the Claimant for an EKG and to Dr. Ashton of the Ashton Family Chiropractic Center. Claimant has incurred out-of-pocket expenses for treatment that she has received from these providers which has not been fully paid by her health insurance. The treatment from St. Thomas More Hospital, CCOM, Drs. Mohr, Foltz, and Ashton going back to July 26, 2009 and continuing is reasonable and necessary and related to Claimant's two industrial injuries occurring on July 24, 2009 and July 26, 2009.

14. It is found that the Claimant's testimony is credible and persuasive. It is found that the Claimant has demonstrated that it is more likely than not that she sustained a compensable work-related injury on July 24, 2009 arising out of and in the course of her employment with employer. It is also found that the Claimant has demonstrated that it is more likely than not that she suffered a substantial aggravation of this injury on July 26, 2009 also arising out of and in the course of her employment with the employer.

15. It is further found that respondents have failed to provide the Claimant with medical treatment, having denied care being provided by CCOM and by failing to provide the Claimant with a list of two physicians or corporate medical providers from which to choose as her authorized treating doctor.

CONCLUSIONS OF LAW

Based upon the Findings of Fact, the Administrative Law Judge makes the following Conclusions of Law:

1. Claimant shoulders the burden of proving by a preponderance of the evidence that her injuries arose out of the course and scope of her employment with respondent-employer. Section 8-41-301(1), C.R.S.; see *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

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. As found, Claimant showed it is more probably true than not that she sustained injuries arising out of the course and scope of her employment with Respondent-Employer on July 24, 2009 and July 26, 2009. Thus, Claimant proved by a preponderance of the evidence that she sustained injuries arising out of the course and scope of

her employment with Respondent-Employer. Therefore, Claimant's claims are compensable.

4. Respondents are responsible for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work-related injury. Section 8-42-101, C.R.S.; *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

5. Authorization refers to the physician's legal authority to treat the injury at respondents' expense, and not necessarily the reasonableness of the particular treatment. *Popke v. Industrial Claim Appeals Office*, 944 P.2d 677 (Colo. App. 1997). Section 8-43-404(5), C.R.S. allows the employer the right in the first instance to designate the authorized treating physician; the right to select however passes to Claimant where the employer fails to properly designate in the first instance. *Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565 (Colo. App. 1987). Section 8-43-404(5)(a)(I)(A), C.R.S. provides that in all cases of injury the employer or insurer shall provide a list of at least two physicians in the first instance to the injured worker from which the injured worker may select the authorized treating physician. Pursuant to Rule 8-2(A) of the WCRP, the designated provider list can initially be provided to the injured worker verbally or through an effective pre-injury designation. If provided verbally or through a pre-injury designation, a written designated provider list shall be mailed, hand-delivered or furnished in some other verifiable manner to the injured worker within seven (7) business days following the date the employer has notice of the injury. Pursuant to Rule 8-2(D), failure on the part of the employer to comply with Rule 8-2 causes respondents to lose their right of selection. In that case the injured worker may select an authorized treating physician of the injured worker's choosing. As found, respondents failed to comply when respondents did not provide the Claimant with the choice of two physicians as required by statute and rule. As such, the right of selection switched to the Claimant. In addition, respondents' failure to authorize the treatment from CCOM to treat beyond the upper left leg acted as a failure to provide medical care in the first instance. Either way, the right of selection has passed to the Claimant. The Claimant has selected Dr. Gary Mohr as the primary authorized treating physician. Dr. Gary Mohr, and his referrals, are authorized to treat the Claimant and to provide medical care to cure or relieve Claimant from the effects of the injuries to her left leg, back, neck, and shoulders that are reasonable, necessary, and related to the injury.

6. A physician may become authorized to treat the Claimant as a result of a referral from a previously authorized treating physician made in the normal progression of the authorized treating. *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). As found, Claimant has established that the medical treatment in this claim including the treatment at the emergency room, treatment with the providers at CCOM, and treatment with Dr. Gary Mohr including his referrals to Drs. Foltz and Ashton are authorized and reasonably necessary to cure and relieve the effects of the injury. Accordingly, respondents are liable for this medical treatment to cure and relieve the effects of her injuries.

7. As found, Claimant proved by a preponderance of the evidence that the medical treatment that she received for her injuries were authorized medical treatment reasonably necessary to cure and relieve her from the effects of her injuries. As found, Claimant proved by a preponderance of the evidence that she is entitled to ongoing, authorized medical treatment reasonable necessary to cure and relieve her from the effects of the injury. Therefore, the insurer shall be required to pay for the medical treatment that the Claimant has received for her injuries from the emergency room, CCOM, Drs. Mohr, Foltz, and Ashton, and their referrals. Also, insurer shall be required to pay for ongoing medical treatment that is authorized and reasonably necessary to cure and relieve Claimant from the effects of her injuries.

ORDER

It is therefore ordered that:

1. Claimant's claims with dates of injury July 24, 2009 and July 26, 2009 are compensable.

2. Respondent-Insurer shall pay for medical treatment, which has been provided to cure and relieve the effects of the Claimant's injury, including the treatment at the emergency room, the treatment with Drs. Mohr, Foltz, and Ashton, and their referrals, including the MRI and EKG requested by Dr. Mohr.

3. Respondent-Insurer shall pay for ongoing medical treatment that is authorized and reasonably necessary to cure and relieve Claimant from the effects of the injury.

4. Respondent-Insurer shall reimburse the Claimant for out-of-pocket expenses for the medical care she has received from these providers.

5. Respondent-Insurer shall pay Claimant interest at the rate of eight percent (8%) per annum on compensation benefits not paid when due.

6. Any and all issues not expressly decided herein are reserved to the parties for future determination.

DATE: December 3, 2009
/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-801-077 and WC 4-800-790

ISSUES

The issues presented for hearing are compensability of each of the two claims which had been previously consolidated by Order dated September 11, 2009, and medical benefits including the passing of the right of selection of an authorized treating physician.

FINDINGS OF FACT

16. The Respondent-Employer employed Claimant as a treatment supervisor in its juvenile treatment facility.

17. On July 24, 2009 Claimant was in her office when she responded to a call for assistance. Upon entering the room to assist, Claimant observed a youth who was being destructive by punching a wall locker. The youth then came at Claimant and Claimant responded by putting the youth in a restraint by restraining the youth's left arm. Other staff members locked hands with the Claimant and they put the youth onto the floor. During this action Claimant also went to the floor. The youth was aggressive and strong and attempting to break free from the restraint. Two additional staff members also came to help. During this altercation, Claimant felt a stabbing pain in the left leg at the top of the thigh. Claimant at the time felt that she had pulled a muscle but did not leave the restraint at that time. The area of injury was the left thigh right below the hip. Claimant experienced a burning shooting pain that extended down to the knee.

18. Claimant did not request medical care on this date because she felt it was just a strain that would go away.

19. Claimant finished her shift on July 24, 2009 and returned to work on July 25, 2009, completing a normal shift. On July 26, 2009 Claimant had minor limping but felt all right.

20. On July 26, 2009 Claimant responded to a call for assistance in another building. While she was running on a rocky area she felt an intense pain in her left leg in the same area as she had injured on July 24, 2009. She was able to continue to respond to the call for assistance and assisted in restraining the subject youth. Claimant reported her symptoms to a supervisor, Mr. William Powers. At this time Claimant completed the paperwork for both the July 24, 2009 incident and the July 26, 2009 incident.

21. Some documentation refers to Claimant's right leg as having been injured. The Administrative Law Judge concludes that there were inadvertent errors in the paperwork and the leg injured was only the left leg.

22. Claimant was referred to St. Thomas More Hospital. After treatment Claimant returned to her home.

23. On Monday, July 27, 2009 Claimant's left leg was in extreme pain and her back was sore. Claimant did go to work this day. She spoke with Dena McCrackin about her condition and she was sent to CCOM that morning. Claimant advised the personnel of her leg and back conditions.

24. The Respondent-Employer did not provide the Claimant with a list of two physicians or corporate medical providers.

25. On July 27, 2009 Steve Quakenbush, P.A, examined the Claimant at CCOM. Mr. Quakenbush assessed a left parascapular strain and left upper leg strain. Mr. Quakenbush recommended restrictions of lift/carry five pounds, no repetitive lifting, pushing or pulling. Walking/standing limited as tolerated. No crawling, kneeling, squatting, climbing, and to avoid youth restraint. Mr. Quakenbush opined that the conditions were work-related by history.

26. Mr. Quakenbush saw the Claimant in follow-up on July 29, 2009. He noted that the Claimant was having increased pain in her upper back. The previously recommended physical therapy had not been approved as of that date. Mr. Quakenbush released the Claimant from work that day and recommended that she return to work with the previously noted restrictions. Mr. Quakenbush provided trigger point injections.

27. The following day, July 30, 2009, Dr. Julian Venegas saw the Claimant at CCOM. Dr. Venegas recommended that the Claimant return to her employment to modify her Worker's Claims. Treatment was not provided. The providers at CCOM would not treat beyond the left thigh according to the medical records because the other conditions were deemed not work-related.

28. The Claimant sought treatment from her family physician, Dr. Gary Mohr. Dr. Mohr saw the Claimant initially on August 6, 2009. Dr. Mohr's assessment was a sprained thoracic region and injury to her shoulder. He recommended an MRI of the thoracic spine. The treatment with Dr. Mohr has not been authorized. Dr. Mohr recommended that the Claimant be off work until released to return to work by her treating doctor. Dr. Mohr has not yet released the Claimant to return to work. On September 22, 2009 Dr. Mohr became concerned with reflex sympathetic dystrophy of the Claimant's upper extremity and referred her to a neurologist for evaluation. The neurologist is Dr. Foltz. Dr. Mohr also referred the Claimant for an EKG and to Dr. Ashton of the Ashton Family Chiropractic Center. Claimant has incurred out-of-pocket expenses for treatment that she has received from these providers which has not been fully paid by her health insurance. The treatment from St. Thomas More Hospital, CCOM, Drs. Mohr, Foltz, and Ashton going back to July 26, 2009 and continuing is reasonable and necessary and related to Claimant's two industrial injuries occurring on July 24, 2009 and July 26, 2009.

29. It is found that the Claimant's testimony is credible and persuasive. It is found that the Claimant has demonstrated that it is more likely than not that she sustained a compensable work-related injury on July 24, 2009 arising out of and in the course of her

employment with employer. It is also found that the Claimant has demonstrated that it is more likely than not that she suffered a substantial aggravation of this injury on July 26, 2009 also arising out of and in the course of her employment with the employer.

30. It is further found that respondents have failed to provide the Claimant with medical treatment, having denied care being provided by CCOM and by failing to provide the Claimant with a list of two physicians or corporate medical providers from which to choose as her authorized treating doctor.

CONCLUSIONS OF LAW

Based upon the Findings of Fact, the Administrative Law Judge makes the following Conclusions of Law:

8. Claimant shoulders the burden of proving by a preponderance of the evidence that her injuries arose out of the course and scope of her employment with respondent-employer. Section 8-41-301(1), C.R.S.; see *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

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. ICAO*, 5 P.3d 385 (Colo. App. 2000).

10. As found, Claimant showed it is more probably true than not that she sustained injuries arising out of the course and scope of her employment with Respondent-Employer on July 24, 2009 and July 26, 2009. Thus, Claimant proved by a preponderance of the evidence that she sustained injuries arising out of the course and scope of her employment with Respondent-Employer. Therefore, Claimant's claims are compensable.

11. Respondents are responsible for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work-related injury. Section 8-42-101, C.R.S.; *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

12. Authorization refers to the physician's legal authority to treat the injury at respondents' expense, and not necessarily the reasonableness of the particular treatment. *Popke v. Industrial Claim Appeals Office*, 944 P.2d 677 (Colo. App. 1997). Section 8-43-404(5), C.R.S. allows the employer the right in the first instance to designate the authorized treating physician; the right to select however passes to Claimant where the employer fails to properly designate in the first instance. *Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565 (Colo. App. 1987). Section 8-43-404(5)(a)(I)(A), C.R.S. pro-

vides that in all cases of injury the employer or insurer shall provide a list of at least two physicians in the first instance to the injured worker from which the injured worker may select the authorized treating physician. Pursuant to Rule 8-2(A) of the WCRP, the designated provider list can initially be provided to the injured worker verbally or through an effective pre-injury designation. If provided verbally or through a pre-injury designation, a written designated provider list shall be mailed, hand-delivered or furnished in some other verifiable manner to the injured worker within seven (7) business days following the date the employer has notice of the injury. Pursuant to Rule 8-2(D), failure on the part of the employer to comply with Rule 8-2 causes respondents to lose their right of selection. In that case the injured worker may select an authorized treating physician of the injured worker's choosing. As found, respondents failed to comply when respondents did not provide the Claimant with the choice of two physicians as required by statute and rule. As such, the right of selection switched to the Claimant. In addition, respondents' failure to authorize the treatment from CCOM to treat beyond the upper left leg acted as a failure to provide medical care in the first instance. Either way, the right of selection has passed to the Claimant. The Claimant has selected Dr. Gary Mohr as the primary authorized treating physician. Dr. Gary Mohr, and his referrals, are authorized to treat the Claimant and to provide medical care to cure or relieve Claimant from the effects of the injuries to her left leg, back, neck, and shoulders that are reasonable, necessary, and related to the injury.

13. A physician may become authorized to treat the Claimant as a result of a referral from a previously authorized treating physician made in the normal progression of the authorized treating. *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). As found, Claimant has established that the medical treatment in this claim including the treatment at the emergency room, treatment with the providers at CCOM, and treatment with Dr. Gary Mohr including his referrals to Drs. Foltz and Ashton are authorized and reasonably necessary to cure and relieve the effects of the injury. Accordingly, respondents are liable for this medical treatment to cure and relieve the effects of her injuries.

14. As found, Claimant proved by a preponderance of the evidence that the medical treatment that she received for her injuries were authorized medical treatment reasonably necessary to cure and relieve her from the effects of her injuries. As found, Claimant proved by a preponderance of the evidence that she is entitled to ongoing, authorized medical treatment reasonable necessary to cure and relieve her from the effects of the injury. Therefore, the insurer shall be required to pay for the medical treatment that the Claimant has received for her injuries from the emergency room, CCOM, Drs. Mohr, Foltz, and Ashton, and their referrals. Also, insurer shall be required to pay for ongoing medical treatment that is authorized and reasonably necessary to cure and relieve Claimant from the effects of her injuries.

ORDER

It is therefore ordered that:

1. Claimant's claims with dates of injury July 24, 2009 and July 26, 2009 are compensable.

2. Respondent-Insurer shall pay for medical treatment, which has been provided to cure and relieve the effects of the Claimant's injury, including the treatment at the emergency room, the treatment with Drs. Mohr, Foltz, and Ashton, and their referrals, including the MRI and EKG requested by Dr. Mohr.

3. Respondent-Insurer shall pay for ongoing medical treatment that is authorized and reasonably necessary to cure and relieve Claimant from the effects of the injury.

4. Respondent-Insurer shall reimburse the Claimant for out-of-pocket expenses for the medical care she has received from these providers.

5. Respondent-Insurer shall pay Claimant interest at the rate of eight percent (8%) per annum on compensation benefits not paid when due.

6. Any and all issues not expressly decided herein are reserved to the parties for future determination.

DATE: December 3, 2009
/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-641-953

ISSUES

1. The issues to be determined by this decision are:
a. Reopening;
b. Maintenance medical care;
c. Causation or intervening injury; and,
d. Penalties.

FINDINGS OF FACT

1. This case arises from an admitted injury that occurred on December 15, 2004.
2. The Respondent's filed a final Admission dated December 11, 2006 based on Dr. Hattem's MMI report dated November 9, 2006.
3. Dr. Hattem documented that Dr. Kersten had diagnosed a knee strain/Achilles bursitis and recommended therapy and anti-inflammatory medication. Dr. Kersten ordered an

MRI and referral to Dr. Baer for neurological evaluation on March 16, 2005. On May 17, 2005 the Claimant was seen at the Memorial Emergency Room complaining of right knee pain. A CT study of June 26, 2005 demonstrated L5-S1 central to right sided disc herniation with contact of the lumbar right S1 nerve root. The Claimant received injections on January 3 and February 1, 2006. Injections were unsuccessful and on July 18, 2006 Dr. Sung performed an L5-S1 diskectomy. Following the surgery, Claimant continued with right knee pain and Dr. Sung referred him for an MRI of the right knee dated November 8, 2005, which showed mild patellofemoral effusion. On November 9, 2006 Dr. Hattem declared the Claimant to be at MMI and gave him a 16% whole person impairment of the lumbar spine, and did not rate the right knee.

4. The Claimant challenged the Final Admission on the issue of maintenance medical care. A hearing was held on April 10, 2007. The Administrative Law Judge found in his order, "The Claimant has had increasing back pain and leg pain and is in need of medical treatment to maintain him at MMI. The Administrative Law Judge finds that Claimant presented in a straight forward manner, and his testimony was reasonable, credible and un-refuted by other persuasive evidence." The ALJ ordered post-MMI medical treatment for his low back and right leg.

5. Pursuant to the ALJ Order of April 30, 2007 the Claimant was referred to Dr. Sandell for post-MMI treatment.

6. Dr. Sandell saw the Claimant from June 26, 2007 through March 4, 2009. Dr. Sandell performed an EMG study of the Claimant's right lower extremity on August 10, 2007, which he found to be abnormal. Dr. Sandell referred the Claimant for a lumbar epidural steroid injection, which did not help. Dr. Sandell referred the Claimant to orthopedic surgeon, Dr. Sanchez for a surgical evaluation on November 1, 2007. Dr. Sanchez did not recommend surgery. On July 11, 2008 Dr. Dr. Sandell referred the Claimant to orthopedic surgeon Dr. Duffey.

7. Dr. Duffey saw the Claimant on January 19, 2009. He diagnosed Patellofemoral chondral lesion and recommended arthroscopic surgery with anticipated patellar or femoral chondroplasty.

8. On February 13, 2009 the Respondent-Insurer issued a denial letter based on a record review only of Dr. Deborah Saint-Phard M.D. a Physical Medicine and Rehabilitation doctor.

9. On March 30, 3009, Dr Duffey authored a letter response to Dr. Saint Phard's record review denial. He stated, "It is well documented in orthopaedic literature that a certain percentage of articular chondral tears and defects will be missed on MRI evaluations. He was shown to have an effusion, which is often a secondary sign of a cartilage injury which may not be seen on the MRI. Studies will estimate that anywhere between 20-50% of articular chondral injuries may be missed by MRI. [Claimant's] symptoms do reveal focal catch in his patellofemoral joint. I feel confident that we could resolve most of his knee symptoms with a simple knee arthroscopy. I am pessimistic that after 3 years additional trials of nonoperative treatment are likely to make his symptoms any better".

10. On March 30, 2009, the Respondent-Insurer issued a second denial letter relying on a record review only by Dr. James McElhenney. For the first time in the case this doctor opines that the right knee injury is not related.

11. The Claimant testified credibly that the knee pain level has increased substantially since the November 11, 2006 date of MMI and his function of the knee has significantly decreased since that date. The Claimant has consistently complained of knee pain since the occurrence of his admitted industrial injury.

12. The Claimant testified he has worked since the date of MMI but has not injured or aggravated his knee in the subsequent work or activities outside of work.
13. The ALJ finds insufficient credible evidence to indicate the Respondents were dictating medical care.

CONCLUSIONS OF LAW

1. CRS 8-43-303(1) provides that a worker's compensation award may be reopened for a change in condition and entitlement to additional benefits. "The original finding of causation cannot be disturbed in a petition to reopen for change of condition. The causation issue in a petition to reopen is limited whether there is a change of claimant's physical condition that can be causally connected to the original injury. (Citing City and County of Denver v Industrial Claim Appeals Office 58 P.3d1163 Colorado App 2002). Colorado Worker's Compensation Practice and Procedure, Douglas R. Phillips and Susan D. Phillips; 2005, p617.
2. In the present case the Claimant has shown by preponderance of evidence that the condition of his right extremity specifically his right knee has worsened. The Claimant credibly testified that his pain level in his knee has significantly increased since the date of MMI and the function of his right knee has significantly decreased.
3. Dr. Sandell in his March 4, 2009 note and Dr. Duffey in his note of June 14, 2009 and his letter of March 30, 2009 both support a finding of a worsening of condition.
4. Claimant has failed to establish that it is more likely than not that the Respondents were dictating medical care hereunder.

ORDER

It is therefore ordered that:

1. The ALJ orders that the claim be reopened for further medical care to cure or relieve Claimant from the effects of his work related injury, which has now worsened.

2. Respondents shall pay for Claimant's course of medical treatment that is reasonable, necessary, and related to his original work related injury, specifically including the lower back and right knee.

3. Claimant's request for penalties is denied and dismissed.

4. In light of the findings and conclusions herein the issue of post-MMI medical treatment is not addressed.
5. Respondents shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.
6. Any and all issues not determined herein are reserved for future decision.

DATE: December 3, 2009
/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-722-757

ISSUES

¬ Did claimant prove by a preponderance of the evidence that he is entitled to permanent partial disability benefits and *Grover*-type medical benefits?

FINDINGS OF FACT

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

1. Claimant works for employer as a security guard. Claimant sustained an admitted injury to his right foot and ankle on June 6, 2006, when he tripped on a step while making his rounds.
2. Employer referred claimant to Concentra Medical Centers, where Physicians Assistant Glenn Petersen, PA, examined him on June 6, 2006. PA Petersen obtained x-ray studies of claimant's right foot and ankle. The x-ray showed a nondisplaced, proximal fracture of claimant's right fifth metatarsal (small toe). The ankle x-ray study appeared normal. PA Petersen placed claimant in a fracture boot, gave him crutches, and referred him to Dr. Hirose, an orthopedic foot and ankle specialist.
3. Dr. Hirose examined claimant on June 9, 2006, and noted an additional fracture of the anterior calcaneus. Dr. Hirose reevaluated claimant on June 30, 2006, and noted claimant was noncompliant because he was wearing flip-flop sandals instead of the fracture boot. Although Dr. Hirose encouraged claimant to wear the fracture boot, claimant appeared for his next appointment on August 4, 2006, again wearing flip-flops instead of the boot. Dr. Hirose treated claimant conservatively, but he continued to complain of pain. Dr. Hirose referred claimant for a magnetic resonance imaging (MRI) scan on March 2, 2007. The MRI revealed a nonunion of the fracture of the anterior process of the calcaneus. On April 23, 2007, Dr. Hirose surgically excised a bone fragment from the anterior process of the calcaneus.
4. Claimant reported to Dr. Hirose that the surgery was unhelpful. Claimant complained of post-operative calf pain and shortness of breath. Although Dr. Hirose referred him for venous Doppler study, claimant failed to appear for the study. Because of claimant's persistent complaints of pain, pain specialist Dr. Villems treated claimant with neuropathic pain medications and an injection blocking the superficial peroneal nerve on January 11, 2008. Dr. Villems recommended against further invasive treatment or recommendations.
5. Claimant's treating providers placed claimant at maximum medical improvement (MMI) and referred him to John Burris, M.D., for an impairment evaluation on March 4, 2008. Dr. Burris agreed claimant had reached MMI and rated his permanent medical impairment at 3% of the lower extremity. Dr. Burris found no range of motion loss at claimant's ankle, and instead rated claimant's impairment of the superficial peroneal nerve based upon decreased sensation with pain. Dr. Burris opined that permanent

work restrictions were unwarranted and recommended against follow-up medical care to maintain claimant's condition at MMI.

6. Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation. The division appointed Jeffrey A. Wunder, M.D., the DIME physician. Dr. Wunder is an interventional physiatrist (pain specialist).

7. Dr. Wunder examined claimant on January 5, 2009, when he reported persistent pain in the dorsolateral aspect of his right foot. Dr. Wunder found claimant's behavioral presentation inconsistent with his report of pain ratings. Dr. Wunder diagnosed noncompliance to medical treatment; he wrote:

8. This patient, in my opinion, experienced delayed healing in his fractures due to his noncompliance with the [fracture] boot. **He saw Dr. Hirose on two separate occasions wearing flip flops, which is probably the worst footwear that can be worn following foot fractures.** Had he been compliant, the calcaneal fracture may well appear healed and he may not have needed surgery.

9. (Emphasis added). Dr. Wunder agreed with Dr. Burris that claimant reached MMI as of March 4, 2008.

10. When evaluating claimant's medical impairment, Dr. Wunder found no evidence of superficial peroneal neuropathy. Dr. Wunder noted that, unlike the full range of motion that Dr. Burris appreciated, claimant had restricted ankle motion at the time of Dr. Wunder's examination. Dr. Wunder rated claimant's impairment at 8% of the lower extremity, based upon restricted range of motion. Dr. Wunder recommended against additional treatment to maintain claimant at MMI; he wrote:

11. [I]n my opinion no further injection, treatment, or therapy is likely to assist this patient. In my opinion, he is not a candidate for further surgery.

12. Claimant is not contesting Dr. Wunder's determination of MMI.

13. On March 27, 2009, insurer filed a Final Admission of Liability (FAL), admitting liability for permanent partial disability (PPD) benefits based upon Dr. Wunder's rating of claimant's impairment at 8% of the right lower extremity. Because claimant is not asserting that his PPD benefits should be based upon a whole person rating rather than a lower extremity rating, there is no statutory presumption that Dr. Wunder's rating is correct unless overcome by clear and convincing evidence.

14. At claimant's request, Joseph P. Ramos, M.D., performed an independent medical examination of claimant on May 12, 2009. Like Dr. Wunder, Dr. Ramos reviewed claimant's medical records and obtained a history from claimant. Claimant reported to Dr. Ramos that pain and limited range of motion affect his function. Claimant gave an example of difficulty driving and repetitively using the brake pedal. Dr. Ramos observed:

15. [Claimant] has become saddened and somewhat depressed over his prolonged period of incomplete recovery.

16. Dr. Ramos rated claimant's impairment at 11% of the lower extremity, based upon range of motion deficits.

17. Dr. Ramos recommended the following medical treatment to maintain claimant's condition: Follow-up with his primary treating physician for medications, reassessments, and reinforcement of a home exercise program; some 4 physical therapy treatments per year to help with pain flares and assistance with a home exercise program; orthopedic follow-up for persistent dysfunction and possible injection therapy; home supplies to

help with home exercise; and an ongoing health club membership so long as claimant uses the membership 3 times per week.
18. Dr. Burris reevaluated claimant on July 28, 2009, when claimant reported constant lower leg pain at a level of 8 to 9 on a scale of 10. Dr. Burris observed inconsistencies between claimant's report of symptoms and examination findings :
19. On today's visit, the patient is a … **poor historian** and cannot tell me if he had an independent medial evaluation or if further treatment was recommended.
20. [Claimant] has a relatively benign examination. **He has a significantly elevated pain complaint but does not appear in any distress** and overall has a relatively normal examination.
****

21. Unfortunately, the **patient is being very evasive in the history**.
22. (Emphasis added). Dr. Burris recommended a referral of claimant for an evaluation by an interventional physiatrist.
23. Dr. Burris wrote an addendum to his July 28, 2009, report after he was provided a copy of Dr. Wunder's report. Because claimant had been evaluated by Dr. Wunder (a pain specialist), Dr. Burris withdrew his recommendation for a one-time evaluation by an interventional physiatrist. Dr. Burris wrote:
24. Dr. Wunder is an interventional physiatrist and now that (sic) I have his records stating that he has nothing further to offer [claimant]. I believe [claimant] remains at [MMI] and no further workup is required.
25. Claimant failed to show it more probably true than not that that *Grover*-type maintenance treatment recommended by Dr. Ramos is reasonably necessary to cure and relieve the effects of his injury. The Judge credits the medical opinion of Dr. Wunder and of Dr. Burris over that of Dr. Ramos. Although Dr. Ramos notes Dr. Wunder's assessment that claimant was noncompliant to medical treatment, it appears that Dr. Ramos failed to factor claimant's history of noncompliance when recommending additional treatment. Dr. Wunder weighed claimant's history of noncompliance and inconsistencies between claimant's report of symptoms and examination findings when recommending no further treatment to maintain claimant's condition. Dr. Burris unequivocally agrees with Dr. Wunder's recommendation against further treatment. The Judge credits the medical opinion of Dr. Wunder over that of Dr. Ramos because Dr. Wunder was appointed by a disinterested tribunal (the division) to evaluate claimant.
26. Claimant failed to show it more probably true than not that Dr. Ramos's medical impairment rating more accurately assesses his lower extremity impairment than does the rating of Dr. Wunder. The difference between the ratings of Dr. Ramos and Dr. Wunder is based upon range of motion deficits of claimant's right forefoot mobility as measured on different examination dates. In contrast, Dr. Burris found that claimant had full range of motion on March 4, 2008, and on July 28, 2009. The Judge infers from these inconsistencies in forefoot motion that claimant might be giving inconsistent effort depending upon the evaluator. The Judge credits the medical opinion of Dr. Wunder as persuasive because Dr. Wunder was appointed by a disinterested tribunal to evaluate claimant.

CONCLUSIONS OF LAW

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

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

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

Where the parties raise questions of non-scheduled medical impairment and MMI, the DIME physician's determination enjoys greater weight than opinions of other evaluating physicians. *See* Sections 8-42-107(8)(b)(III) and (c), *supra*, which provide that the determination of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. This 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. ***Grover*-Type Medical Benefits:**

Claimant argues he has proven by a preponderance of the evidence that he is entitled to *Grover*-type medical benefits recommended by Dr. Ramos to maintain his condition at MMI. The Judge disagrees.

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).

The need for medical treatment may extend beyond the point of maximum medical improvement where claimant requires periodic maintenance care to prevent further deterioration of his physical condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). An award for *Grover* medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that claimant is actually receiving medical treatment. *Holly Nursing Care Center v. Industrial Claim Appeals Office,* 992 P.2d 701 (Colo. App. 1999); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995). Section 8-42-101, *supra*, thus authorizes the ALJ to enter an order for future maintenance treatment if supported by substantial evidence of the need for such treatment. *Grover v. Industrial Commission*, *supra.*

Here, the Judge found that claimant failed to show it more probably true than not that that *Grover*-type maintenance treatment recommended by Dr. Ramos is reasonably necessary to cure and relieve the effects of his injury. Claimant thus failed to prove by a preponderance of the evidence that he is entitled to *Grover*-type medical benefits recommended by Dr. Ramos.

The Judge credited the medical opinion of Dr. Wunder over that of Dr. Ramos. because Dr. Wunder was appointed by a disinterested tribunal to evaluate claimant. Although Dr. Ramos notes Dr. Wunder's assessment that claimant was noncompliant to medical treatment, it appears that Dr. Ramos failed to factor claimant's history of noncompliance when recommending additional treatment. In contrast to Dr. Ramos, Dr. Wunder weighed claimant's history of noncompliance and inconsistencies between claimant's report of symptoms and examination findings when recommending no further treatment to maintain claimant's condition. Dr. Burris agreed with Dr. Wunder's recommendation against further treatment.

The Judge concludes that claimant's request for an award of *Grover*-type medical benefits should be denied and dismissed.

B. Permanent Partial Disability Benefits:

Claimant argues he has proven by a preponderance of the evidence that he is entitled to additional permanent partial disability PPD benefits based upon the lower extremity rating of Dr. Ramos. The Judge disagrees.

The term "injury" refers to the part of the body that has sustained the ultimate loss. *Mountain City Meat Co. v. Oqueda,* 919 P.2d 246 (Colo. 1996). In the context of §8-42-107(1), the term "injury" refers to the part or parts of the body that have been functionally impaired or disabled as a result of the injury. *Maree v. Jefferson County Sheriff's Department*, W.C. No. 4-260-536 (ICAO August 6, 1998), citing *Strauch v. PSL Swedish Healthcare*, 917 P.2d 366 (Colo. App. 1996). Section 8-42-107(1)(a), C.R.S. (2003), limits medical impairment benefits to those provided in subsection (2) where the

claimant's injury is one enumerated on the schedule. Section 8-42-107(1)(b), *supra*, provides that, where claimant sustains an injury not enumerated on the schedule, his permanent medical impairment shall be compensated based upon the whole person.

The Judge found that claimant failed to show it more probably true than not that Dr. Ramos's medical impairment rating more accurately assesses his lower extremity impairment than does the rating of Dr. Wunder. Claimant thus failed to prove by a preponderance of the evidence that he is entitled to PPD benefits beyond those admitted by insurer under the FAL.

As found, the difference between the ratings of Dr. Ramos and Dr. Wunder is based upon range of motion deficits of claimant's right forefoot mobility as measured on different examination dates. In contrast, Dr. Burris found that claimant had full range of motion on March 4, 2008, and on July 28, 2009. The Judge inferred from these inconsistencies in forefoot motion that claimant might be giving inconsistent effort depending upon the evaluator. The Judge thus credited the medical opinion of Dr. Wunder as persuasive because Dr. Wunder was appointed by a disinterested tribunal to evaluate claimant.

The Judge concludes that claimant's request for an award of PPD benefits based upon Dr. Ramos's rating of 11% of the right lower extremity should be denied and dismissed.

ORDER

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

1. Claimant's request for an award of *Grover*-type medical benefits is denied and dismissed.

2. Claimant's request for an award of PPD benefits based upon Dr. Ramos's rating of 11% of the right lower extremity is denied and dismissed.

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

DATED: _December 3, 2009__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-791-854

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

FINDINGS OF FACT

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

Employer operates a retail sporting goods business. Claimant worked for employer as receiving manager. Claimant supervised 3 employees, who unloaded pallets and boxes of merchandise from trailers and moved the merchandise onto the sales floor. Claimant's date of birth is August 17, 1968; his age at the time of hearing was 41 years.

On February 7, 2009, claimant fell at home, struck his chest on the corner of the family's couch, and bruised his sternum. According to claimant, his wife thought he was having a heart attack from the pain. Claimant sought emergent medical attention at the Emergency Department of Swedish Hospital (ER) on Sunday, February 8th. The ER physician diagnosed a contusion to the chest, prescribed rest, and instructed claimant not to perform any heavy-lifting activity or strenuous exertion that caused pain.

At hearing, claimant testified that the ER physician told him not to lift anything over 5 pounds. The ER physician's written restrictions however restrict claimant only from heavy lifting. Claimant changed his testimony later on cross-examination when he agreed the ER physician did not tell him not to lift greater than 5 pounds. Claimant's testimony concerning his restrictions following his initial ER visit was inconsistent, unpersuasive, and unreliable.

Claimant testified he gave a copy of the ER physician's restrictions to employer's store manager, Matt Petty, when he returned to work on February 9th. In his answers to interrogatories, claimant stated that he gave Mr. Petty a copy of the ER physician's restrictions on February 10th. Claimant's testimony here was inconsistent, unpersuasive, and unreliable.

Claimant stated that, while he attempted to work within the ER physician's restrictions on February 9th and 10th, he had to exceed those restrictions in order to get his work done. After finishing his shift on February 11th, claimant saw his personal care physician, Andreas J. Edrich, M.D. Dr. Edrich restricted claimant from lifting anything heavier than 5 pounds. Claimant testified that he exceeded Dr. Edrich's 5-pound lifting restriction when working for employer on February 12th; however, claimant later agreed on cross-examination that he last worked for employer on February 11th. It is clear that claimant was not subject to the restrictions provided by Dr. Edrich until after the last day he worked for employer.

After agreeing he last worked on February 11th, claimant testified that he brought Dr. Edrich's restrictions to work around February 11th and continued working beyond those restrictions on February 12th and 13th. When confronted with employer's records indicating he did not work on February 12th and 13th, claimant admitted he could not recall whether he worked. Claimant's testimony here was inconsistent, unpersuasive, and unreliable.

Claimant sought treatment at the Emergency Department of Littleton Adventist Hospital on February 14, 2009. There, Thomas Drake, M.D., obtained a history of claimant's fall at home. Claimant told Dr. Drake that his pain increased after the fall to the point he needed emergent treatment. There is no record evidence that claimant reported to Dr. Drake that his pain increased because of lifting activity at employer. Dr. Drake administered intravenous Dilaudid, a strong pain medication. Dr. Drake obtained x-ray studies that revealed evidence of a fracture of the sternum. Dr. Drake admitted claimant to hospital for further evaluation and pain control.

Claimant testified that he believes he attempted to telephone Mr. Petty on December 14th and 15th to tell him he could not work. Claimant then stated he was uncertain whether he attempted to call Mr. Petty because he was on Dilaudid. Claimant's testimony here was inconsistent, unpersuasive, and unreliable.

Mr. Petty, claimant's direct supervisor, testified at hearing that the first indication he had from claimant that he had suffered an injury to his chest at home was on February 11, 2009, when claimant came to him complaining of such pain. Mr. Petty testified that at that time claimant did not indicate that his symptoms had worsened as a result of his work activities. Mr. Petty further testified that he was unaware of any work restrictions until claimant telefaxed a copy of the ER physician's restrictions and a copy of Dr. Edrich's restrictions to employer on February 26th. Mr. Petty's testimony was amply supported by the February 26th telefax containing a copy of those restrictions. The fact that claimant telefaxed the ER physician's restrictions on February 26th is inconsistent with his testimony that he gave a copy of the ER physician's restrictions to Mr. Petty on February 9th. The Judge finds Mr. Petty's testimony here credible, persuasive, and consistent with record evidence.

Doug Legg, employer's Regional Human Resource Manager, testified at hearing that on February 16, 2009, he learned from Mr. Petty that claimant needed time off because of his injury at home. Mr. Legg asked claimant to provide work restrictions from his physician. On February 16th, claimant told Mr. Legg he would fax restrictions the next day. As found, claimant did not fax his restrictions until February 26th. Employer was unable to accommodate Dr. Edrich's restrictions. Mr. Legg's testimony on this issue was credible, persuasive, and consistent with record evidence.

Claimant had not worked sufficient time at employer to qualify for leave under the Family Medical Leave Act. Mr. Legg spoke with claimant four times by telephone and, on February 26th, offered him the option of a 30-day leave of absence (LOA) to recover from his chest injury. Claimant accepted employer's offer of a LOA and signed forms on February 28th. Crediting the testimony of Mr. Legg, claimant never mentioned any work-

related injury or aggravation of his fractured sternum during the times he and claimant discussed the LOA.

After claimant's LOA expired on March 20, 2009, James Hamilton, employer's District Manager, telephoned claimant and told him his LOA had expired. Claimant told Mr. Hamilton he could not return to his prior work at employer. Mr. Hamilton terminated claimant, subject to rehire. Mr. Hamilton continued to attempt to get claimant interviews with managers of other stores. Crediting the testimony of Mr. Hamilton, claimant never mentioned any work-related injury or aggravation of his fractured sternum during the times he and claimant discussed the LOA or termination. Mr. Hamilton's testimony on this issue was credible, persuasive, and consistent with record evidence.

Claimant testified that his pain drastically increased while working for employer. Claimant stated he felt like his sternum shattered, but could not recall what specific work activity he was performing at the time he experienced this sensation of a shattering sternum. Claimant's testimony here lacked credibility because he described this excruciating episode of pain but dissembled when asked when it occurred and what activity he was performing when it occurred. Claimant was unable to persuasively answer these questions. This testimony provided by claimant was inconsistent, unpersuasive, and lacking credibility.

Claimant failed to show it more probably true that his work activity at employer on February 9th, 10th, or 11th aggravated or worsened his fractured sternum, or otherwise caused his need for medical attention, or resulted in disability. The Judge is unable to credit claimant's story when weighed the following: There is no persuasive medical evidence otherwise showing that claimant's work aggravated or worsened his sternum contusion/fracture. Claimant failed to report any work-related injury or aggravation until after employer terminated him on March 20, 2009. Claimant had ample opportunity prior to March 20th to report a work-related aggravation or injury to Mr. Petty, to Mr. Legg, and to Mr. Hamilton. Claimant's conduct in accepting the LOA was inconsistent with having sustained a work-related injury resulting in lost time. Claimant's testimony was replete with inconsistencies and lacking credibility.

CONCLUSIONS OF LAW

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

Claimant argues he has proven by a preponderance of the evidence that he sustained an 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 entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A

preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

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

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. 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. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990).

Here, the Judge found claimant failed to show it more probably true that his work activity at employer on February 9th, 10th, or 11th aggravated or worsened his fractured sternum, or otherwise caused his need for medical attention, or resulted in disability. Claimant thus failed to prove by a preponderance of the evidence that he sustained a compensable injury at employer.

As found, there was no persuasive medical evidence otherwise showing that claimant's work aggravated or worsened his sternum contusion/fracture, which he sustained at home. Claimant failed to report or otherwise claim any work-related injury or aggravation until after employer terminated him on March 20, 2009. Although claimant had ample opportunity prior to March 20th to report a work-related aggravation or injury to Mr. Petty, to Mr. Legg, and to Mr. Hamilton, claimant failed to do so. Further, claimant's conduct in accepting the LOA was inconsistent with having sustained a work-related injury resulting in lost time. Claimant's testimony was replete with inconsistencies and lacking credibility. In contrast to claimant's testimony, the testimony of Mr.

Petty, of Mr. Legg, and of Mr. Hamilton was credible, persuasive, and consistent with record evidence.

The Judge concludes claimant's claim for workers' compensation benefits under the Act should be denied and dismissed. In light of this finding, the Judge further concludes that claimant's request for medical and temporary disability benefits should be denied and dismissed.

ORDER

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

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

2. Claimant's request for medical and temporary disability benefits is denied and dismissed.

DATED: _December 3, 2009_

Michael E. Harr

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-759-244

ISSUES

Whether Claimant has proven by a preponderance of the evidence that he sustained a compensable occupational disease of right carpal tunnel syndrome.

If compensable, whether Claimant is entitled to an award of medical benefits for the treatment and surgery provided by Dr. James Reid, M.D.

At hearing, the parties stipulated that if compensable Claimant's Average Weekly Wage is $842.28.

FINDINGS OF FACT

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

1. Claimant has been employed for 15 years with Employer working at a company known as Labor Saving Devices. Claimant was initially employed as an assembler. More recently, Claimant's job is as a research and development ("R & D") and production manager.

2. As an R & D and production manager Claimant works an 8-hour day. In the R & D portion of his job Claimant works on lathes and mills to produce parts for potential company products. The lathes and mills Claimant works on are non-automated machines that sometimes require Claimant to forcefully grip or grasp with his hands.

3. On occasion Claimant may work on the machines for an entire day requiring use of his hands. On other occasions, Claimant may do no machine work at all during a workday. Claimant estimated that 30% of his job required hand use. Claimant testified, and it is found, that his work does not have a "typical" day and that the work activities he engages in depend on the type of project he is working at on any particular day.

4. Claimant was evaluated by Dr. James Reid, M.D. on April 2, 2008. Claimant gave the physician a history that he had right hand numbness and tingling that had been present for the past two to three years and had slowly been worsening. Claimant had been referred to Dr. Reid by his primary care physician, Dr. Mackell. Dr. Reid diagnosed moderate right carpal tunnel syndrome and felt Claimant was a good candidate for carpal tunnel release surgery. Dr. Reid performed this surgery on May 2, 2008 and the surgery relieved Claimant's symptoms.

5. The reports of Dr. Reid do not contain a history of Claimant's right hand symptoms diagnosed as carpal tunnel syndrome as being related to Claimant's work duties at Employer. Dr. Reid does not provide any opinion regarding the causal relationship of Claimant's right carpal tunnel syndrome to the conditions of Claimant's employment at Labor Saving Devices.

6. In a report of August 31, 2006 Dr. Mackell stated he was suspicious that Claimant may have a right carpal tunnel. Claimant was seeing Dr. Mackell for complaints of neck pain following a motor vehicle accident in 1998. Dr. Mackell subsequently saw Claimant for further evaluations through at least February 2009. The records of Dr. Mackell submitted into evidence do not contain a history from Claimant relating his right hand numbness or carpal tunnel syndrome to the conditions of his employment. Dr. Mackell does not provide an opinion on the causal relationship of Claimant's right carpal tunnel syndrome to the conditions of Claimant's employment.

7. In October 2006 Claimant underwent an electro-myogram ("EMG") performed by Dr. Stilp for a chief complaint of right upper extremity pain. Dr. Stilp diagnosed a right C-7 radiculopathy but also noted that Claimant presented with "double crush" syndrome and may be a candidate for a right carpal tunnel release. Dr. Stilp noted that Claimant worked with his hands frequently but did not offer an opinion as to the causal relationship between Claimant's hand use and his right carpal tunnel syndrome.

8. Claimant is a diabetic and suffers from diabetic peripheral neuropathy affecting primarily his feet and left leg.

9. Bill George, a vocational and medical case manager, performed a work-site job analysis at Claimant's work on February 19, 2009. Mr. George observed Claimant working on a project that day on the machines. Mr. George noted that this work involved fine manipulation and firm gripping/grasping with both hands, pushing/pulling with both hands and twisting of hands and wrists. Mr. George issued a report of his findings on February 20, 2009.

10. Subsequent to his report of February 20, 2009 Mr. George reviewed additional documents presented to him by Claimant regarding the physical requirements of Claimant's job. These consisted of "labor records" from specific days in July and August 2009. Mr. George stated that if Claimant's job demands or duties involved more of the work as detailed by Claimant on July 24 and August 4 then Mr. George would change his analysis to assess that Claimant uses his hands on a frequent basis to push/pull or to grip/grasp, finger and handle.

11. Dr. Greg Reichhardt was qualified at hearing as an expert in physical medicine and rehabilitation and electro-diagnostic medicine. Dr. Reichhardt performed an evaluation of Claimant at the request of Respondents on April 22, 2009. Dr. Reichhardt obtained a history from Claimant regarding Claimant's job duties and was also provided at a later date with further documentation from Claimant describing his job duties.

12. Dr. Reichhardt testified that diabetes is a predisposing condition for carpal tunnel syndrome. Of the diabetic population, 14% develop carpal tunnel syndrome compared to 2% of the non-diabetic population. Of the diabetic population with diabetic peripheral neuropathy, 30% develop carpal tunnel syndrome. In general, carpal tunnel syndrome is the most common nerve entrapment.

13. Dr. Reichhardt testified that taking into account Claimant's description of his job as well as the job site analysis and given the balance of the available information Claimant's right carpal tunnel syndrome was likely not work related. Dr. Reichhardt opined that Claimant's job activities did not involve enough repetition, high-force activity, vibration, or awkward work postures to qualify Claimant's job as presenting a hazard for the development of carpal tunnel syndrome. Dr. Reichhardt was guided in reaching this opinion by the Cumulative Trauma Disorder Treatment Guidelines of the Division of Workers' Compensation, medical literature and his experience as a physical medicine and electro-diagnostic physician.

14. Dr. Reichhardt further testified and opined that even after the changes in the job analysis done by Mr. George following his receipt of further job description information from Claimant it remained his opinion that Claimant's carpal tunnel was not aggravated by Claimant's work related activities.

15 Dr. Reichhardt testified that many diabetics do develop carpal tunnel syndrome without any occupational risk factors or specific physical risk factors in terms of activities of that they do with their hands outside of just normal activities of daily living. Dr. Reichhardt further testified that the fact that Claimant does not have a "typical" work

day is actually a positive factor in that in cumulative trauma disorders such as carpal tunnel syndrome part of the problem is that a worker is required to do the same activity over and over such that a task that is not by itself exceedingly demanding causes overload because of the constant daily repetition. In Claimant's case this is not present as Claimant does not have a "typical" workday and there are days when Claimant will not work on the machines at all.

16. The ALJ finds the testimony and opinions of Dr. Reichhardt concerning the causal relationship between Claimant's right carpal tunnel syndrome and Claimant's work duties at Labor Saving Devices to be credible, persuasive and are found as fact.

17. Claimant has failed to carry his burden of proving by a preponderance of the evidence that his job duties caused his right carpal tunnel syndrome or intensified or aggravated his right carpal tunnel syndrome to cause a disability or need for medical treatment.

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

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

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

23. An occupational disease is "a disease which results directly from the employment or 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 which the worker would have been equally exposed outside of the employment." Section 8-40-201(14), C.R.S.

24. A claimant seeking benefits for an occupational disease must first establish the existence of the disease and that it was directly and proximately caused by claimant's employment or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claims,* 989 P.2d 251, (Colo. App. 1999); *Cowin & Co. v. Medina*, 860 P. 2d 535 (Colo. App. 1992). In addition, a claimant must show that the identified disease resulted in disability. *Cowin, supra.*

25. A claimant is entitled to recovery for an occupational disease injury only if the hazards of employment cause, intensify or aggravate – to some degree – the disability for which compensation is sought. *Anderson v. Brinkhoff*, 839 P.2d 819, 824 (Colo. 1993). Where the disease for which a claimant is seeking compensation is produced solely by some extrinsic or independent cause, it is not compensable. *Id.* At 824. Further, where an occupational exposure is not a "necessary precondition" to the development of the disease, a claimant sustains an occupational disease only to the extent that the conditions of the employment contributed to the disability. *Id*. At 824; *Masdin v. Gardner-Denver-Cooper Indus.*, 689 P2d 714, 717 (Colo.App. 1984). The purpose of this rule "is to ensure that the disease results from the claimant's occupational exposure to hazards of the disease and not hazards which the claimant is equally exposed to outside of employment." *Saenz-Rico v. Yellow Freight System, Inc.*, W.C. No. 4-320-928 (January 20, 1998); *see also Stewart v. Dillon Co.*, W.C. No. 4-257-450 (November 20, 1996).

26. As found, Claimant has failed to sustained his burden of proving that he sustained a compensable occupational disease of right carpal tunnel syndrome related to his work with Employer. Neither Dr. Reid, Dr. Mackell or Dr. Stilp offered opinions on the critical causal relationship question. As found, Dr. Reichhardt's opinions are credible and persuasive. Dr. Reichhardt considered the range of available information regarding the duties of Claimant's job and the prior medical records in reaching his opinion. In addition, Dr. Reichhardt obtained guidance from Division of Workers' Compensation publications on the subject of cumulative trauma disorders including their diagnosis

and the factors to be assessed in addressing causal relationship. Dr. Reichhardt was also guided by his knowledge of the medical literature and experience as a physician treating cumulative trauma disorders such as carpal tunnel syndrome. Dr. Reichhardt considered that Claimant's diabetic condition may either directly cause or predispose Claimant to development of carpal tunnel syndrome and that this predisposition may make it more likely for a diabetic Claimant to develop carpal tunnel for work activities. After consideration of all such factors, it remained Dr. Reichhardt's opinion that Claimant's work did not cause or aggravate Claimant's right carpal tunnel syndrome. The ALJ finds this opinion persuasive. It is not reasonably probable or reasonably likely that the conditions of Claimant's employment caused, intensified or aggravated his right carpal tunnel syndrome.

ORDER

It is therefore ordered that:

Claimant's claim for compensation and benefits for an occupational disease of right carpal tunnel syndrome is denied and dismissed in its entirety.

DATED: December 3, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-777-705

ISSUES

Whether Claimant is entitled to an award of TTD benefits from March 4, 2009 and continuing.

As an affirmative defense to Claimant's claim for TTD benefits, whether Claimant was responsible for his separation from employment and thereby barred from receipt of TTD benefits by the provisions of Section 8-42-103(1)(g) and 8-42-105(4), C.R.S. Respondents also raise the defense that Claimant was released to return to regular duty and therefore not entitled to TTD benefits under Section 8-42-105(3)(c), C.R.S.

FINDINGS OF FACT

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

1. Claimant was employed as a leadman by Employer. Claimant's job involved working out of a truck assigned to him installing ductwork, air conditioning and

heating equipment and supervising the start-ups of heating and ventilation equipment installations.

2. Claimant sustained an admitted injury to his right elbow on November 19, 2008. Claimant was diagnosed with traumatic right lateral epicondylitis and referred to Dr. George Schwender for treatment. Dr. Schwender became the Claimant's authorized treating and attending physician.

3. On February 3, 2009 Employer sent Claimant a written offer of modified duty that had been approved by Dr. Schwender as being within Claimant's restrictions. Claimant was to begin work in February 12, 2009 under the terms of the modified duty offer. Claimant returned to work and began the modified duty on February 16, 2009.

4. Claimant was evaluated by Dr. Schwender on March 2, 2009. Dr. Schwender continued Claimant on work restrictions that on that date were determined to be lifting/carrying, push/pull limited to 50 pounds. Dr. Schwender noted that Claimant had been working in the office within his restrictions and was anxious to return to his regular work so he could be out in the field.

4. Claimant continued working modified duty until March 4, 2009. Claimant's last day of work for Employer was March 3, 2009. Claimant has not worked since March 3, 2009.

5. On March 3, 2009 Claimant received a call at work from his daughter's school advising him that his daughter had broken her leg and that he needed to come care for her. Claimant left work on March 3, 2009 after working his full 8-hour shift to pick up his daughter. Prior to leaving work that day Claimant spoke with Ruth Rial, the president-owner of Employer, to ask if his leaving work to care for his daughter would affect his job. Claimant was advised by Ms. Rial that it would not. Claimant also called Ms. Rial on March 4, 2009 to advise that he would not be in to work.

6. Claimant did not report for work or call in to the Employer on March 5 or 6, 2009 although Claimant was scheduled to work on those dates. Claimant did not contact Employer during the week of March 9 through 13, 2009. Claimant did not call in because he relied upon his conversation with Ruth Rial and his past experience with Employer when he had been off work for an extended period for family reasons and had not been required to call in.

7. Claimant did not work on March 5, 6, and the week of March 9 through 13, 2009 because he was at home caring for his daughter and because he was also sick with the flu. During this time Employer continued to have the same modified duty work available for Claimant. Claimant intended to return to work on March 16, 2009. On March 15, 2009 Claimant received a call from Ruth Rial advising him that his employment had been terminated because he had been "no-call/no-show". Claimant did not leave work during the period from March 4 through March 15, 2009 on account of his work injury.

8. Employer's personnel manual provides that "repeated tardiness can result in termination". Employer's personnel manual does not contain any specific provision addressing the number of days an employee can be "no-call/no-show" prior to becoming subject to termination of employment. Employer does not issue either verbal or written warnings to employees for tardiness or instances of "no-call/no-show". As testified by Ruth Rial, Employer's decision to terminate Claimant for "no-call/'no-show" was at the discretion of Employer. Ms. Rial felt that because Claimant had not called in during the week of March 9 through 13, 2009 Claimant had abandoned his job.

9. Claimant was evaluated by Dr.Schwender on March 16, 2009. On that date Dr. Schwender released Claimant to return to regular work without restrictions and placed Claimant at MMI.

10. Following his release to return to regular work and placement at MMI on March 16, 2009 by Dr. Schwender Claimant underwent a Division-sponsored independent medical examination by Dr. Linda Mitchell, M.D. Dr. Mitchell offered an opinion that Claimant was not at MMI.

11. Claimant returned to Dr. Schwender for evaluation on September 8, 2009. Dr. Schwender noted Dr. Mitchell's opinion that Claimant was not at MMI. Dr. Schwender obtained a history from Claimant that the benefits of a previous injection into the elbow had lasted only a few weeks and that thereafter the pain had returned. Claimant had since then had episodes of his whole right hand going numb occurring multiple times per day. Dr. Schwender stated that he no longer considered Claimant to be at MMI and assigned work restrictions of 2 pounds lift/carry with the right hand, no pushing/pulling with the right hand and no gripping/grasping with the right hand. The ALJ finds that subsequent to being released to return to work at regular duty and placement at MMI by Dr. Schwender Claimant's condition worsened as reflected by the return of pain and symptoms causing Dr. Schwender to re-instate physical restrictions.

12. Prior to his termination by Employer on March 15, 2009, Claimant had not been given any written disciplinary action by Employer. There is no persuasive evidence in the record that Employer warned Claimant after March 4, 2009 that his continued absence from work without calling in would subject him to termination. There is further no persuasive evidence in the record that Employer attempted to call or contact Claimant during the week of March 9 through 13, 2009 to determine if and when Claimant intended to return to work. The ALJ finds that Claimant intended to return to work on March 16, 2009 and had not abandoned his job.

13. The ALJ finds that Claimant was not responsible for his separation from employment. Claimant's employment with Employer was terminated at the discretion of Ms. Rial. Claimant did not engage in a volitional act or exercise substantial control over the circumstances that lead to his termination.

14. There is no persuasive evidence that since September 9, 2009 Claimant has been released to return to his regular work, has returned to work, has been placed back at MMI or been provided a written offer of modified duty.

15. As reflected in the General Admission filed by Insurer on February 13, 2009 Claimant's Average Weekly Wage is $985.68 and Claimant is entitled to TTD benefits at the rate of $657.12 per week.

CONCLUSIONS OF LAW

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

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

18. To prove entitlement to TTD benefits, claimant must prove (1) that the industrial injury caused a disability lasting more than three work shifts; (2) that he left work as a result of the disability and; (3) that the disability resulted in an actual wage loss. *Anderson v. Longmont Toyota, Inc.,* 102 P.3d 323 (Colo. 2004); *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995); *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 637 (Colo. App. 1997). Section 8-42-103(1)(a), C.R.S., requires the 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). 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). TTD benefits ordinarily continue until one of the occurrences listed in § 8-42-105(3), C.R.S.; *City of Colorado Springs v. Industrial Claim Appeals Office, supra*. TTD benefits are precluded when the work-related injury plays no part in the subsequent loss of wages.

19. Under the provisions of Sections 8-42-105(4) and 8-42-103(1)(g), C.R.S. where it is determined that a temporarily disabled worker is responsible for termination of employment the resulting wage loss shall not be attributable to the on-the-job injury. A Claimant is responsible for a termination if the Claimant performs a volitional act or

exercises some degree of control over the circumstances leading to the termination considering the totality of the circumstances. This concept is broad and turns on the specific facts of each case. *Padilla v. Digital Equipment Corp.,* 902 P.2d 414 (Colo. App. 1994). Claimant is responsible for the separation of employment when Claimant commits a volitional act that an employee would reasonably expect to result in termination of employment. *Martinez v. Colorado Springs Disposal,* W.C. No. 4-437-497 (March 7, 2001). The burden to show that Claimant was responsible for the separation from employment rests with Respondents. *Colorado Compensation Insurance Authority v. Indus. Claim Appeals Office,* 18 P.3d 790 (Colo. App. 2000).

20. *Anderson v. Longmont Toyota*, Colo. 102 P.3d 323 (Colo. 2004) held that section 8-42-105(4), C.R.S. was not a permanent bar to receipt of TTD benefits and such benefits could be awarded if claimant's worsened condition caused the wage loss. The *Anderson* holding applies equally to scenarios involving a worsening of condition or the development of a disability after the termination. *Grisbaum v. Industrial Claim Appeals Office,* 109 P.3d 1054 (Colo.App. 2005)

21. As found, Claimant did not leave work during the period from March 4, through 16, 2009 as a result of his work injury. Claimant remained off work during this period because of his daughter's injury, his need to care for her and his own personal illness. Although Claimant had a disability related to his work as he was still under physical restrictions for his injury, Claimant did not leave work as a result of the injury and the injury did not cause Claimant's subsequent wage loss. Claimant has failed to prove by a preponderance of the evidence that he is entitled to TTD benefits for the period from March 4 through March 16, 2009.

22. As found, Claimant was not responsible for his separation from employment. Claimant's termination was a discretionary act on the part of Ms. Rial. Claimant reasonably relied upon Employer's past practice of allowing him to take time off without calling in and Ms. Rial's assurances that his absence in March 2009 would not affect his job. Respondents' argument that the lack of a specific policy regarding 'no-call/no-show" is of no bearing on the issue of responsibility for termination is unpersuasive. In the absence of any established policy regarding "no-call/no-show" it is exceedingly difficult to find that a Claimant who didn't call in exercised a significant degree of control over the circumstances leading to the termination. In the absence of any specific policy, prior warnings or communication from Employer an employee is without a sufficient basis to make an informed, volitional decision that a failure to call in would reasonably be expected to result in termination. Ms. Rial's further contention that Claimant had abandoned his job is likewise unpersuasive. As found, Claimant intended to return to work on March 16, 2009 once his daughter's injury and his own personal illness had improved. Because Claimant was not responsible for his separation from employment, his termination from employment does not serve to bar Claimant from receipt of TTD benefits.

23. However, Claimant was released to return to work at his regular duty as of March 16, 2009. This release to return to work is binding upon the ALJ. *Burns v. Rob-*

inson Dairy, Inc., 911 P.2d 661 (Colo. App. 1995). Because Claimant was released to return to work as of March 16, 2009 he is not entitled to TTD benefits so long as he continued to be released to work at his regular job. Section 8-42-105(3)(c), C.R.S.

24. As of September 9, 2009 Claimant was not released to return to his regular job as evidenced by the imposition of significant work restrictions by Dr. Schwender. In addition, Claimant was no longer at MMI as found by Dr. Schwender and Dr. Mitchell. As of September 9, 2009 Claimant's condition has worsened and he had re-established a connection between his subsequent wage loss and his work-related injury. *PDM Molding v. Stanberg,* supra. Thus, even if it were found that Claimant was responsible for his separation from employment, Claimant's worsened condition and the re-instatement of work restrictions as of September 9, 2009 re-established the causal connection between Claimant's work injury and his subsequent wage loss. *Anderson v. Longmont Toyota, Inc.,* supra. Claimant is therefore entitled to TTD benefits beginning September 9, 2009 until the occurrence of one of the events in Section 8-42-105(3)(a) – (d), C.R.S. *Fantin v. King Soopers,* W.C. No. 4-465-221 (February 15, 2007).

ORDER

It is therefore ordered that:

1. Claimant's claim for TTD benefits from March 4 through and including September 8, 2009 is denied and dismissed.

2. Insurer shall pay Claimant TTD benefits at the rate of $657.12 per week beginning September 9, 2009 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: December 4, 2009

Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-780-637

ISSUES

1. Whether Claimant's right ankle injury, occurring on May 27, 2009, during the course of a visit to ATP Dr. Sacha's office is compensable; and

2. Medical benefits for the right ankle injury.

FINDINGS OF FACT

1. Claimant is a credible witness and her testimony is persuasive and consistent with the medical records in the case.

2. Claimant sustained an admitted back injury on December 11, 2009. Respondents admitted liability and have provided medical treatment.

3. Respondents referred Claimant to Concentra for treatment. Concentra referred Claimant to Dr. Sacha.

4. On May 27, 2009, Claimant had returned to see Dr. Sacha for a follow-up appointment.

5. Dr. Sacha's records of that date note as follows:

> I did see [Claimant] in the office today for a follow up visit. Since last being seen, the patient had a fall in the parking lot today. She states her leg gave out. She attributes this to pain. . . .

6. Claimant credibly testified, and it is found, that on May 27, 2009, she had exited her vehicle and was walking to the entrance of Dr. Sacha's office when she felt pain on her right lower back which radiated into her right leg. Her right leg gave out causing her to fall, straining her right ankle.

7. Concentra refused to treat Claimant's right ankle sprain for non-medical reasons and referred her to her primary care physician. Thus, Claimant sought medical attention from Kaiser for this problem.

8. At Kaiser Claimant underwent an x-ray and her right ankle was placed in a cast. She remained in the cast for approximately five weeks.

9. Claimant was eventually placed at maximum medical improvement by Dr. Sacha. This determination is not challenged by the Claimant at hearing having been reserved for a DIME. § 8-42-107 (8), C.R.S.

10. Claimant has a history of right and left ankle injuries that are not work related. Claimant's pre-existing ankle injuries did not cause her fall on May 27, 2009.

11. Any determination concerning other issues is premature at this time, as a matter of fact.

CONCLUSIONS OF LAW

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

2. 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. (2002).

3. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits and compensability by a preponderance of the evidence. Respondents bear the burden of proving their defenses. 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).

4. 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.

5. 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).

6. Injuries that result from a Claimant's weakened condition caused by an initial injury are compensable because they are the natural, albeit not necessarily the direct, result of the first injury. *See Standard Metals Corp. v. Ball,* 172 Colo. 510, 474 P.2d 622 (Colo. 1970) (injury resulting from fall caused by weakened condition of leg due to prior injury compensable, even though fall occurred while employee was off work); *See also Employers Fire Ins. Co. v. Lumbermens Mut. Cas. Co.,* 964 P.2d 591 (Colo. App. 1998). These injuries are compensable because of their relationship to the underlying workers' compensation case.

7. In *Standard Metals Corp. v. Ball, supra*, the Claimant's right leg was fractured in an admitted accident in the course of his employment. Thereafter, the Claimant underwent corrective surgery, including a bone graft. Fourteen months later, the Claimant slipped and fell on an icy sidewalk, re-fracturing his right leg. The medical testimony in that case showed that the second fracture probably would not have occurred except for the weakened condition of the bone and the weakened musculature of the leg caused by the initial fracture and resulting surgery. The ALJ found that there was a

causal connection between the second fracture and the original compensable injury, and the award of benefits for the second fracture was upheld by the Colorado Supreme Court: As the Supreme Court noted, "Once the injury is determined to have arisen out of and during the course of claimant's employment obviously the results flowing proximately and naturally therefrom come under the aegis of the statute."

8. Nothing in *Standard Metals Corp. v. Ball, supra,* suggests that a subsequent injury resulting from the weakened condition is a "new" injury. Rather, the court recognized that an injury resulting from a weakened condition was within the range of potential compensable consequences stemming from the underlying industrial injury. Therefore, where the industrial injury leaves the body in a weakened condition subsequent injuries might be compensable consequences of the original injury. *See Standard Metals Corp. v. Ball, supra*.

9. The rationale for compensability of the subsequent injury is the causal relationship to the underlying workers' compensation injury. *See Jarosinski v. Industrial Claim Appeals Office of State,* 62 P.3d 1082 (Colo. App. 2002); *Price Mine Serv, Inc., v. Indus. Claim Appeals Office*, 64 P.3d 936 (Colo. App. 2003) (quasi-course of employment injuries and injuries that are naturally and proximately caused by an industrial injury do not give rise to new claims in the contrast to separate intervening causes which do not give rise to new claims).

10. In the instant case Claimant stated that her subsequent right ankle injury occurred while walking to Dr. Sacha's office for an appointment on May 27, 2009, when back pain caused her right leg to give way. Although Claimant's right ankle injury did not occur through the course and scope of Claimant's employment on December 11, 2009, it resulted from the weakened condition caused by her original back injury.

11. Accordingly, Claimant's right ankle injury on May 27, 2009, is a compensable consequence stemming from the underlying admitted injury.

12. Section 8-43-404(5)(a) 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). 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.*

13. The authorized provider, Concentra, refused to treat Claimant's right ankle injury for non-medical reasons. Claimant sought treatment at Kaiser. Therefore, Respondents shall pay for the reasonable and necessary medical care and treatment provided by Kaiser for the right ankle injury.

ORDER

It is therefore ordered that:

1. Claimant's right ankle injury of May 27, 2009, is a compensable injury related to the December 11, 2008 admitted claim.

2. Respondents shall pay pursuant to the fee schedule for the reasonable and necessary medical care and treatment provided by Kaiser for the right ankle injury.

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

DATED: December 4, 2009

Barbara S. Henk

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-352

ISSUES

The issue for determination is medical benefits for treatment of Claimant's shoulder.

FINDINGS OF FACT

1. On May 21, 2008, Claimant injured his low back in an accident arising out of and in the course of his employment with Employer. Claimant was off work following this injury and treated with a number of different physicians, including Dr. John Sacha and Dr. Lon Noel.

2. Prior to the May 21, 2008 accident, Claimant had experienced back problems. Dr. Scot Hompland reviewed medical records going back to 1992 that show Claimant had two prior work-related back injuries and had undergone a prior back surgery.

3. On July 6, 2008, Claimant, while taking a shower, sneezed and developed back spasms that caused him to fall. Claimant fractured his right wrist as a result of that fall.

4. Claimant was placed at maximum medical improvement by Dr. John Sacha on October 30, 2008. Claimant had been treated for a prolonged period with medications, physical therapy, a TENS Unit, and a strengthening program. Claimant had been found not to be a surgical candidate. Claimant had a completely non-physiologic presentation. Claimant did not receive a rating as his range of motion studies were inva-

lid. In a follow up report dated December 31, 2008, Dr. Sacha gave Claimant an 11% whole person impairment rating. He then apportioned out 8% for Claimant's pre-existing condition giving Claimant a 3% whole person impairment rating as a result of his work-related injuries.

5. Respondents filed a Final Admission of Liability on February 11, 2009, admitting for a three percent whole person impairment rating. Claimant objected to the Final Admission of Liability and was seen by Dr. Hompland for a Division independent medical examination.

6. On April 29, 2009, Claimant was walking across the kitchen floor when he sneezed and experienced the onset of back spasms resulting in a fall. As he fell, his right shoulder struck the refrigerator. He was seen later that day at the St. Anthony Central emergency room. The ER report states that Claimant was at home when he lost his balance and fell in the kitchen hitting his right shoulder on the counter. The reference to the counter was incorrect. Claimant was diagnosed with a right shoulder separation.

7. Claimant's sister was washing dishes on the day of Claimant's fall. She heard Claimant sneeze. She immediately turned her head and Claimant was already lying on the floor. Claimant's mother was ironing on the day of the fall. She heard a sneeze, and before she could say "God Bless you", Claimant had fallen to the floor.

8. Claimant returned to Dr. Sacha's office on April 28, 2009, for a follow up examination. The report noted that Claimant recently fell, that he hit his right shoulder, and that he was experiencing some pain. The report makes no mention of Claimant sneezing or experiencing the onset of muscle spasms prior to the fall.

9. Claimant returned to see Dr. Lon Noel on May 29, 2009. The doctor's note states that Claimant fell on April 29, 2009, injuring his right shoulder. The report states Claimant was walking in the kitchen with a cane in his left hand when he sneezed and fell forward. The report also states that, because of the sudden onset of muscle spasms, Claimant hit his shoulder directly on the refrigerator. Dr. Noel referred Claimant to Dr. James Ferrari. At the time of the doctor's initial evaluation on June 8, 2009, the doctor noted that Claimant had a long history of back problems and occasionally gets back spasms. He notes that Claimant injured his right shoulder when he fell at home. The doctor found that Claimant was suffering from a Grade 3 AC separation on the right and recommended that Claimant undergo an AC joint reconstruction.

10. Dr. Noel, in his deposition, agreed that the history he had received from Claimant differed from the history given to the emergency room by Claimant on the date of the shoulder injury and the history given to Dr. Sacha's office two days after the fall. In giving an opinion on causation, the doctor stated that he had assumed that the history given to him by Claimant was correct and the quality of his opinions would be based on the quality of the history given by Claimant. Claimant did give him an accurate history. It was the doctor's opinion that Claimant's sneeze had caused Claimant to fall and was the immediate cause of the shoulder injury.

11. Claimant was examined by Dr. Hompland on August 25, 2009. The doctor received a history of Claimant sneezing that caused a back spasm resulting in the fall and injury to the right shoulder. The doctor indicates that the medical records that he reviewed suggested a different history and it was his opinion that the right shoulder injury should not be included as part of the May 21, 2008 industrial accident.

12. It is found that on April 29, 2009, Claimant sneezed and suffered a back spasm. Claimant fell as a result of the back spasm and hit his shoulder on a refrigerator, resulting in an injury to his shoulder.

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. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and scope of his employment. Section 8-41-301(1), C.R.S.; *See City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of Claimant nor in favor of the rights of Respondents. Section 8-43-201, C.R.S.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice or interests. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936). A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The 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 a claimant has a subsequent accident as a result of an efficient intervening cause and not arising out of or in the course of employment, those injuries are not compensable. *Post Printing and Publishing Co. v. Erickson,* 30 P.2d, 327 (Colo. 1934) This is true even if the injury would not have happened if the claimant had retained all his former physical powers. In the later case of *Standard Metals Corporation v. Ball*, 474 P.2d 622 (Colo. 1970), the Court did find intervening injuries to be compensable when a Claimant suffered a slip-and-fall which caused a re-fractured of his original leg injury. The court differentiated the case from the *Post Printing and Publishing Co.* case in that the weakened condition did not cause the claimant to fall but rather the re-fracture resulted from the weakened condition of the bone that was as the result of surgery from the original indus-

trial injury. The question of whether a particular condition is as the result of an independent intervening event or, if it flows naturally and proximately from the original industrial injury, is a question of fact. See *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo.App. 2000); *Owens v. Industrial Claim Appeals Office*, 49 P.3d 1187 (Colo. App. 2002).

4. Claimant therefore carries the burden of proof to establish that his right shoulder injuries occurring on April 29, 2009, flowed directly and naturally from his back injuries suffered on May 21, 2008. Claimant sneezed and this caused him to experience back spasms that resulted in a fall where he struck his right shoulder on the refrigerator. The fall occurred so quickly following the sneeze that, before Claimant's mother could say "God Bless you", Claimant had already fallen to the floor. The event on April 29, 2009, resulted in back spasms, an aggravation of Claimant's work-related back condition. The aggravation resulted in the shoulder injury

5. Claimant has established that the injuries occurring on April 29, 2009, resulted naturally and proximately from his original industrial injuries. Claimant's fall was caused by a back spasm that was not an efficient independent intervening cause or event. Therefore, Claimant established by a preponderance of the evidence that his right shoulder injuries are causally related to his industrial injuries occurring on May 21, 2008.

ORDER

It is therefore ordered that Insurer is liable for the medical care Claimant receives from authorized providers that is reasonably needed to cure and relieve Claimant from the effects of the shoulder injury.

Issues not determined herein are reserved for future determination.

DATED: *December 7, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-732-992

ISSUES

1. Whether BT has overcome the Division Independent Medical Examination (DIME) opinion of Joseph H. Fillmore, M.D.

2. Whether Claimant has established by a preponderance of the evidence that he sustained the compensable occupational disease of cubital tunnel syndrome or ulnar neuropathy during the course and scope of his employment with BT.

3. Whether Claimant suffered a substantial permanent aggravation of his cubital tunnel syndrome or ulnar neuropathy during the course and scope of his employment with AW.

4. Whether Claimant has proven by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of cubital tunnel syndrome or ulnar neuropathy.

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

STIPULATIONS

The parties agreed to the following:

1. Claimant earned an Average Weekly Wage (AWW) of $981.77 while employed by BT;

2. Claimant is not seeking to recover Temporary Total Disability (TTD) benefits against AW because he did not incur any lost time while working for AW.

FINDINGS OF FACT

1. Claimant worked for BT as a mechanic from 1998 until October 12, 2007. On December 14, 2006 Claimant filed a Workers' Compensation claim against BT alleging that he had suffered bilateral Carpal Tunnel Syndrome (CTS). BT acknowledged the claim by filing a Final Admission of Liability (FAL) and Claimant subsequently underwent bilateral CTS surgeries with Kenneth H. Duncan, M.D. When Dr. Duncan released Claimant he noted minor, occasional symptoms in the ulnar nerve that were related to Claimant sleeping with bent elbows. However, Claimant's symptoms were not significant enough to warrant additional treatment. On June 20, 2007 Authorized Treating Physician (ATP) David L. Orgel, M.D. released Claimant at Maximum Medical Improvement (MMI) with no impairment or restrictions.

2. Claimant began working for AW in November 2007. AW is a full service repair shop with four bays owned by Terry Kness. Claimant had no work restrictions when Mr. Kness hired him as an automobile technician or mechanic. Claimant also assumed duties as a service writer/manager if Mr. Kness was out of the shop. Claimant used a full range of hand tools and performed duties as required by Mr. Kness. He never reported a new injury while employed for AW but continued to attend appointments and receive treatment for his CTS. Claimant ceased working for AW in approximately October 2008 to begin his own business.

3. Claimant continued to experience numbness and tingling in the ulnar distribution and visited doctors Duncan and Orgel for additional treatment. Dr. Orgel commented that Claimant's symptoms constituted an old problem from the CTS release. Dr. Duncan reviewed an EMG study that demonstrated "possible minor ulnar neuropathy"

that reflected a minor worsening. Claimant subsequently underwent physical therapy for his condition. On August 14, 2008 Dr. Orgel determined that Claimant again reached MMI without impairment.

4. Claimant challenged his MMI determination and underwent a DIME with Joseph H. Fillmore, M.D. on December 10, 2008. Dr. Fillmore concluded that Claimant remained at MMI for his CTS. However, after reviewing Claimant's medical records and performing a physical examination, Dr. Fillmore determined that Claimant was not at MMI for his ulnar neuropathy. He explained:

> It does not appear that his ulnar neuropathy has been evaluated properly or worked up for any type of surgical correction. I would recommend re-evaluation by a qualified upper extremity Orthopedic Surgeon. If it is determined that additional treatment, such as surgery, is appropriate, this should be reevaluated. If no surgery is recommended, the patient would be at MMI, in my opinion. It does appear that he has had occupational therapy for his ulnar neuropathy.

Dr. Fillmore concluded that Claimant had suffered a 23% right upper extremity impairment and a 23% left upper extremity impairment for his ulnar nerve condition.

5. On May 4, 2009 Claimant underwent an independent medical examination with Mark Steinmetz, M.D. Dr. Steinmetz also testified at the hearing in this matter. After reviewing Claimant's medical records and conducting a physical examination, Dr. Steinmetz concluded that he generally supported Dr. Fillmore's diagnostic and treatment determinations. Nevertheless, he acknowledged that a recent EMG of Claimant's ulnar nerve yielded normal results. Dr. Steinmetz specifically attributed all of Claimant's arm symptoms to his work for BT and remarked that none of Claimant's arm conditions could be attributed to his work for AW. He commented that Claimant did not incur a substantial permanent aggravation of his ulnar nerve condition while employed by AW. Dr. Steinmetz noted that Claimant remained at MMI for his CTS.

6. On May 19, 2009 Brian Lambden, M.D. conducted an independent medical examination of Claimant. He also testified at the hearing in this matter. After completion of his initial evaluation, Dr. Lambden stated that he was not convinced Claimant even had cubital tunnel syndrome. In an attempt to clarify the diagnosis, he performed updated EMG testing of Claimant's ulnar nerve. The study was normal and showed no electrodiagnostic evidence of cubital tunnel syndrome or ulnar neuropathy. Dr. Lambden's findings are consistent with the other testing conducted of Claimant's ulnar nerve over the years. Dr. Kawasaki performed an EMG on October 15, 1999 that was normal. Dr. Green performed testing on January 5, 2007 that revealed only mild median findings and no ulnar findings. Dr. Vandenhoven performed studies on June 10, 2008 that demonstrated "conflicting results" as to the ulnar nerve.

7. Dr. Lambden explained that Claimant thus does not have a clinical diagnosis of ulnar neuropathy or cubital tunnel syndrome. Dr. Lambden opined that Dr. Fillmore's opinion was based solely on symptomatic complaints because there is no objec-

tive evidence to support the diagnosis. Because Claimant did not have any EMG evidence of ulnar nerve entrapment, Dr. Lambden stated that surgery is not recommended and no additional evaluation by an orthopedic surgeon is warranted. Dr. Lambden concluded that Claimant has thus reached MMI for his ulnar nerve condition and Dr. Fillmore's opinion was clearly incorrect.

8. Dr. Lambden also explained that ulnar neuropathy is typically a congenital defect and not an occupational disease. Nevertheless, he acknowledged that ulnar neuropathy could be caused by highly repetitive job duties that stretch the ulnar nerve. However, Dr. Lambden explained that Claimant's work at BT did not constitute repetitive activity that was capable of causing cubital tunnel syndrome or ulnar neuropathy.

9. BT has established that it is more probably true than not that Dr. Fillmore's MMI determination regarding Claimant's ulnar neuropathy was incorrect. Dr. Fillmore determined that that Claimant had reached MMI for his CTS. However, he concluded that Claimant's ulnar neuropathy had not been properly considered and required additional evaluation. Nevertheless, Dr. Fillmore explained that, if Claimant's ulnar neuropathy did not require surgery, then he had reached MMI for his condition. Dr. Lambden commented that, in an attempt to clarify Claimant's diagnosis, he performed updated EMG testing of Claimant's ulnar nerve. The study was normal and showed no electrodiagnostic evidence of cubital tunnel syndrome or ulnar neuropathy. Dr. Lambden's findings are consistent with previous electrodiagnostic testing of Claimant's ulnar nerve.

10. Because Claimant did not have any EMG evidence of ulnar nerve entrapment, Dr. Lambden persuasively explained that surgery is not recommended and no additional evaluation by an orthopedic surgeon is warranted. Dr. Lambden concluded that Claimant has thus reached MMI for his ulnar nerve condition. Furthermore, although Dr. Steinmetz testified that he agreed with Dr. Fillmore's DIME determination, he acknowledged that Claimant's recent EMG of the ulnar nerve yielded normal results. Therefore, BT has presented sufficient evidence to establish that it is more probably true than not that Dr. Fillmore erroneously determined that Claimant had not reached MMI for his ulnar nerve condition. Therefore, as determined by Dr. Orgel, Claimant reached MMI on August 14, 2008 without impairment.

11. Claimant has failed to demonstrate that it is more probably true than not that he suffered the occupational disease of cubital tunnel syndrome or ulnar neuropathy during the course and scope of his employment with BT. Initially, Dr. Orgel commented that Claimant's symptoms constituted an old problem from the CTS release. Dr. Lambden persuasively explained that, based on electrodiagnostic studies, Claimant does not suffer from ulnar neuropathy. His findings are consistent with the other testing conducted on Claimant's ulnar nerve over the years. The previous electrodiagnostic studies revealed that Claimant had no ulnar neuropathy or exhibited "conflicting results" regarding the ulnar nerve. Furthermore, Dr. Lambden commented that ulnar neuropathy is typically a congenital defect and not an occupational disease. He remarked that Claimant's work at BT did not constitute repetitive activity that was capable of causing cubital tunnel syndrome or ulnar neuropathy.

12. Claimant did not suffer a substantial permanent aggravation of cubital tunnel syndrome or ulnar neuropathy during the course and scope of his employment with AW. Initially, Dr. Lambden persuasively explained that, based on electrodiagnostic testing, Claimant does not even suffer from ulnar neuropathy. Moreover, Dr. Steinmetz commented that Claimant did not incur a substantial permanent aggravation of his ulnar nerve condition while employed by AW. While working at AW Claimant used a full range of hand tools and performed duties as required by Mr. Kness. He never reported a new injury and ceased working for AW in approximately October 2008 to begin his own business. Claimant thus did not suffer a prolonged exposure in sufficient concentration while employed by AW to cause an ulnar nerve condition.

13. As a result of Claimant's CTS surgery he incurred scarring in both the left and right palm areas. The disfigurement consists of one and one-half inch scars on each palm. The disfigurement is serious, permanent and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $500.00.

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

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

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

Overcoming the DIME

4. A DIME physician's findings of MMI, causation, and impairment are binding on the parties unless overcome by "clear and convincing evidence." §8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004). "Clear and convincing evidence" is evidence that demonstrates that it is "highly probable" the DIME physician's rating is incorrect. *Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998). In other words, to overcome a DIME physician's opinion, "there must be evidence establishing that the DIME physician's determination is incorrect and this evidence must be unmistakable and free from serious or substantial doubt." *Adams v. Sealy, Inc*., W.C. No. 4-476-254 (ICAP, Oct. 4, 2001). 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. DIME physician Dr. Fillmore concluded that Claimant had suffered a 23% right upper extremity impairment and a 23% left upper extremity impairment. Because Claimant has suffered scheduled impairments, Dr. Fillmore's opinion is not entitled to increased deference.

5. As found, BT has established by a preponderance of the evidence that Dr. Fillmore's MMI determination regarding Claimant's ulnar neuropathy was incorrect. Dr. Fillmore determined that that Claimant had reached MMI for his CTS. However, he concluded that Claimant's ulnar neuropathy had not been properly considered and required additional evaluation. Nevertheless, Dr. Fillmore explained that, if Claimant's ulnar neuropathy did not require surgery, then he had reached MMI for his condition. Dr. Lambden commented that, in an attempt to clarify Claimant's diagnosis, he performed updated EMG testing of Claimant's ulnar nerve. The study was normal and showed no electrodiagnostic evidence of cubital tunnel syndrome or ulnar neuropathy. Dr. Lambden's findings are consistent with previous electrodiagnostic testing of Claimant's ulnar nerve.

6. As found, because Claimant did not have any EMG evidence of ulnar nerve entrapment, Dr. Lambden persuasively explained that surgery is not recommended and no additional evaluation by an orthopedic surgeon is warranted. Dr. Lambden concluded that Claimant has thus reached MMI for his ulnar nerve condition. Furthermore, although Dr. Steinmetz testified that he agreed with Dr. Fillmore's DIME determination, he acknowledged that Claimant's recent EMG of the ulnar nerve yielded normal results. Therefore, BT has presented sufficient evidence to establish that it is more probably true than not that Dr. Fillmore erroneously determined that Claimant had not reached MMI for his ulnar nerve condition. Therefore, as determined by Dr. Orgel, Claimant reached MMI on August 14, 2008 without impairment.

Compensability

7. 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.

8. 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. 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.

9. 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.*

10. As found, Claimant has failed to demonstrate by a preponderance of the evidence that he suffered the occupational disease of cubital tunnel syndrome or ulnar neuropathy during the course and scope of his employment with BT. Initially, Dr. Orgel commented that Claimant's symptoms constituted an old problem from the CTS release. Dr. Lambden persuasively explained that, based on electrodiagnostic studies, Claimant does not suffer from ulnar neuropathy. His findings are consistent with the other testing conducted on Claimant's ulnar nerve over the years. The previous electrodiagnostic studies revealed that Claimant had no ulnar neuropathy or exhibited "conflicting results" regarding the ulnar nerve. Furthermore, Dr. Lambden commented that ulnar neuropathy is typically a congenital defect and not an occupational disease. He remarked that Claimant's work at BT did not constitute repetitive activity that was capable of causing cubital tunnel syndrome or ulnar neuropathy.

Substantial Permanent Aggravation

11. The last injurious exposure rule provides, in relevant part:

> Where compensation is payable for an occupational disease, the employer in whose employment the employee was last injuriously exposed to the hazards of such disease and suffered a substantial permanent aggravation thereof and the insurance carrier ... on the risk when such employee was last so exposed ... shall alone be liable therefore, without right of contribution from any prior employer or insurance carrier.

§8-41-304(1), C.R.S. Under section 8-41-304(1), C.R.S. a claimant is not required to exactly pin point which period of employment most injuriously exposed him to the hazards of his occupational disease; instead, the claimant is allowed to recover from the last employer in whose employ the last injurious exposure occurred and resulted in an aggravation that is both permanent and substantial. *Monfort, Inc. v. Rangel,* 867 P.2d 122, 124-25 (Colo. App. 1993).

12. The "last injurious exposure" test and the "substantial permanent aggravation" test impose separate prerequisites for liability. *In Re Powell,* W.C. No. 4-569-418 (ICAP, Feb. 28, 2007). An injurious exposure occurs when a claimant suffers a prolonged exposure to the hazards of a disease in a sufficient concentration. *Id.* The length of employment with a particular employer is immaterial to a finding of liability. *Monfort,* 867 P.2d at 124. The focus is on both the harmful nature of the concentration of the exposure and the magnitude of the effect of the exposure. *Id.*

13. The "substantial permanent aggravation" requirement was added to §8-41-304(1), C.R.S. to "mitigate the harsh effects of the last injurious exposure rule on subsequent employers and insurers." *In Re Sorden,* W.C. No. 4-630-309 (ICAP, Jan. 31, 2006); *see Monfort,* 867 P.2d at 124-25. The "substantial permanent aggravation" component mitigates the "last injurious exposure" rule by focusing on whether the "effect" of the exposure substantially and permanently aggravated the condition. *In Re Powell,* W.C. No. 4-569-418 (ICAP, Feb. 28, 2007). The "substantial permanent aggravation" requirement establishes a standard for apportioning occupational disease liability when the disease was incurred over a series of different employments. *In Re Sorden,* W.C. No. 4-630-309 (ICAP, Jan. 31, 2006).

14. As found, Claimant did not suffer a substantial permanent aggravation of cubital tunnel syndrome or ulnar neuropathy during the course and scope of his employment with AW. Initially, Dr. Lambden persuasively explained that, based on electrodiagnostic testing, Claimant does not even suffer from ulnar neuropathy. Moreover, Dr. Steinmetz commented that Claimant did not incur a substantial permanent aggravation of his ulnar nerve condition while employed by AW. While working at AW Claimant used a full range of hand tools and performed duties as required by Mr. Kness. He never reported a new injury and ceased working for AW in approximately October 2008 to begin

his own business. Claimant thus did not suffer a prolonged exposure in sufficient concentration while employed by AW to cause an ulnar nerve condition.

Disfigurement

15. 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 CTS surgery he incurred scarring in both the left and right palm areas. The disfigurement consists of one and one-half inch scars on each palm. The disfigurement is serious, permanent and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $500.00.

ORDER

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

1. BT has overcome Dr. Fillmore's DIME determination that Claimant suffered a 23% right upper extremity impairment and a 23% left upper extremity impairment. Therefore, as determined by Dr. Orgel, Claimant reached MMI on August 14, 2008 without impairment.

2. Claimant did not suffer the compensable occupational disease of cubital tunnel syndrome or ulnar neuropathy during the course and scope of his employment with BT.

3. Claimant did not sustain a substantial permanent aggravation of his cubital tunnel syndrome or ulnar neuropathy during the course and scope of his employment with AW.

4. Claimant shall receive a disfigurement award in the amount of $500.00.

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

DATED: December 7, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-733-532

CORRECTED FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUES

The issues to be determined by this decision concern average weekly wage (AWW); temporary total (TTD) and/or temporary partial (TPD) disability benefits; and, whether child care expenses under the specific circumstances of this case may be awarded as ancillary to medical care. Claimant disputes Respondents' calculation of TTD benefits for using an improper AWW, and Claimant seeks TPD and TTD benefits. Claimant also seeks recovery of child-care costs for child-care allegedly incidental to her medical treatment. Respondents allege that Claimant's child care is not compensable, that Claimant is not entitled to temporary benefits pursuant to the applicable law, and that Respondents' calculation of Claimant's AWW without health benefits paid by the Employer at the time of her termination is proper. Claimant bears the burden of proof, by a preponderance of the evidence, on all issues heard.

FINDINGS OF FACT

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

Preliminary Findings

1. The Claimant is a dental hygienist and teacher who was injured by a fall in the parking lot of the Employer in October 2006. A program of conservative care failed to improve her back injury from the October 2006 fall and as a consequence, she has been unable to work as often as she had prior to the injury, and she underwent surgery in August 2009. Claimant did not receive indemnity benefits from Respondents until August 2009. She is a 43 year-old female.

2. On October 27, 2006, the Claimant slipped and fell on ice in the parking lot of the Employer, sustaining injuries to her left leg, lower back, shoulders, and neck.

3. The Claimant received treatment for her injuries at Concentra Clinic.

4. After the injury, Claimant's injuries to her neck, shoulders, and legs improved following a course of physical therapy, trigger point injections, steroid injections, and bio- feedback. Nonetheless, the Claimant continued to suffer pain in her back and an associated limited range of motion.

5. The Claimant received care through the Concentra Health System and its doctors throughout her recovery process, including physical examinations, physical therapy, as well as physical medicine consultations.

6. Eric Tentori, D.O., at the Concentra Clinic issued unqualified full duty return to work releases for the Claimant on November 28, 2006, and December 5, 2006.

7. Robert Kawasaki, M.D., issued a full duty return to work release for Petitioner on May 17, 2007.

8. John Burris, M.D., issued a full duty return to work release for the Claimant on January 15, 2008.

9. On October 15, 2008, Edwin Healy, M.D., conducted an independent medical examination (IME) of the Claimant, recommending more aggressive treatment. Dr. Healy issued a return to work release with limits on Claimant: no lifting over 10 pounds and no twisting at the waist.

10. Claimant underwent back surgery on August 17, 2009, in order to treat her continuing back pain.

11. The Claimant had two jobs at the time of her injury. She worked as a teacher with the Employer, and as a dental assistant with HC, where she cared for patients in various nursing homes.

12. The Claimant has had a variable employment history since her back injury. She left the Employer herein on September 6, 2007, and undertook subsequent employment at KIND.

13. On March 11, 2008, KIND terminated the Claimant as a result of her inability to focus and her fatigue.

14. The Claimant secured employment in the dental practice of WM, beginning April 1, 2008. WM terminated Claimant's employment on August 21, 2008, due to the fatigue and pain associated with her injury and medications.

15. The Claimant presently works at Pima Institute teaching dental assistants in four, four-hour shifts per week. She also continues to work on a limited, contractual basis with HC.

Average Weekly Wage and Temporary Disability Benefits

16. Upon her termination on March 11, 2008, from her job with KIND, the Claimant was eligible for COBRA benefits at a cost of $509.01 per month, or $117.46 per week.

17. On August 17, 2009, Respondents began paying the Claimant TTD benefits following her back operation.

18. To calculate TTD benefits, Respondents set an AWW of $660.71 based on the Claimant's employment with the Employer herein in October 2006. Neither Respondents nor Claimant contest that the $660.71 figure represents $593.95 earned by the Claimant in her primary job as a teacher for the Employer, and $66.76 earned in her secondary job as a dental assistant at HC

19. Respondents deny that Claimant should receive any temporary disability benefits pursuant to § 8-40-105(3)(c), C.R.S. (2009), because her authorized treating

doctors released her to return to work at full duty. Moreover, Respondents claim that the $42.00 to be added to the Claimant's AWW represents a fringe benefit not contemplated by § 8-40-201(19)(b), C.R.S. (2009).

20. In addition to earning $593.95 in income each week from the Employer, and $66.76 per week at HC, the Employer paid health care benefits for the Claimant in the amount of $42.00 per week, as reflected in a Statement of Weekly Earnings issued by the Employer on August 2, 2007.

21. Respondents' AWW calculation does not include the $42.00 in Employer paid health care benefits.

22. The Claimant alleges that a proper AWW calculation would either include the $42.00 in health care benefits for a total AWW of $702.71, or it should reflect the COBRA benefits available upon her termination from KIND.

23. The cost for Claimant to maintain group health coverage following her injury has been $117.46 weekly, which is her cost of COBRA coverage following termination from KIND in March 2008. Accordingly, the ALJ finds that the AWW should be $778.17, which represents the sum total of $593.95 for Claimant's salary with the Employer at the time of injury, $66.76 for her weekly income from HC at the time of injury, and $117.46 for the costs to maintain group health coverage available from a subsequent employer whereby her employment ended because of the compensable injury herein.

24. Claimant requests: (1) an AWW that reflects either $42.00 in weekly health care benefits provided by the Employer at the time of her injury, or an AWW that reflects COBRA coverage available to her upon her termination from KIND on March 11, 2008; (2) two periods of TTD, the first period covering three weeks following her termination from KIND in March 2008, and the second covering a one-week period after her termination from the office of WM in August 2008; (3) a payment of $9.53 per day for 1,022 days, less $954.50 earned in 2007 and 2008; (4) a TPD award of $10,781.96 for the period from August 28, 2008, to August 17, 2009; (5) a TPD award of $680.03 for the period from September 28, 2009, through October 11, 2009; and, (5) reimbursement of $2,310.00 for child care services while Petitioner received medical care from Concentra Clinic.

25. Claimant temporarily returned to work on September 28, 2009, and worked through October 11, 2009, both dates inclusive, a total of 13 calendar days, earning $425.09 during this period of time. This amount calculates to $228.89 per week, thus, establishing a temporary wage loss of $549.28 and an entitlement to TPD benefits of $366.18 per week, or $52.31 per day during this period of time, in the aggregate subtotal amount of $680.03 for this period of time.

<u>Child Care Services</u>

26. While receiving care from Concentra Clinic, the Claimant had to find child-care for her three children for whom she otherwise provides continuous supervision.

27. The Claimant brought her children to one medical appointment at the Concentra Clinic, resulting in an atmosphere that the attending doctor, Dr. Kawasaki, described as "very chaotic."

28. The Claimant incurred $2,310.00 in child-care expenses to place her children in supervised care while she attended medical appointments.

29. There is no persuasive evidence that any physician prescribed child-care services as part and parcel of her medical treatment.

Ultimate Findings

30. Claimant has proven, by a preponderance of the evidence, that her AWW includes the cost of replacing her Employer-financed health insurance benefits, thus, her AWW at present is $778.17, inclusive of the cost to her of maintaining group health care benefits following her termination from KIND. The cost for Claimant to maintain group health coverage following her injury has been $117.46 weekly, which is her cost of COBRA coverage following termination from KIND in March 2008.

31. Claimant failed to prove, by preponderant evidence, that she was temporarily disabled at any time prior to her surgery of August 17, 2009. Respondents have admitted TTD from August 17, 2009 and continuing, with the exception of the period from September 28, 2009, through October 11, 2009, both dates inclusive, a total of 13 days, during which Claimant sustained a temporary wage loss of $549.28 per week, entitling her to a TPD rate of $366.18 per week, or aggregate TPD benefits of $680.03 for this period of time. Otherwise, the General Admission of Liability, filed on August 26, 2009, is effective concerning TTD benefits. The admitted AWW and TTD rate is what was disputed.

32. Claimant has failed to prove, by preponderant evidence, that the costs of child-care amount to medically prescribed medical care and treatment.

CONCLUSIONS OF LAW

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

Average Weekly Wage

a. Respondents admitted an AWW of $660.91 and TTD benefits of $440.47 per week from August 17, 2009 and continuing (General Admission, filed August 26, 2009). Whether or not Claimant actually purchased that health coverage at the time of her separation from employment, proximately caused by the original compensable in-

jury, should not preclude the cost thereof as a factor in calculating AWW to reflect the cost of continuation of heath coverage. *Sears Roebuck & Co. v. Indus. Claim Appeals Office*, 140 P.3d 336 (Colo. App. 2006); *Ray v. Indus. Claim Appeals Office*, 124 P.3d 891 (Colo. App. 2005). Moreover, the Colorado Supreme Court has held that an ALJ may properly consider the cost to an employee of purchasing a subsequent employer's COBRA insurance in the calculation of a claimant's AWW. *Avalanche Indus., Inc. v. Clark*, 198 P.3d 589 (Colo. 2008). Accordingly, as found the Claimant's AWW is $778.17, which represents the sum total of $593.95 of her salary with the Employer at the time of injury, $66.76 for her weekly income from HC at the time of injury, and $117.46 for the costs of maintaining group health coverage available from a subsequent employer, whereby her separation from employment with the subsequent employer was proximately caused by the effects of her original compensable injury. The differential between the admitted TTD rate and the re-established TTD rate is $78.30 per week.

Temporary Disability Benefits

b. § 8-42-105(3)(c), C.R.S. (2009), provides that "[t]emporary total disability benefits shall continue until the first occurrence of any one of the following: . . . (c) [t]he attending physician gives the employee a written release to return to regular employment." As found, the Claimant received unqualified return to work releases from her authorized treating physicians on November 26, 2006, December 5, 2006, May 17, 2007, and January 15, 2008. Until she underwent back surgery in August 2009, she had not received work-related restrictions by a doctor. Moreover, as Respondents note, Dr. Healy's IME on October 15, 2008, is without legal standing on the issue of a release to return to work. *See Dejoy v. The Shaw Group*, W.C. No. 4-741-382 [Industrial Claim Appeals Office (ICAO), May 14, 2009]. Despite Claimant's prolonged recovery, the ALJ cannot find pursuant to § 8-42-105, that Claimant is entitled to temporary benefits prior to her August 2009 surgery. Her variable employment during this time negates the idea of temporary disability prior to the August 2009 surgery.

c. § 8-42-106 (1), C.R.S. (2009), provides that TPD benefits shall be 2/3rds of the difference between the AWW and the actual weekly earnings during TPD. As found, the differential was $549.28 per seek, thus, entitling Claimant to TPD benefits of $366.18 per seek during the period from September 28, 2009, through October 11, 2009, a total of 13 days, in the aggregate subtotal amount of $680.03.

Child Care

d. Medical benefits in the child-care context are compensable, only if the service requested is medical in nature or "incidental to obtaining such medical . . . treatment." *Country Squire Kennels v. Tarshis*, 899 P.2d 362 (Colo. App. 1995), citing *Indus. Comm'n v. Pacific Employers Ins. Co.*, 120 Colo. 373, 209 P.2d 908 (1949). Services that are "medical in nature" include home health services in the nature of "attendant care" if reasonably needed to cure or relieve the effects of the industrial injury. *Atencio v. Quality Care, Inc.*, 791 P.2d 7 (Colo. App. 1990). In *Kuziel v. Pet Fair, Inc.*,

931 P.2d 521, 522-23 (Colo. App. 1996), the court held that a claimant's $300 expenditure on a plane ticket for a family member to fly to Colorado to provide child care while the claimant underwent treatment for a work-related injury was **not** compensable because the services "did not relieve the symptoms or effects of the injury and were not directly associated with the claimant's physical needs." One year later, the court held in *Bellone v. Indus. Claims Appeals Office*, 940 P.2d 1116, 1118 (Colo. App. 1997), that child care services were compensable following medical testimony from a claimant's neuropsychologist affirming the need for child care so that the claimant could rest while recovering from a work-related injury. The court distinguished *Kuziel* on the basis that there was no medical testimony in *Kuziel* as in *Bellone* that suggested the child care services were essential to the claimant's course of recovery. *Id*. The ALJ concludes that *Bellone* controls in this case. As found, Claimant presented no persuasive medical testimony that child care services were essential to the course of her recovery. At most, Dr. Kawasaki noted that the presence of Claimant's children in the attending room created a "very chaotic" atmosphere," but he was nonetheless able to complete his examination.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Claimant's average weekly wage is hereby re-established at $778.17, which yields a temporary total disability benefit rate of $518.77 per week.

B. In addition to temporary disability benefits paid pursuant to the recent General Admission of Liability, Respondents shall pay Claimant the differential of $78.30 per week from August 17, 2009 through September 27, 2009, retroactively and forthweith. From September 28, 2009, through October 11, 2009, both dates inclusive, a total of 13 days, Respondents shall pay the Claimant aggregate temporary partial disability benefits of $680.03, retroactively and forthwith. From October 23, 2009 and continuing, Respondents shall pay the Claimant temporary total disability benefits of $518.77 per week until termination thereof is warranted by law.

C. Any and all claims for child-care services are hereby denied and dismissed.

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

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

DATED this_____day of December 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-745-833

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUES

The issues to be determined by this decision concern Respondents' request to overcome the Division Independent Medical Examination (DIME) inclusion of a cervical spine rating; and Respondents' request to overcome the conversion of Claimant's left upper extremity (LUE) impairment rating from being converted to a whole person award.

At the outset, the parties agreed that Respondents had the burden of proof on both issues as well as the burden of going forward with the evidence. It was further agreed that Respondents' burden of proof with regard to overcoming the DIME physician's inclusion of the cervical spine was by clear and convincing, whereas overcoming the conversion of the LUE rating to a whole person rating was by a preponderance of the evidence.

FINDINGS OF FACT

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

1. Claimant injured his left shoulder, neck and cervical spine in this admitted compensable accident on December 14, 2007. The Claimant's initial evaluation includes a diagnosis of contusion of the left shoulder with a cervical strain and some radicular symptoms.

2. The Claimant's initial evaluation was with Lawrence Cedillo, D.O. Dr. Cedillo was the Claimant's authorized treating physician (ATP) and throughout his treatment and evaluation of the Claimant, repeatedly included contusion of the left shoulder and a cervical strain as his work-related medical diagnosis.

3. The Claimant has continued to suffer left shoulder, neck and upper back pain with associated headaches as documented by various providers, including Re-

spondents' expert, L. Barton Goldman, M.D. The Claimant's injuries were the result of a fall wherein he landed on his left shoulder. The Claimant was referred to an orthopedic surgeon for an MRI ((magnetic resonance imaging) which documented a 1.5 cm tear of the distal supraspinatus at the distal insertion point. The Claimant underwent surgery on January 28, 2008, at the hands of Terry Wintory, D.O. The procedure was a "left shoulder open rotator cuff repair with acromioplasty and resection of coracoacromial ligament."

4. Dr. Cedillo placed theClaimant at maximum medical improvement (MMI) on December 18, 2008, and gave the Claimant an impairment rating consisting of 21% of the LUE which he mechanically converted to a 13% whole person rating, pursuant to the requirements of the *AMA Guides to the Evaluation of permanent Impairment,* 3rd Ed., Rev. Dr. Cedillo indicated that the diagnosis at the time of MMI was "slip and fall same level with a contusion of the left shoulder, rotator cuff tear and cervical strain. Status post left shoulder open rotator cuff repair with acromioplasty and resection of the coracoacromial ligament January 28, 2008, with subsequent development of adhesive capsulitis status post manipulation under general anesthesia May 5, 2008."

5. The Claimant requested a DIME that was performed by Edwin Healey, M.D., on November 14, 2008. Dr. Healey found that the Claimant was not at MMI, needed further evaluation of his neck, shoulder and axillary nerve neuropathy versus C5 radiculopathy. Dr. Healey stated "based on the clinical findings today in the involvement of his trapezius neck muscles and headaches, he does have involvement in symptoms above the left glenohumeral joint which in my opinion would require a whole person impairment of his left shoulder." Since Dr. Healy found that Claimant was not at MMI, his opinions on impairment were premature and speculative at this juncture.

6. After additional testing and treatment, Dr. Healey re-examined the Claimant on April 29, 2009, determined that he had reached MMI on January 29, 2009, and made the following findings in his report: "Claimant's chief complaint was chronic neck pain and headaches and chronic left shoulder pain. I noted that the Claimant had a mild axillary nerve neuropathy. He states he has had constant cervical pain since his injury had not returned to work and that the pain interfered with his general activity and interferes with his sleep." Dr. Healey noted that the "chronic neck pain interferes with his ability to turn his head, particularly to the left, and therefore, interferes with his driving." Dr. Healey's physical exam noted, "left cervical and suboccipital tenderness, and deep palpation over the tender and trigger points reproduces cervical pain and left frontotemporal pressure-type headaches. He also has tenderness over his left trapezius and left supraspinatus." Dr. Healey noted crepitus on range of motion and all planes in the left and decreased range of motion in the left shoulder and cervical spine. Dr. Healey's diagnosis was:

I. History of the left shoulder rotator cuff tear post fall; surgery postop open rotator cuff repair, acromioplasty and resection of the coracoacromial ligament, and secondary manipulation of his left shoulder for adhesive capsulitis on August 5, 2008, with residual

chronic pain, loss of range of motion and weakness of his left shoulder girdle musculature.

II. Left axillary nerve neuropathy secondary to his December 14, 2007, injury.

III. History of cervical strain and ongoing left cervical and trapezius myofascial pain, with MRI showing some mild cervical degenerative disc disease at C5-C6.

IV. Secondary cervical tension-type headaches secondary to his myofascial pain and chronic cervical strain.

7. Dr. Healey's impairment rating included a 9% cervical spine and an 18% LUE impairment which he mechanically converted to an 11% whole person impairment for a combined total of 19% whole person impairment with no apportionment. Dr. Healy stated no opinion, at this time, as to the appropriateness of a conversion. His pre-MMI opinion to the effect that a conversion was appropriate does not carry over for inclusion in the final opinion. Indeed, because Dr. Healy did not reiterate it at the time of his final rating, the ALJ infers and finds that Dr. Healy changed his position on the appropriateness of a conversion at the time of his final ratings.

8. In the Respondents' case in chief, Dr. Goldman testified that the situs of Claimant's functional impairment is proximal to the glenohumeral joint. It was Dr. Goldman's conclusion, however, that a cervical spine impairment rating should not be included. While Dr. Goldman's testimony is convincing, it is a difference of opinion with Dr. Healey's opinion. With regard to the cervical spine rating, the Respondents have failed to prove that it was highly probable and free from serious and substantial doubt that the inclusion of a cervical spine rating by Dr. Healey was wrong. Consequently, the ALJ finds that Respondents have failed to prove by clear and convincing evidence that the DIME physician's rating of Claimant's cervical spine at 9% whole person was erroneous. Therefore, this rating must stand.

9. Claimant indicated that he had no other evidence than the evidence in the records as of the time that Claimant moved for a judgment at the conclusion of Respondents' case-in-chief. Based on the evidence in the record as of that time, Claimant did not have sufficient preponderant evidence that a conversion was warranted. A few days after the ALJ ruled from the bench on the cervical and LUE issues, and before Claimant was to submit a proposed decision, Claimant moved to reopen the evidence to present additional evidence in the LUE conversion issue. The ALJ will not allow Claimant, after moving for a judgment in the nature of a directed verdict, to later change his mind and request the opportunity to further litigate the LUE conversion issue after re-thinking the matter and deciding to essentially withdraw his motion in the nature of a directed verdict. This is analogous to waiting and seeing whether the decision has gone one's way and, if not, to ask for more hearings in order to achieve a different decision.

10. Although the parties postured the LUE issue with Respondents having the burden of overcoming the proposition that Dr. Healy's LUE rating of 18% should be con-

verted to a whole person rating of 11% whole person, pursuant to Dr. Healy's mechanical conversion thereof at the time of MMI, ordinarily, Claimant would have the burden of proving that a conversion is warranted, by a preponderance of the evidence. Either way, there was no persuasive evidence that the situs of functional impairment transcended the Claimant's LUE, thus, and there was not preponderant evidence warranting a conversion, at the conclusion of the November 12 hearing a granting of Claimant's motion in the nature of a directed verdict.

CONCLUSIONS OF LAW

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

a. 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 respondents is justified on the claimant's evidence. *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*, 914 P.2d 411 (Colo. App. 1995). In this case, the question is whether Respondents carried their burden as of the conclusion of their case-in-chief. Claimant moved for a judgment on all issues in the nature of a directed verdict at that time. As found, Respondents had not met their burden as of the time when their evidence could not get any better. Therefore, a judgment in the nature of a directed verdict was granted.

b. The party seeking to overcome a DIME physician's opinions on degree of impairment, MMI and causal relatedness of a condition to permanent impairment bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000). The DIME physician's determination of MMI and degree of permanent impairment is binding unless overcome by "clear and convincing evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995); § 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 overcome the DIME rating of 9% of the cervical spine. Therefore, it must stand.

c. There must be preponderant of evidence that an extremity rating should be converted to a whole person ratiing. §§ 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). Also, the burden of proof is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P. 2d 535 (Colo. App. 1992). A “preponderance of the evidence” is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, at the time of Claimant’s motion for judgment in the nature of a directed verdict, there was not preponderant evidence that the LUE rating of 18% should be converted to a whole person rating.

d. The situs of functional impairment controls whether a scheduled extremity rating should be converted to a whole person rating. *Strauch v. PSL Swedish Healthcare System,* 917 P.2d 366 (Colo. App. 1996). *Also see Delaney v. Industrial Claim Appeals Office,* 30 P.3d 691 (Colo. App. 2000). As found, there was not preponderant evidence that the situs of functional impairment transcended the Claimant’s LUE.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Claimant is awarded permanent medical impairment benefits based on DIME Dr. Healey’s 9% cervical spine rating and 18% left upper extremity rating. Claimant was at MMI on January 29, 2009. Therefore, Respondents shall pay additional benefits due and owing from that date.

B. Respondents are entitled to credit for $27,238.23 in benefits paid since the date of maximum medical improvement.

C. Respondents shall pay the costs of post-maximum medical improvement maintenance medical treatment.

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

DATED this_____day of December 2009.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-795-084

ISSUES

1. Whether Claimant suffered a compensable stress claim pursuant to C.R.S. §8-41-301(2);

2. Whether Claimant is entitled to medical benefits.

FINDINGS OF FACT

1. Claimant began employment for Employer in 1976 as an intern and was eventually hired as a certified deputy patrol officer in 1980. Claimant was reassigned to investigation and ultimately promoted to Sergeant in May 1999. In 2003, after Claimant worked patrol, investigations, and in the crime lab, she was transferred to work at the county jail. Claimant considered the transfer a punishment for telling an inappropriate joke that resulted in an internal affairs complaint. However, her superiors told her it was not a punishment. The jail consists of multiple pods. Claimant eventually worked in all of the pods; often requesting a transfer to a different job or pod. On occasion, Claimant helped fill jobs of others who were gone due to promotion, transfer, illness, etc. Claimant admitted it was normal to fill in for others.

2. Claimant was the subject of five sustained disciplinary matters regarding judgment and decision making over the past few years. For example, in 2003 Claimant was admonished for telling an inappropriate joke. In October 2007 a letter of reprimand issued after Claimant decided not to fully participate during in-service training. In August 2008 an internal investigation resulted in one-year probation and twenty hour suspension because Claimant failed to follow orders to have no further contact or involvement with an inmate. After Claimant appealed and the decision became final, she was advised that any future violations would result in more severe discipline. In January 2009, while on probation, Claimant gave a tour to cub scouts in a lock down unit that

resulted in another internal investigation. After exhausting the appellate process, Claimant was disciplined for conduct due to poor judgment, issues of truthfulness, and lack of compliance with the sheriff's office value based directive system. Claimant's lieutenant was bothered most because Claimant did not see that she did anything wrong. Claimant was demoted to deputy, suspended for eighty hours, and her probation extended until March 16, 2010.

3. On March 4, 2009, Clamant met with Lieutenants Vinot and Crecelius. Claimant could not recall details of the meeting but recalled that Lieutenant Vinot was upset that Claimant failed to follow directions regarding email copies and that ultimately Claimant and Lieutenant Vinot raised their voices. Claimant left the office and requested to be placed on administrative leave. Bureau Chief Spence tried to resolve the issue. He called Claimant and offered to assign her to work with a different lieutenant. Claimant declined the offer.

4. Claimant requested a leave of absence pursuant to FMLA. On March 14, 2009, Claimant alleged work related stress and depression after disciplinary action was recommended.

5. Claimant's FMLA expired July 8, 2009. Claimant failed to return to work. The Employer sent Claimant a letter on July 22, 2009, and advised that she will be separated from employment effective July 28, 2009, unless she reports for duty with a medical release. Claimant communicated to Captain Line that she was medically unable to return to work. As a result, on July 28, 2009, the Employer sent Claimant a letter and advised that she would be separated from employment. The Employer allowed Claimant six days to appeal. Claimant did not and her employment terminated

6. Claimant has a history of mental health treatment. Claimant's mother committed suicide in 1974 when Claimant was 15 years old. She treated with Dr. Fisher at Arapahoe Mental Health for marital counseling. She reported to Dr. Kleinman she has flashbacks of her mother's suicide. Claimant was on Prozac for ten years; initially prescribed when Claimant was promoted to Sergeant and felt overwhelmed.

7. In 2009, Claimant sought treatment with psychologist, Dr. Nicolletti to help manage feelings of depression, anxiety, and stress while undergoing an Internal Affairs investigation. Subsequently, Claimant treated at Kaiser with Mark Spragins, LPC, and Joe Barfoot, LCSW, for depression and stress. On May 7, 2009, Joe Barfoot reported Claimant has a long history of depression with extensive family history of depression. He diagnosed major depression appearing to be worsened over the last several months specific to disciplinary matters.

8. Dr. Kleinman performed an independent psychiatric examination on September 14, 2009. Dr. Kleinman met with Claimant and recorded her mental health history, disciplinary history, medical history, and employment history in his reports dated September 18, 2009. Dr. Kleinman reviewed and summarized medical records and

employment records. He diagnosed Claimant with a recurrent depressive disorder and pointed out that she has been on antidepressant medication for the last ten years. Claimant increased her Prozac from 20 mg to 40 mg about one year ago when Claimant felt overwhelmed and stressed which she related to overwork. Claimant was involved in several internal investigations; the last two resulted in reprimands. Dr. Kleinman concluded that there was no psychologically traumatic event outside of Claimant's usual work experience; her depression is due to disciplinary action, work evaluation, and a demotion apparently taken in good faith after following proper procedures; the claim is based on facts and circumstances common to all fields of employment; and Claimant is not permanently disabled from a mental health perspective from pursuing the occupation from which the claim arose. Dr. Kleinman's opinion is credible and persuasive and found as fact.

9. Clamant testified at hearing. At one point she based her stress claim on her meeting with Lieutenant Vinot. She testified that they both were shouting and angry. She could not recall the details of the conversation other than it started when Lieutenant Vinot complained that Claimant continued to send copies of all emails to her contrary to previous instructions. Claimant admitted that the subject matter of the conversation was probably appropriate or reasonable, however, she did not like the fact that Lieutenant Vinot screamed at her. On cross-examination, Claimant admitted that Lieutenant Vinot was upset about legitimate issues and met with Claimant in good faith. Claimant admitted that other employees may have reacted differently and that supervisors in other jobs or areas of employment may also raise their voices. Later, Claimant testified that the meeting with Lieutenant Vinot on March 4, 2009, was the straw that broke the camel's back and Claimant's stress was also based on prior disciplinary matters. Claimant admitted that her Employer had the right to discipline her although she disagreed with the results. She admitted discipline occurs in other jobs or areas of employment.

CONCLUSIONS OF LAW

1. A claimant in a worker's compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. C.R.S. §8-43-201

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

3. Pursuant to C.R.S. §8-41-301, a claim is compensable if it arises out of and in the course and scope of employment. Stress claims, however, must meet very specific requirements before they will be considered compensable. C.R.S. §8-41-301(2). A claim of mental impairment must be proven by evidence supported by a physician or psychologist. The mental impairment must be a recognized permanent disability. The mental impairment must arise out of and in the course of employment and con-

sist of a psychologically traumatic event generally outside of the worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. Mental impairment is not considered work related if it results from a disciplinary action, work evaluation, job transfer, lay off, demotion, promotion, termination, retirement, or a similar action taken in good faith by the employer. The mental impairment that is the basis of the claim must arise primarily from claimant's employment. The claim of mental impairment cannot be based in whole or in part upon facts and circumstances common to all fields of employment: The mental impairment which is the basis of the claim must be, in and of itself, either sufficient to render the employee temporarily or permanently disabled from pursuing the occupation from which the claim arose or require medical or psychological treatment.

4. Claimant failed to prove by a preponderance of the evidence that she sustained a compensable claim of mental impairment pursuant to Section 8-41-301, C.R.S. For example, 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 by an objective standard for a worker with experience, training, and duties similar to the claimant. See Davidson v. City of Loveland Police Department, W.C. No. 4-292-298 (October 28, 2001). A condition is "common" to all fields if it is usual, ordinary or customary. White Star Linen v. Industrial Claim Appeals Office, 787 P.2d 189 (Colo. App. 1989). In this case, Claimant failed to prove by a preponderance of the evidence that the psychologically traumatic events are generally outside of her usual experience and would evoke significant symptoms of distress in a worker in similar circumstances.

5. Additionally, Claimant based her stress claim on multiple disciplinary matters and a meeting with her supervisor. The disciplinary actions taken by Employer in this matter were taken in good faith. Claimant admitted the Employer had a legitimate right to discipline Claimant although she disagreed with the results. Claimant was afforded and took advantage of multiple appellate levels. Claimant's bureau chief tried to resolve Claimant's concerns about working with Lieutenant Vinot and offered to reassign Claimant to a different lieutenant, which she declined.

6. Dr. Kleinman concluded, and it was found as fact, that there was no psychologically traumatic event outside of Claimant's usual work experience; her depression is due to disciplinary action, work evaluation, and a demotion apparently taken in good faith after following proper procedures; the claim is based on facts and circumstances common to all fields of employment; and Claimant is not permanently disabled from a mental health perspective from pursuing the occupation from which the claim arose.

ORDER

It is therefore ordered that:

1. Claimant's claim is denied and dismissed.

DATED: December 9, 2009

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-769-745

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that on August 27, 2008, he sustained an injury arising out of and in the course of his employment?
¬ Did the claimant prove by a preponderance of the evidence that he is entitled to temporary disability benefits as a result of the alleged injury?
¬ Did the claimant prove by a preponderance of the evidence that he is entitled to medical benefits as a result of the alleged injury?
¬ Did the respondents prove by a preponderance of the evidence that the claimant was responsible for his post-injury termination from employment?

FINDINGS OF FACT

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

1. The claimant alleges that on August 27, 2008, he sustained a compensable low back injury arising out of and in the course of his employment as a convenience store clerk.
2. The medical records reflect that in February 2008, approximately six months prior to the alleged injury in this case, the claimant sustained a low back injury at work. On September 4, 2008, the claimant advised Dr. Eric Tentori, D.O., an authorized treating physician for the alleged injury of August 27, 2008, that he sustained a low back injury in February 2008 when he fell off of a chair. The claimant told Dr. Tentori that he has experienced ongoing tenderness since the February injury injury.
3. The claimant testified that on August 27, 2008, between 2 and 3 p.m., he injured his low back while lifting a bag of syrup to refill a soft drink dispenser. The claimant stated that he continued working after this injury, although he was in pain. The claimant further stated that after the injury he was required to assist a coworker, Janu Sigdel, to stock the cooler. The claimant recalled he was able to stock the cooler, but was in substantial pain while doing so.
4. The claimant testified that he reported the injury to his supervisor, Melissa Serafin, on the same day it happened. Thus, the claimant effectively testified that he reported the injury to Serafin on August 27.
5. The claimant's testimony that he sustained an injury to his low back on August 27, 2008, is not credible.
6. The claimant's testimony concerning the reporting of the alleged injury is contradicted by the credible testimony of Melissa Serafin, the claimant's supervisor. Ms.

Serafin testified that the claimant did not report any injury to her on August 27, 2008, although she twice spoke with the claimant by telephone on that day. Indeed. Ms. Serafin credibly testified that the claimant did not report the alleged injury until August 28, 2008, *after* he was placed on administrative leave because of an allegation of misconduct unrelated to this case.

7. The claimant's testimony concerning the alleged injury is also contradicted by the credible testimony of his coworker. Ms. Sigdel testified that she worked with the claimant on August 27, 2008. Ms. Sigdel stated that she observed the claimant lift a box of syrup but was not aware of any injury to the claimant. The claimant did not tell Ms. Sigdel he was injured, and she did not observe any behavior that suggested the claimant was injured. Ms. Sigdel recalled the claimant was able to help her stock the cooler. Ms. Sigdel credibly testified that prior to August 27, 2008, the claimant would occasionally complain about back problems.

8. The claimant's testimony is further contradicted by the contents of a video recording that depicts the claimant stocking the employer's walk-in cooler on August 27, 2008. The video, which commences at approximately 2:44 p.m., shows no obvious signs or behaviors indicating that the claimant had just sustained a painful low back injury. To the contrary, the claimant is seen to bend at the waist on several occasions and perform some twisting movements of the back. The claimant is also shown to stoop down with his knees bent, reach forward with his hands, then easily rise to his feet. The ALJ is persuaded that this video depicts the incident where the claimant and Ms. Sigdel stocked the cooler as described in the claimant's testimony. The ALJ is also persuaded that if the claimant had actually been experiencing severe pain, as he testified he was, he would not have been able to smoothly perform many of the actions shown in the video.

9. The claimant's testimony is further contradicted by the contents of video recordings that depict the claimant's activities on November 26, 2008 and December 2, 2008. These videos show the claimant performing work activities as a convenience store clerk for another employer. The ALJ observed no obvious signs or behaviors suggesting that the claimant was suffering from a painful low back injury. To the contrary, the claimant is seen bending, twisting, squatting, and reaching throughout the videos.

10. The medical records do not persuade the ALJ that the claimant actually sustained any injury on August 27, 2008. Although Dr. Tentori assessed the claimant with a lumbar strain and back pain, and treated the claimant accordingly, this diagnosis appears to be based largely on the claimant's history that he injured his back lifting a box on August 27, and the claimant's reports of ongoing symptoms. As set forth above, the claimant's report of accident is not credible, and neither are his reports of symptoms. Moreover, Dr. Tentori noted that the claimant's x-rays demonstrate an "old compression fracture," and the CT scan revealed the "presence of degenerative changes involving the patient's lumbar spine."

11. On October 29, 2009, Dr. Tentori noted that the claimant was in "no acute distress" but reported ongoing tenderness with palpation." Further, the claimant demonstrated very limited active range of motion. Dr. Tentori continued the diagnosis of a lumbar strain with back pain but also assessed "concern for delayed recovery." Dr. Tentori referred the claimant for a psychological evaluation.

12. The respondents presented the report and testimony of Dr. Henry J. Roth, M.D. In July 2009 Dr. Roth performed an IME at the respondents' request. Dr. Roth examined the claimant and reviewed medical records from the claimant's treatment, including the results of diagnostic studies. Dr. Roth noted that during his examination the claimant exhibited severe pain behaviors and could not cooperate. Dr. Roth noted the claimant reported pain from head to toe across anatomical and neurological boundaries. Dr. Roth also reviewed videos of the claimant performing work activities in November and December 2008. Dr. Roth found the claimant's level of activity on the videos to be distinctly different than his presentation at the time of the IME.

13. Dr. Roth credibly opined in his report of July 13, 2009, that there is no medically observed probable cause for the claimant's symptoms, and that there is no medically determined probable disorder. Dr. Roth also credibly testified that he is unable to say to a reasonable degree of medical probability that the claimant sustained any injury on August 27, 2008. Dr. Roth's opinions constitute persuasive evidence tending to establish that the claimant did not sustain any injury on August 27, 2008.

14. The claimant failed to prove it is more probably true than not that on August 27, 2008, he sustained an injury arising out of and in the course of his employment. Evidence and inferences inconsistent with these findings and conclusions are not found to be credible and persuasive.

CONCLUSIONS OF LAW

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

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

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

COMPENSABILITY

The claimant alleges that he sustained a low back injury on August 27, 2008, when he lifted a bag of soft drink syrup. The ALJ concludes the claimant failed to prove that he sustained the alleged injury.

The claimant must prove by a preponderance of the evidence that the alleged injury was proximately caused by an injury arising out of and in the course of his employment with the employer. Section 8-41-301(1)(b) & (c), C.R.S.*; see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). An injury occurs "in the course of" employment where the claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The "arising out of " element is narrower and requires claimant to show a causal connection between the employment and the injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *See Triad Painting Co. v. Blair*, *supra.* The question of whether the claimant met the burden of proof to establish a compensable injury is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

As determined in Finding of Fact 14, the claimant failed to prove it is more probably true than not that on August 27, 2008, he sustained a low back injury arising out of and in the course of his employment. As set forth, the ALJ finds the claimant's testimony that he sustained an injury on August 27 is not credible because it is contradicted by the credible testimony of witnesses Sigdel and Serafin, and by the August 27 video depicting the claimant stocking the cooler, and the subsequent videos showing the claimant performing various activities for other employer's after the alleged date of injury. Finally, the ALJ finds that Dr. Roth's credible testimony supports the conclusion the claimant did not sustain any low back injury on August 27, 2007.

Because the ALJ finds the claimant failed to prove that he sustained any work-related injury on August 27, 2008, the issues of medical benefits, temporary disability benefits, and termination for cause need not be addressed.

ORDER

IT IS THEREFORE ORDERED that the claim for workers' compensation benefits in W.C. No. 4-769-745 is DENIED and DISMISSED.

DATED: December 9, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-699-565

ISSUES

¬ Did claimant prove by a preponderance of the evidence that she is unable to earn wages such that she is entitled to permanent total disability benefits?

FINDINGS OF FACT

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

15. Employer manufactures photographic supplies. Claimant resides in Greeley; her age at the time of hearing was 54 years. Claimant sustained an admitted injury to her lower back on July 11, 2006, when she bent over to pick up a bucket of metal shavings.
16. Employer referred claimant Bruce Hutson, M.D., and Brian Thompson, M.D. Dr. Hutson first examined claimant on July 11, 2006, when she reported a past history of sciatica. Dr. Hutson diagnosed a low back strain, without radicular symptoms. Following his examination of her on July 14, 2006, Dr. Thompson referred claimant for physical therapy treatment.
17. Dr. Hutson referred claimant for a magnetic resonance imaging (MRI) scan of her lumbar spine on September 11, 2006. Dr. Hutson reviewed the MRI scan on September 12th and recommended a referral of claimant to Scott Parker, D.C., for chiropractic treatment.
18. Dr. Hutson referred claimant to Physiatrist Douglas Hemler, M.D., for a physical medicine and rehabilitation consultation on October 31, 2006. Dr. Hemler felt claimant's symptoms were consistent with a left-sided facet syndrome at the L4-5 and L5-S1 levels of her lumbar spine. On November 10, 2006, Dr. Hemler administered a left-sided epidural steroid injection (ESI) at those levels.
19. In follow-up with Dr. Thompson on November 14, 2006, claimant reported no improvement from the ESI four days earlier. Dr. Hemler recommended a core stabilization program, which claimant completed without reporting much improvement. After that, Dr. Hutson placed claimant at maximum medical improvement (MMI) in January of 2007.
20. Dr. Hutson referred claimant for a functional capacity evaluation, which she underwent at HealthSouth on February 5, 2007 (2007 FCE). Claimant demonstrated the capacity to lift up to fifteen pounds occasionally and twelve pounds frequently.
21. Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation. The division appointed Sander Orent, M.D., who examined claimant on July 25, 2007. Dr. Orent disagreed with Dr. Hutson's determination of MMI. Dr. Orent wrote:

> Although there are some very soft **signs of symptom magnification** in general, I think this patient is quite sincere, profoundly debilitated and is not at MMI.

(Emphasis added). Dr. Orent recommended a surgical consultation and electrodiagnostic nerve conduction/EMG testing before placing claimant at MMI. Dr. Orent further commented:

> Claimant's restrictions, in my opinion, would need to be even more profound given that she has worsened since [the 2007 FCE]. She basically could do sedentary work only with no lifting at all, she can barely get in and out of a chair right now, ambulation is minimal, she cannot climb stairs or operate a motor-vehicle by herself at this time.

22. On August 24, 2007, claimant returned to Dr. Thompson, who referred her for a surgical consult with Orthopedic Surgeon William D. Biggs, M.D. Dr. Briggs examined claimant on September 6, 2007. Dr. Briggs found it difficult to correlate claimant's MRI findings, showing mild degenerative changes, with her complaints. Dr. Briggs also noted claimant displayed mild symptom magnification. Dr. Briggs opined that surgery would not help claimant return to work. Dr. Briggs instead recommended claimant undergo a work-hardening program to improve her function so that she could return to work. Dr. Briggs also recommended a repeat MRI to compare with her earlier MRI in an effort to see whether claimant's complaints could be explained by interim changes in pathology.

23. On September 18, 2007, Dr. Hemler performed nerve conduction/EMG testing of claimant's lower extremities. The nerve conduction/EMG findings were normal, with no evidence of lumbar radiculopathy, plexopathy, or peripheral entrapment.

24. Dr. Briggs reevaluated claimant on November 27, 2007, after her repeat MRI study. Dr. Briggs noted that the repeat MRI failed to reveal any significant change in pathology. Dr. Briggs reported:

> I am having a hard time explaining all of her symptoms based on her MRI.
>
> ****
>
> I do not see anything that would be contributing to her leg pain aside from referred pain from one of the facet joints, but actually the facet joints look slightly worse on the opposite side.

Dr. Briggs continued to recommend against surgical intervention and instead recommended claimant undergo an evaluation by a physiatrist, like Dr. Hemler.

25. Dr. Thompson referred claimant to Neurosurgeon Hans C. Coester, M.D., for another surgical consultation on May 23, 2008. Claimant complained of back pain that she characterized as significantly worse than her leg pain. Dr. Coester reviewed the second MRI scan, but was unable to explain claimant's complaints of left lower extremity symptoms based upon pathology. Dr. Coester opined that claimant's back pain could be partially related to her degenerative disc disease and facet disease. Dr. Coester however opined that the benefits of any potential surgery would be greatly outweighed by the risks of the surgery.

26. While claimant appeared at her appointment using a cane, Dr. Coester had her put aside her cane, stand, and walk. Claimant told Dr. Coester that, while she enjoyed

vacationing in Las Vegas, she had a difficult time ambulating and needed the assistance of a wheelchair and sometimes a scooter. Dr. Coester noted:

> She is very interested in whether or not a scooter would help her with her daily living.

Dr. Coester strongly discouraged claimant from using a scooter. Dr. Coester explained to claimant that, using a scooter, she would experience progressive weakness, deterioration of her muscles, and de-conditioning over time, leading to a decrease in her level of health. Dr. Coester instead recommended that claimant begin a dedicated exercise program to maximize her strength and flexibility and to try to stay as close as she could to her ideal body weight. Dr. Coester recommended that claimant work on her gait, posture, and strengthening for pain management.

27. Dr. Orent wrote an addendum on December 17, 2008, determining that claimant had reached MMI. Dr. Orent noted that the nerve conduction/EMG study was negative, with no evidence of radiculopathy.

28. On February 4, 2009, employer filed a Final Admission of Liability, showing it had paid $19,824.26 in medical benefits, some $51,000 in temporary disability benefits, and some $61,000 in permanent partial disability benefits.

29. At employer's request, Physiatrist Nicholas K. Olsen, D.O., performed an independent medical examination of claimant on May 12, 2009. Dr. Olsen reviewed claimant's medical records, including past records dating back to 2001. Dr. Olsen testified as an expert in the following areas: Physical Medicine and Rehabilitation, electrodiagnostic testing, and as a Level II physician accredited by the Division of Workers' Compensation.

30. Dr. Olsen opined that claimant suffered a temporary aggravation of her preexisting back pain complaints when she injured herself on July 11, 2006. Dr. Olsen noted that, based upon the medical records, claimant's condition significantly improved by September 6, 2006, when Michael Bates, P.T., documented that her lumbar range of motion (ROM) was within 80 to 90% of normal. Claimant however attended a massage therapy treatment on her own and reported to Dr. Parker on September 27, 2006, that she experienced a significant aggravation of her symptoms. Dr. Olsen opined that claimant had sustained an intervening injury during that third week of September that markedly increased her symptoms and markedly decreased her lumbar ROM. Dr. Olsen supported his opinion with interval, lumbar ROM measurements throughout the medical records. Dr. Olsen opined that claimant reached MMI from her injury at employer by mid-September of 2006.

31. Upon examination, Dr. Olsen noted that claimant ambulated with the use of a cane in her left hand. Although claimant reported her that her functioning was quite limited, Dr. Olsen noted that the physical examination demonstrated no true objective signs. Dr. Olsen found signs that claimant was self-limiting her range of motion, and he found positive signs of symptom magnification. Dr. Olsen found no loss of focal strength in the lower extremities to suggest a specific radicular source. Dr. Olsen opined that claimant likely would benefit from continuing her home exercise program.

32. In his September 9, 2009, addendum report, Dr. Olsen noted that Dr. Coester found that claimant has a non-surgical back condition and that Dr. Coester recom-

mended she manage her condition with an exercise program. Dr. Olsen assigned permanent physical activity restrictions allowing claimant to lift up to twenty pounds on and occasional basis and ten pounds frequently. Dr. Olsen limited claimant's walking to one hour at a time before taking a ten-minute change of activity and sitting to one hour at a time before taking a five-minute change of activity.

33. Claimant underwent a second FCE with Pat McKenna, OTR, over the course of July 13-15, 2009 (2009 FCE). According to the results of the 2009 FCE, claimant is limited to lifting 5 pounds maximum; sitting on a rare basis from 45-60 minutes and optimum sitting time 15-20 minutes; static standing 3-5 minutes and walking 15-20 minutes.

34. Dr. Olsen opined that the 2007 FCE represented a more accurate assessment of claimant's actual physical capabilities. Dr. Olsen explained that the validity of an FCE depends upon the effort given by the subject. Absent documentation of vital signs during testing to compare the resting rate to the rate during testing, there is no way to determine whether the subject gave best effort. According to Dr. Olsen, the 2007 FCE followed standard practice of monitoring claimant's heart rate during lifting to test for effort. Dr. Olsen noted that the 2007 FCE documented an increase in blood pressure in the low 100s when claimant demonstrated lifting at 15 pounds. In contrast, Dr. Olsen noted that the 2009 FCE failed to monitor or document claimant's pulse or blood pressure. Dr. Olsen opined that the failure of the 2009 FCE to document claimant's heart rate undermines the validity of the conclusions and restrictions. Dr. Olsen explained that the 2007 FCE was more consistent with his findings because it balanced claimant's perceived abilities against objective evidence. The Judge credits Dr. Olsen's testimony here as persuasive.

35. Dr. Olsen also testified that claimant's perceived level of functioning is inconsistent with objective evidence of her condition. Dr. Olsen explained that claimant uses a cane in her left hand, which is inconsistent with her complaint of left-sided pain. Dr. Olsen noted that no medical evaluator has recommended a cane or a scooter and that claimant has sought those items herself to support her perspective that her disability is greater than her non-surgical back condition warrants. Dr. Olsen testified claimant's characterization of her functional activity is severely limited compared to other patients he has cared for with the same or similar conditions as claimant. Dr. Olsen's medical opinion here is amply supported by findings of various medical providers that claimant engaged in some degree of symptom magnification. The Judge credits Dr. Olsen's testimony here as persuasive.

36. The Judge credits Dr. Olsen's medical opinion in adopting, as reasonable, Dr. Olsen's permanent physical activity restrictions allowing claimant to lift up to twenty pounds on an occasional basis and up to ten pounds on a frequent basis. As found, several of claimant's treating or examining physicians have found evidence of symptom magnification. The Judge thus finds claimant's report of her symptoms, complaints, and disability unreliable and unpersuasive.

37. Claimant's highest level of education is as a high school graduate. Claimant has worked at a donut factory, at a sewing factory, as a cook, and as a server, waiting on tables. Claimant began working as a sales associate at Montgomery Wards in 1987. Claimant later worked in customer service, and then sales, at MCI. As a customer service representative at MCI, claimant spoke with customers and input information on the computer system, indicating whether the customer was staying with MCI. Claimant

worked for MCI in customer service until the company sent that work to a different MCI location. In 1992, claimant began working at employer initially as a finishing operator and then later as a punch press operator. At employer, claimant has been using a computer for some fifteen years since 1992, with the help of an instruction booklet. Claimant also trained other employees to use of the punch press.

38. Claimant uses a laptop computer at home to check her email. While claimant testified that she is unable to initiate emails on her computer, her testimony here lacked credibility. For instance, claimant explained that she is able to send text messages on her phone because her boyfriend showed her how to text. Yet claimant doubted whether she could ever learn to send an email, even with help from boyfriend. Considering the totality of the evidence, the Judge finds unpersuasive claimant's testimony that she lacks even basic computer skills to send a simple email. The Judge instead is persuaded that claimant possesses basic computer skills because she has demonstrated such skills both at her customer service position with MCI and again at her job with employer.

39. At claimant's request, John A. Macurak, M.A., performed a vocational assessment. At employer's request, Katie G. Montoya, M.S., performed a vocational assessment. Both Mr. Macurak and Ms. Montoya testified as experts.

40. Crediting Mr. Macurak's opinion, claimant's commutable labor market includes Greeley, where she resides, and the area within a 25-mile commute of Greeley. Mr. Macurak's vocational opinion is based upon restrictions that place claimant in the modified-sedentary work range. Mr. Macurak attached to his report several pages of jobs generated by a computer program named "LifeStep". Mr. Macurak stated that, while the sedentary positions attached to his report would be appropriate for claimant based upon those restrictions, those positions are unavailable to claimant in the relevant labor market. Mr. Macurak concluded:

> [I]t is my opinion that [claimant] will be unemployable as a result of her … work injury.
>
> ****
>
> Given her advanced age, lack of any continued formal educational background beyond her high school education, limited skills and extent of her physical limitations and working restrictions that have been assigned, [claimant] will not be capable of securing and maintaining gainful employment.

Mr. Macurak thus opined that claimant is unable to earn any wages as a result of her injury at employer.

41. Ms. Montoya interviewed claimant on May 8, 2009, when claimant stated that her activities were limited and that, when she goes to the grocery store, she uses a motorized cart. Ms. Montoya initially noted claimant's best option for employment would involve using her customer service and cashier skills.

42. Ms. Montoya updated her report on September 9, 2009, utilizing physical activity restrictions from Dr. Hutson, Dr. Thompson, and Dr. Olsen. Ms. Montoya conducted vo-

cational research based upon restrictions from Dr. Hutson and Dr. Thompson that placed claimant in the sedentary duty work classification. Ms. Montoya reviewed sedentary job titles such as interviewer, cashier, customer service, counter, and reception work. Dr. Olsen's restrictions increase claimant's access to jobs available to her within the light duty work classification. Ms. Montoya concluded that claimant is capable of employment in the relevant labor market.

43. Unlike Mr. Macurak, Ms. Montoya actually conducted research in the labor market for the job titles on the LifeStep list attached to Mr. Macurak's report. Ms. Montoya opined that claimant remains employable in positions involving customer service due to her work at MCI. Crediting Ms. Montoya's opinion, people typically retain customer service skills, which do not dissipate over time. Ms. Montoya identified an entry-level customer service position at Advance America, an entry-level clerical position at NES staffing, and another customer service position at Car Quest that are available within claimant's restrictions and vocational profile. Ms. Montoya noted that the categories of positions she researched and identified appear on the LifeStep list submitted by Mr. Macurak. Ms. Montoya actually conducted research to confirm the existence and availability of those positions that Mr. Macurak felt were appropriate for claimant but that he believed did not exist based upon information from LifeStep. The Judge thus credits the vocational opinion of Ms. Montoya as more persuasive than that of Mr. Macurak.

44. Claimant failed to show it more probably true than not that she is unable to earn any wages in the same or other employment. As found, several of claimant's treating and examining physicians found evidence of symptom magnification. The Judge found claimant's report of her symptoms, complaints, and disability alike unreliable and unpersuasive. The Judge credited the medical opinion of Dr. Olsen concerning reasonable physical activity and work restrictions. The Judge also credited the vocational opinion of Ms. Montoya in finding that there is work available to claimant within the sedentary and light-duty classifications that is within her commutable labor market and for which claimant retains skills to perform. The Judge thus found that employment exists that is reasonably available to claimant under her particular circumstances.

CONCLUSIONS OF LAW

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

Claimant argues she has proven by a preponderance of the evidence that she is unable to earn wages such that she is entitled to permanent total disability (PTD) benefits. The Judge disagrees that claimant sustained her burden of proof.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all

of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

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).

To prove her claim that she is permanently and totally disabled, claimant shoulders the burden of proving by a preponderance of the evidence that she is unable to earn any wages in the same or other employment. Sections 8-40-201(16.5)(a) and 8-43-201, C.R.S. (2003); *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). The term "any wages" means more than zero wages. *See Lobb v. Industrial Claim Appeals Office,* 948 P.2d 115 (Colo. App. 1997); *McKinney v. Industrial Claim Appeals Office,* 894 P.2d 42 (Colo. App. 1995). In weighing whether claimant is able to earn any wages, the Judge may consider various human factors, including claimant's physical condition, mental ability, age, employment history, education, and availability of work that the claimant could perform. *Weld County School Dist. Re-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). The critical test is whether employment exists that is reasonably available to claimant under his or her particular circumstances. *Weld County School Dist. Re-12 v. Bymer*, *supra*.

Here, the Judge found claimant failed to show it more probably true than not that she is unable to earn any wages in the same or other employment. Claimant thus failed to prove by a preponderance of the evidence that she is entitled to PTD benefits.

As found, several of claimant’s treating and examining physicians found evidence of symptom magnification. The Judge found claimant’s report of her symptoms, complaints, and disability alike unreliable and unpersuasive. The Judge credited the medical opinion of Dr. Olsen concerning reasonable physical activity and work restrictions. The Judge also credited the vocational opinion of Ms. Montoya in finding that there is work available to claimant within the sedentary and light-duty classifications that is within her commutable labor market and for which claimant retains skills to perform. The Judge thus found that employment exists that is reasonably available to claimant under her particular circumstances.

The Judge concludes claimant’s request for an award of PTD benefits should be denied and dismissed.

ORDER

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

1. Claimant's request for an award of PTD benefits is denied and dismissed.

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

DATED: _December 9, 2009_

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-795-247

ISSUES

Whether Claimant sustained a compensable injury in the nature of an occupational disease from exposures at work on April 8, 2009 and June 3, 2009.

Whether Claimant is entitled to an award of medical benefits and whether Dr. Ronald Swarsen, M.D. should be considered to be the authorized treating physician.

Whether Claimant is entitled to an award of temporary total disability benefits from June 4 through and including June 15, 2009.

At hearing, the parties stipulated that if the claim was found compensable Claimant's Average Weekly Wage should be determined to be $531.20.

FINDINGS OF FACT

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

1. Claimant was employed as a clerk for ServiceSource, a part of Employer's business. Claimant's job duties consisted of reviewing military records for accuracy and then scanning them for storage. Claimant previously served in the military in the Army Reserves for 15 years.

2. On April 8, 2009 Claimant was working in her cubicle and got up to go to the bathroom. While Claimant was in the bathroom a co-worker sprayed Claimant's work cubicle with Lysol disinfectant spray because Claimant had a cold. The co-worker had sprayed all parts of Claimant's work cubicle including the panels, floor and Claim-

ant's chair. When Claimant returned to her cubicle she began to have difficulty breathing and began coughing.

3. Claimant left work on April 8, 2009 and called her supervisor who directed her to seek medical care at HealthOne.

4. Claimant was evaluated at HealthOne on April 8, 2009 be Dr. Martin Kalevik, D.O. Dr. Kalevik diagnosed "inhalation/coughing" and kept Claimant off work until she returned for evaluation the next day. Dr. Kalevik recommended rest and fluids.

5. Dr. Kalevik again evaluated Claimant on April 9, 2009. Dr. Kalevik noted that Claimant was doing much better. Claimant presented with a little stiffness in her chest but without shortness of breath, headache or dizziness. On physical examination of Claimant's chest Dr. Kalevik noted that the chest was clear, with no wheezes, rales, or rhonchi. Claimant was not coughing. Dr. Kalevik released Claimant to return to her regular and full duty. Claimant returned to work at her usual job on April 10, 2009.

6. After being released to return to work Claimant continued to follow up with Dr. Kalevik. Following an evaluation of April 23, 2009 Dr. Kalevik placed Claimant at maximum medical improvement and discharged her from his care without permanent impairment.

7. Following the discharge from treatment from Dr. Kalevik, Claimant continued working her usual job for Employer. By June 3, 2009 Claimant's previous symptoms of coughing, shortness of breath and chest pain had cleared.

8. On June 3, 2009 Claimant was again working in her cubicle with her headset on when she alleges that she smelled something being sprayed and began to experience coughing and noted that her voice became high-pitched. Claimant testified, and it is found, that she does not know what was sprayed and does not know who was doing any spraying. Claimant asked to leave work and reported her condition to the Human Resources department of Employer.

9. On June 3, 2009 Claimant came to the Human Resources office of Employer stating, "someone was spraying". Claimant did not see anyone spraying or hear anything. Claimant described her injury to Human Resources as coughing, shortness of breath, a chemical taste on her tongue and stated that "someone was spraying something into the air." Claimant admitted in her testimony at hearing that she could not say that what she smelled on June 3, 2009 smelled like Lysol.

10. Claimant was evaluated by Dr. Kalevik at HealthOne on June 4, 2009. Claimant gave a history to the physician that she was not sure who sprayed what but she though she may have heard the spray while she had her headset on. Claimant could not tell the physician who sprayed this or what was sprayed and could not tell the physician what it smelled like. Dr. Kalevik noted the previous history of inhalation in April 2009 that had resolved without permanent impairment. Dr. Kalevik observed that Claimant was not coughing while she was filling out paperwork in his office but began

coughing once he began to interview her. On physical examination Dr. Kalevik noted Claimant's chest to be clear, without wheezes, rales, or rhonchi. Dr. Kalevik's assessment was: "By history, inhalation. Patient with cough. Exact source or cause unknown." Dr. Kalevik was not sure why Claimant was so sensitized and noted her exam was very benign. Dr. Kalevik advised Claimant to remain off work and prescribed medications.

11. Dr. Kalevik again evaluated Claimant on June 5, 2009 and noted her examination was very benign. Claimant stated to the physician that she was better, her cough was much less and she did not have shortness of breath or current chest pain. Dr. Kalevik noted that Claimant was already improving on her symptoms. Dr. Kalevik stated that he was not sure what Claimant was exposed to and that she was no sure either.

12. Claimant was evaluated at HealthOne on June 8, 2009 by Dr. Hiep Ritzer, M.D. Dr. Ritzer performed a chest X-ray with essentially normal reading. A pulmonary function test was done that showed mild restriction.

13. Claimant was evaluated at HealthOne on June 11, 2009 be Dr. Sharon O'Connor, M.D. On physical examination Dr. O'Connor found Claimant's breath sounds to be clear and equal. No wheezes, rales or rhonchi were present. Dr. O'Connor found no prolonged expiratory phase or wheezing even with forced expirations.

14. Dr. Ritzer evaluated Claimant on June 15, 2009 and released her to return to her regular work at that time.

15. Dr. Kalevik evaluated Claimant on June 18, 2009. Dr. Kalevik again noted that Claimant's physical examination was very benign. Dr. Kalevik was unclear on why Claimant continued to have symptoms of a cough and high-pitched voice.

16. Claimant was evaluated by Dr. Ronald Swarsen, M.D. on July 20, 2009. Dr. Swarsen obtained a history from Claimant, reviewed medical records from Claimant's prior treatment and performed a physical examination. Dr. Swarsen noted that Claimant presented with a negative exam. Dr. Swarsen opined that Claimant appeared to have sustained an aerosolization exposure to an irritative chemical from a spray disinfectant resulting in chemical bronchitis. Dr. Swarsen noted that Claimant now complained of being easily triggered by aerosolized chemicals but also noted an apparent fear element involved. Dr. Swarsen's assessment was: 1) Aerosol exposure (Lysol), 2) Episodic reactive airway disease related to aerosol exposure, and 3) Query psychological component to reactive airway disease.

17. Upon referral from HealthOne, Dr. Lawrence Repsher, M.D. performed an evaluation of Claimant on October 13, 2009. Dr. Repsher was qualified at hearing as an expert in pulmonary medicine and psychosomatic disease.

18. In connection with his evaluation Dr. Repsher reviewed the Material Safety Date Sheet for Lysol. Dr. Repsher opined, and it is found, that Lysol contains mostly denatured ethanol and ammonium solution. As opined by Dr. Repsher, Lysol does not

cause an allergic respiratory reaction as it does not contain any allergens. Dr. Repsher testified, and it is found, that Lysol can be an irritant if it is aspirated. Dr. Respher felt that Claimant's symptoms were indicative of a somatization disorder as there was no medical reason evident for her symptoms. Dr. Repsher noted the previous history of normal physical examinations.

19. Claimant has proven by a preponderance of the evidence that she was exposed to Lysol on April 8, 2009 and as a result sustained an irritant reaction that cause the need to seek medical care. This irritant reaction had cleared by June 3, 2009. The ALJ finds that this irritant reaction to Lysol did not sensitize or predispose the Claimant to further reactions to aerosolized chemicals. The ALJ finds Dr. Swarsen's assessment of reactive airways disease not to be credible or persuasive.

20. Claimant has failed to prove by a preponderance of the evidence that her symptoms on and after June 3, 2009, the subsequent medical care and disability from work were causally related to a hazard of her employment. Claimant has failed to prove that she was exposed to any hazard on June 3, 2009 as a condition of her employment with Employer.

CONCLUSIONS OF LAW

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

22. 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*.

23. 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).

24. 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).

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. An occupational disease is "a disease which results directly from the employment or 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 which the worker would have been equally exposed outside of the employment." Section 8-40-201(14), C.R.S.

27. A claimant is entitled to recovery for an occupational disease injury only if the hazards of employment cause, intensify or aggravate – to some degree – the disability for which compensation is sought. *Anderson v. Brinkhoff*, 839 P.2d 819, 824 (Colo. 1993). Where the disease for which a claimant is seeking compensation is produced solely by some extrinsic or independent cause, it is not compensable. *Id.* At 824. Further, where an occupational exposure is not a "necessary precondition" to the development of the disease, a claimant sustains an occupational disease only to the extent that the conditions of the employment contributed to the disability. *Id*. At 824; *Masdin v. Gardner-Denver-Cooper Indus.*, 689 P2d 714, 717 (Colo.App. 1984). The purpose of this rule "is to ensure that the disease results from the claimant's occupational exposure to hazards of the disease and not hazards which the claimant is equally exposed to outside of employment." *Saenz-Rico v. Yellow Freight System, Inc.*, W.C. No. 4-320-928 (January 20, 1998); *see also Stewart v. Dillon Co.*, W.C. No. 4-257-450 (November 20, 1996).

28. The claimant was required to prove by a preponderance of the evidence that the conditions for which he seeks medical treatment were proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(c), C.R.S. The claimant must prove a causal nexus between the claimed disability and the work-related injury. *Singleton v. Kenya Corp.,* 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990).

29. Section 8-41-301(1)(c), C.R.S., requires that an injury be "proximately caused by an injury or occupational disease arising out of and in the course of the em-

ployee's employment." Thus, the claimant is required to prove a direct causal relationship between the injury and the disability and need for treatment. However, the industrial injury need not be the sole cause of the disability if the injury is a significant, direct, and consequential factor in the disability. See *Subsequent Injury Fund v. Industrial Claim Appeals Office,* __P.3d__ (Colo. App. No. 05CA0278, February 9, 2006); *Joslins Dry Goods Co. v. Industrial Claim Appeals Office,* 21 P.3d 866 (Colo. App. 2001); *Seifried v. Industrial Commission,* 736 P.2d 1262 (Colo. App. 1986).

30. As found, Claimant has proven by a preponderance of the evidence that she sustained a compensable occupational disease on April 8, 2009 when she was exposed to Lysol that had been sprayed in her cubicle by a co-worker. Although not an allergen, Lysol is an irritant and Claimant's inhalation of the Lysol sprayed into her cubicle caused her to have a reaction resulting in coughing and shortness of breath. Claimant sought treatment and was treated for these symptoms by Dr. Kalevik. These symptoms then cleared and Claimant reached MMI as of April 23, 2009 and was discharged from care. There is no persuasive evidence that this irritant reaction was more than a temporary condition that cleared. There is likewise no persuasive evidence that this temporary irritant reaction caused Claimant to be sensitized to aerosolized chemicals or predisposed Claimant in the future to be sensitized to aerosol sprays.

31. As found, Claimant has failed to prove by a preponderance of the evidence that she was exposed to a hazard from the conditions of her employment on June 3, 2009. Claimant smelled "something" but doesn't know that anything was actually sprayed in or around her workspace and doesn't know what might have been sprayed. In the absence of more persuasive evidence the ALJ cannot determine that even if Claimant was exposed to "something" being sprayed in her workplace on June 3, 2009 that this "something" was a substance that can be seen as a hazard likely to cause the types of symptoms that Claimant complained of. The mere allegation of a reaction at work is not sufficient to show that Claimant was exposed to a particular hazard of the employment or that this hazard caused a disability or need for medical treatment. Claimant has failed to prove a causal nexus between her symptoms on and after June 3, 2009 and the conditions of her employment. Claimant has also failed to prove a causal connection or nexus between her symptoms on and after June 3, 2009 and the temporary effects of her irritant exposure to Lysol in April 2009. Both Dr. Swarsen and Dr. Respsher credibly opined that a psychological component or element of somatization disorder exists with respect to Claimant's complaints. As opined by Dr. Repsher, there is no medical explanation for Claimant's post-June 3, 2009 complaints given the normal physical examinations as evidenced by the reports of the treating physicians at HealthOne. Claimant has failed to prove that she sustained a compensable occupational disease on June 3, 2009 or that her symptoms after June 3, 2009 were causally related to her exposure to Lysol on April 8, 2009.

ORDER

It is therefore ordered that:

Claimant's claim for medical benefits for an occupational disease of April 8, 2009 is granted.

Insurer shall pay the medical expenses for Claimant's treatment with HealthOne from April 8 to and including April 23, 2009 in accordance with the Medical Fee Schedule of the Division of Workers' Compensation.

Any and all claims for compensation and medical benefits as a result of Claimant's alleged exposure on June 3, 2009, including Claimant's claim for medical expenses for the treatment by Dr. Swarsen and Claimant's claim for temporary total disability benefits for the period from June 4 to and including June 15, 2009, are denied and dismissed in their entirety.

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

All matters not determined herein are reserved for future determination.

DATED: December 9, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-703-500

ISSUES

The issues for determination are permanent partial disability benefits (schedule or whole person) and medical benefits after maximum medical improvement.

FINDINGS OF FACT

1. Claimant sustained an admitted injury to his right shoulder on September 14, 2006, while lifting and twisting a scaffold.

2. Claimant reported the injury to Employer. Concentra became the authorized treating provider. From Concentra, Claimant was referred to Dr. Jenkins, an orthopedic surgeon. Dr. Jenkins administered a series of shoulder injections and a repeat MRI. Surgery was recommended.

3. On April 12, 2007, Dr. Jenkins preformed a diagnostic arthroscopy, extensive labral debridement with synovectomy, subacromial decompression, and release of coraco-acromial ligament. Claimant's shoulder pain complaints continued after the surgery.

4. Claimant was referred to Dr. Weinstein for a second opinion. Dr. Weinstein diagnosed right upper extremity shoulder girdle myofascial pain. He recommended an independent exercise program.

5. On November 8, 2007, Dr. Hattam placed Claimant at MMI and assessed him with an impairment of 15% of the upper extremity, which converts to a 9% whole person impairment.

6. Respondents admitted permanent partial disability based on an impairment of 15% of the arm at the shoulder in the November 19, 2007, Final Admission of Liability. Claimant applied for hearing on the issue of converting the extremity rating to a whole person rating.

7. Stretching his arm above shoulder level and away from the body causes pain to Claimant's shoulder. Pain from Claimant's shoulder flows into his collarbone and across the shoulder blade towards the neck.

8. The situs of Claimants functional impairment is the shoulder and is not limited to the arm. Claimant has functional impairment proximal to the arm. Claimant's impairment is not limited to the schedule.

9. No authorized physician has recommended medical treatment after maximum medical improvement.

CONCLUSIONS OF LAW

When a claimant's injury is listed on the schedule of disabilities, the award for that injury is limited to a scheduled disability award. Section 8-42-107 (1)(a), CRS. In this context, "injury" refers to the situs of the functional impairment, meaning the part of the body that sustained the ultimate loss, and not necessarily the situs of the injury itself. *Sprauch v. PSL Swedish Healthcare Systems*, 917 P2d 366 (Colo. App. 1996). Whether a claimant suffered an impairment that can be fully compensated under the schedule of disabilities is a factual question for the ALJ. *Langston v. Rocky Mountain Healthcare Corp.* 937 P2d 883 (Colo.App. 1996).

Claimant testified as to pain in the shoulder area extending into the collarbone and across the shoulder blade. Medical records document complaints of pain in the shoulder. Claimant's functional impairment is to his shoulder, not to his arm. Claimant's impairment is not limited to the "loss of an arm at the shoulder." Section 8-42-107(2) (a), C.R.S. Claimant has established by a preponderance of the evidence that his impairment is not limited to the schedule of disabilities at Section 8-42-107(2), C.R.S. Claim-

ant's impairment must be calculated based on an impairment of 9% of the whole person. Section 8-42-107(8)(c) & (d), CRS.

Claimant has not shown substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve Claimant from the effects of the injury or to prevent further deterioration of his condition. *Grover v. Industrial Commission,* 759 P.2d 705 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo.App. 1995). Insurer is not liable for treatment after maximum medical improvement.

ORDER

It is therefore ordered that:

1. Insurer shall pay Claimant permanent partial disability benefits based on an impairment of 9% of the whole person. Insurer may credit any previous payment of permanent disability benefits. Insurer shall pay Claimant interest at the rate of 8% per annum on any benefits not paid when due.

2. Claimant's request for medical treatment after maximum medical improvement is denied.

DATED: *December 9, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-786-424

ISSUES

1. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to recover penalties because Respondents "unilaterally" filed an Amended Final Admission of Liability (FAL).

2. A review of the propriety of the DIME Panel selection process.

3. Whether Claimant has established by a preponderance of the evidence that he is entitled to recover penalties against employees of the Division of Workers' Compensation (DOWC) for proceeding with the selection of a DIME physician.

FINDINGS OF FACT

1. On November 26, 2008 Claimant suffered compensable industrial injuries. Respondents filed a FAL on March 11, 2009 acknowledging Claimant's injuries.

2. On March 24, 2009 the DOWC advised Insurer that the FAL was defective. The DOWC thus directed Insurer to file an Amended FAL.

3. Insurer responded to the DOWC in a March 26, 2009 letter and explained the basis for Temporary Total Disability (TTD) payments. On April 14, 2009 Insurer filed an Amended FAL in accord with the DOWC's request.

4. Claimant timely objected to both the March 11, 2009 FAL and the April 14, 2009 Amended FAL. He also filed a Notice and Proposal designating requested Division Independent Medical Examination (DIME) physicians.

5. The parties were unable to agree on a DIME physician. Respondents therefore filed a Notice of Failed IME Negotiation on April 21, 2009. On May 27, 2009 the DOWC DIME Unit sent the IME Physician Panel to the parties. Claimant did not strike any of the physicians from the Panel.

6. On June 4, 2009 Claimant filed an Application for Hearing and Notice to Set. Claimant requested penalties against "IME Unit, Lori Olmstead-Lessley, IME Supervisor, Rebecca Greben, Medical Services Delivery Manager, for knowingly proceeding with the selection of an IME physician in violation of the stay provisions of W.C.R.P. 11-3(N) and 11-10, in accordance with the long standing pattern and practice of such harassment and abuse of the undersigned and his clients." Claimant also challenged the propriety of the DIME selection process. He specifically challenged the "propriety of DIME panel selection and physician specialties, contrary to Claimant's DIME rights as expressed in *AFL-CIO v. Donlon* and *Whiteside v. Smith*, contrary to the Claimant's true treatment and diagnostic needs and extent of his occupational impairments." Claimant did not endorse any other issues on the Application for Hearing.

7. On June 5, 2009 Respondents filed a Motion to Strike Application for Hearing and subsequently struck one of the physicians from the Panel. On June 24, 2009 Administrative Law Judge (ALJ) Broniak issued an Order striking Claimant's Application for Hearing and concluding that the DIME procedure was no longer in abeyance. ALJ Broniak directed Claimant to strike one of the physicians from the IME Physician Panel and ordered that, if Claimant elected not to strike a physician, the DIME physician should be selected in accordance with W.C.R.P. 11-3(F).

8. On July 8, 2009 Claimant filed a second Application for Hearing. He listed issues identical to those enumerated in the June 4, 2009 Application.

9. On July 16, 2009 the DOWC IME Unit issued a DIME Physician Confirmation. Claimant did not subsequently schedule a DIME appointment with the designated physician.

10. Claimant has failed to establish that it is more probably true than not that he is entitled to recover penalties from Respondents for filing an Amended FAL. On March 24, 2009 the DOWC advised Insurer that the March 11, 2009 FAL was defective. The DOWC thus directed Insurer to file an Amended FAL. On April 14, 2009 Insurer complied with the DOWC's directive by filing an Amended FAL. Claimant has not produced sufficient evidence to support a determination that Respondents violated a provision of the Act or a Rule by filing the Amended FAL. Therefore, Claimant's request for penalties against Respondents is denied and dismissed.

11. By challenging the propriety of the DIME selection process, Claimant contends that the DOWC has failed to comply with § 8-42-107.2 and WCRP 11-3(c). Claimant's assertion does not constitute a dispute with an employer regarding a work-related injury, but instead involves a challenge to the DOWC's application of a relevant statute and corresponding Rule. Therefore, a determination of whether the DOWC has complied with §8-42-107.2, C.R.S. and WCRP 11-3(c) is not a matter "arising under" the Act. The ALJ thus lacks jurisdiction to consider Claimant's challenge to the propriety of the DIME selection process. Similarly, Claimant's request for penalties against employees of the DOWC for proceeding with the DIME selection process is also denied.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

Penalties against Respondents

4. Claimant requests penalties against Respondents for "unilaterally" filing an Amended FAL on April 14, 2009. He asserts that the filing of the Amended FAL violated §8-42-107.2 and the WCRP.

5. Section 8-42-107.2, C.R.S. addresses the procedures for selecting a DIME physician. Section 8-43-304(1), C.R.S. is a general penalty provision under the Act that authorizes the imposition of penalties up to $500 per day where a party violates a statute, rule, or lawful order of an ALJ. *Holliday v. Bestop, Inc.,* 23 P.3d 700, 705, 706 (Colo. 2001). The term "order" as used in §8-43-304 includes a rule or regulation promulgated by the Director of the DOWC. §8-40-201(15), C.R.S.; *see Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176, 177 (Colo. App. 2002).

6. The imposition of penalties under §8-43-304(1) requires a two-step analysis. *See In re Hailemichael,* W.C. No. 4-382-985 (ICAP Nov. 17, 2004). The ALJ must first determine whether the disputed conduct violated a provision of the Act or a Rule. *Allison v. Industrial Claim Appeals Office,* 916 P.2d 623, 624 (Colo. App. 1995). If a violation has occurred, penalties may only be imposed if the ALJ concludes that the violation was objectively unreasonable. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office,* 907 P.2d 676, 678-79 (Colo. App. 1995). The reasonableness of an insurer's actions depends upon whether the action was predicated on a "rational argument based on law or fact." *In re Lamutt,* W.C. No. 4-282-825 (ICAP, Nov. 6, 1998).

7. As found, Claimant has failed to establish by a preponderance of the evidence that he is entitled to recover penalties from Respondents for filing an Amended FAL. On March 24, 2009 the DOWC advised Insurer that the March 11, 2009 FAL was defective. The DOWC thus directed Insurer to file an Amended FAL. On April 14, 2009 Insurer complied with the DOWC's directive by filing an Amended FAL. Claimant has not produced sufficient evidence to support a determination that Respondents violated a provision of the Act or a Rule by filing the Amended FAL. Therefore, Claimant's request for penalties against Respondents is denied and dismissed.

Propriety of DIME Selection Process

8. Claimant challenges the propriety of the DIME selection process and requests penalties against employees of the DOWC for proceeding with the selection of a DIME physician. Section 8-42-107.2, C.R.S. addresses the procedures for selecting a DIME physician. Section 8-42-107.2(3)(a), provides, in relevant part, that if the parties are unable to agree on a DIME physician, written notice shall be provided to the DOWC. Within 10 days after receiving written notice the DOWC shall "select three physicians by a revolving selection process" from a list of physicians maintained by the DOWC. The selection of a DIME physician must be based on various factors including fields of specialization.

9. The DOWC has promulgated Rules that address the DIME selection process. WCRP 11-3(c) states that the DOWC will use a revolving selection process to cre-

ate a panel of three physicians qualified to perform the DIME. In creating the panel the DOWC "shall consider to the extent possible" the criteria identified in the application for a DIME. The DOWC will then correlate the body parts or medical conditions on the DIME application with the appropriate medical treatment guideline. The panel will be composed of physicians based on their accreditation to perform impairment ratings on the body parts or medical conditions designated by the requesting party in the DIME application.

10. Section 8-43-201, C.R.S. provides, in relevant part, that the Director and ALJ's "shall have original jurisdiction to hear and decide all matters arising under" the Act. The Act "embodies a comprehensive scheme for compensation to employees of participating employers for job-related injuries." *Kandt v. Evans*, 645 P.2d 1300, 1302 (Colo. 1982). Under the Act the employer assumes liability for work-related injuries, regardless of fault, and in return, employees are precluded from bringing common law actions against employers. *Id.*; *MGM Supply Co. v. ICAO*, 62 P.3d 1001, 1004 (Colo. App. 2002). The Act thus addresses disputes between employers and employees involving work-related injuries.

11. As found, by challenging the propriety of the DIME selection process, Claimant contends that the DOWC has failed to comply with § 8-42-107.2 and WCRP 11-3(c). Claimant's assertion does not constitute a dispute with an employer regarding a work-related injury, but instead involves a challenge to the DOWC's application of a relevant statute and corresponding Rule. Therefore, a determination of whether the DOWC has complied with §8-42-107.2, C.R.S. and WCRP 11-3(c) is not a matter "arising under" the Act. The ALJ thus lacks jurisdiction to consider Claimant's challenge to the propriety of the DIME selection process. Similarly, Claimant's request for penalties against employees of the DOWC for proceeding with the DIME selection process is also denied.

ORDER

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

1. Claimant's request for penalties against Respondents is denied and dismissed.

2. Claimant's request to determine the propriety of the DIME selection process is denied and dismissed.

3. Claimant's request for penalties against employees of the DOWC is denied and dismissed.

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

DATED: December 9, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-743-716

ISSUES

¬ Did claimant prove by a preponderance of the evidence that she is entitled to temporary total disability (TTD) benefits from August 28, 2008, through April 15, 2009?

FINDINGS OF FACT

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

45. Employer operates a chain of grocery stores. Claimant worked for employer for some 4.5 years as a delivery truck driver, shopping for groceries and delivering them to customers. Claimant sustained an admitted injury to her left foot on October 23, 2007, when she stepped out of employer's van and experienced a sudden onset of pain in the medial ball of her foot.

46. Employer referred claimant to John P. Mars, M.D. Claimant has a preexisting, non-work-related hallux abductor valgus deformity (bunion) on her left foot. Dr. Mars diagnosed a left foot contusion and imposed physical activity restrictions.

47. Dr. Mars placed claimant's left foot in a cam boot. Dr. Mars referred claimant for physical therapy treatment. Claimant underwent some 20 such treatments between November 13, 2007, and June 16, 2008.

48. Dr. Mars referred claimant for a bone scan study of her left foot on January 16, 2008, that showed no evidence of sesamoiditis (a bony inflammatory condition). Claimant underwent a cortisone injection that provided temporary, moderate-to-good results.

49. Dr. Mars referred claimant for acupuncture treatments, orthotic therapy, and activity modification. Claimant continued to complain of pain in the great toe and arch of her left foot.

50. At employer's request, Orthopedic Surgeon Jorge O. Klajnbart, D.O., performed an independent medical examination of claimant on July 26, 2008. Dr. Klajnbart opined that claimant temporarily aggravated her bunion when she stepped out of the van. Dr. Klajnbart believes claimant's injury was a soft-tissue injury. Based upon the normal bone scan study of January 16, 2008, Dr. Klajnbart opined that claimant should have reached maximum medical improvement (MMI) within 4 to 6 months. Regarding additional treatment, Dr. Klajnbart wrote:

> I would have [claimant] on an at-home, self-directed therapeutic program, to include ice, stretching, and orthotics.

Dr. Klajnbart also recommended a magnetic resonance imaging (MRI) scan of claimant's foot to evaluate her for a soft-tissue injury.

51. On August 28, 2008, Dr. Mars placed claimant at MMI. Claimant continued to report pain in the left great toe that would increase after walking for 15 minutes. Dr. Mars imposed permanent work restrictions of no lifting or carrying over 20 pounds and limiting walking to 15 minutes out of every 30.

52. On her own, claimant sought an evaluation by Orthopedic Surgeon Peter D. Wood, M.D., on September 3, 2008. On physical examination, Dr. Wood found that claimant had tenderness directly over the medial sesamoid of her great toe at the tarsal head, with palpable grating causing discomfort. Dr. Wood recommended a repeat bone scan with instructions for claimant to walk after the injection to infuse the injectate into the area of the medial sesamoid. Claimant underwent the repeat bone scan on September 10th.

53. Dr. Wood reevaluated claimant on September 16, 2008. Dr. Wood noted that the repeat bone scan showed an increased uptake in the area of the medial sesamoid bone, indicating probable sesamoiditis. Dr. Wood recommended surgical excision of the medial sesamoid of claimant's left great toe.

54. Claimant returned to Dr. Mars for an evaluation on October 16, 2008. Dr. Mars reviewed Dr. Wood's records and the bone scan; he reported:

> I reviewed … the new bone scan and it appears to light up now at the sesamoid. The old bone scan did not light up at the sesamoid.

Based upon new evidence from the repeat bone scan, Dr. Mars diagnosed sesamoiditis and determined claimant no longer at MMI. Dr. Mars reported:

> I feel [claimant] is no longer at MMI and that removing the sesamoid bone is now indicated, as the bone scan is positive now.

Dr. Mars continued to impose the same work restrictions, which prevent claimant from performing her regular work at employer. Dr. Mars also referred claimant back to Dr. Wood for surgical treatment.

55. Crediting her testimony, employer eventually approved the surgery recommended by Dr. Wood, which she underwent on April 16, 2009. The condition of claimant's left foot remained the same from the time Dr. Mars placed her at MMI on August 28, 2008, until the time of surgery on April 16th. Claimant had no other injury to her left foot during that interval of time. Claimant earned some $1,500 while working as a bell-ringer for the Salvation Army during the Christmas season of 2008.

56. On April 27, 2009, employer filed a General Admission of Liability (GAL), admitting liability for TTD benefits from April 16, 2009, ongoing. The GAL reflects that employer paid claimant TTD benefits from November 6, 2007, through August 25, 2008, when Dr. Mars placed claimant at MMI.

57. Claimant showed it more probably true than not that Dr. Mars mistakenly placed her at MMI on August 28, 2008. Dr. Mars placed claimant at MMI in August and then determined that she was no longer at MMI less than 2 months later as of October 16, 2008. During that period of time, claimant's left foot symptoms and pain remained the same. As of August 28th, Dr. Mars had not diagnosed sesamoiditis based upon the negative bone scan study in January of 2008. Dr. Mars however changed his diagnoses to include sesamoiditis after Dr. Wood ordered a repeat bone scan. The repeat bone scan had positive indications of sesamoiditis because it was conducted under special instructions from Dr. Wood about the injectate. This indicates it more probably true that the January bone scan failed to detect the underlying sesamoiditis that was present in January of 2008. Dr. Mars thus mistakenly placed claimant at MMI in August because the January bone scan failed to detect claimant's condition. The Judge finds it more probably true that claimant had not reached MMI as of August 28, 2008.

58. Claimant showed it more probably true than not that her injury at employer proximately caused her wage loss between August 28, 2008, and April 15, 2009. As found, Dr. Mars mistakenly placed claimant at MMI on August 28, 2008. As of the time of hearing, there was no persuasive evidence otherwise showing that claimant has reached MMI. Dr. Mars continued to impose work restrictions between August 28, 2008, and April 15, 2009, that preclude claimant from performing her regular work at employer.

CONCLUSIONS OF LAW

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

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

A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

A. MMI Discussion:

Claimant contends Dr. Mars mistakenly placed her at MMI as of August 28, 2008. The Judge agrees.

The ALJ may not resolve a dispute regarding MMI determinations between conflicting authorized treating physicians. *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002). However, the court, in *Blue Mesa Forest v. Lopez*, 928 P.2d 831 (Colo. App. 1996), permitted the ALJ to resolve an internal conflict in MMI determinations by the authorized treating physician.

Here, the Judge found claimant showed it more probably true than not that Dr. Mars mistakenly placed her at MMI on August 28, 2008, and that she had not reached MMI as of that date.

The Judge resolved an internal conflict in the opinion of Dr. Mars concerning MMI. As found, Dr. Mars placed claimant at MMI in August and then determined that she was no longer at MMI less than 2 months later. During that period of time, claimant's left foot symptoms and pain remained the same. As of August 28th, Dr. Mars had not diagnosed sesamoiditis based upon the negative bone scan study in January of 2008. Dr. Mars however changed his diagnoses to include sesamoiditis after Dr. Wood ordered a repeat bone scan. The repeat bone scan had positive indications of sesamoiditis because it was conducted under special instructions from Dr. Wood about the injectate. This indicates it more probably true that the January bone scan failed to detect the underlying sesamoiditis that was present in January of 2008. Dr. Mars thus mistakenly placed claimant at MMI in August because the January bone scan failed to detect claimant's condition.

The Judge concludes that, based upon the totality of the evidence, claimant has not reached MMI as of the time of hearing in this matter.

B. TTD Benefits:

Claimant argues she has proven by a preponderance of the evidence that she is entitled to TTD benefits from August 28, 2008, through April 15, 2009. The Judge agrees.

To prove entitlement to TTD benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), *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 her 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 her regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998).

As found by the Judge, claimant showed it more probably true than not that her injury at employer proximately caused her wage loss between August 28, 2008, and April 15, 2009. Claimant thus proved by a preponderance of the evidence that she is entitled to TTD benefits from August 28, 2008, through April 15, 2009.

As found, Dr. Mars mistakenly placed claimant at MMI on August 28, 2008. As of the time of hearing, there was no persuasive evidence otherwise showing that claimant has reached MMI. Dr. Mars continued to impose work restrictions between August 28, 2008, and April 15, 2009, that preclude claimant from performing her regular work at employer.

The Judge concludes that employer should pay claimant TTD benefits from August 28, 2008, through April 15, 2009.

ORDER

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

1. Employer shall claimant TTD benefits from August 28, 2008, through April 15, 2009.

2. Employer may offset claimant's earnings at the Salvation Army against its liability for TTD benefits.

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

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

DATED: __December 10, 2009__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-711-862

ISSUE

Whether Claimant has established by a preponderance of the evidence that his 6% right upper extremity impairment rating should be converted to a 4% whole person impairment rating.

FINDINGS OF FACT

1. On January 6, 2007 Claimant suffered an industrial injury to his right shoulder area during the course and scope of his employment with Employer. He slipped and fell on his right side while spreading salt on a sidewalk and parking area. Claimant required a right rotator cuff surgical repair as a result of the injury.

2. On August 22, 2007 Claimant reached Maximum Medical Improvement (MMI) for his industrial injury and received a 6% upper extremity impairment rating. Because Claimant continued to experience pain and discomfort in his shoulder area Respondents voluntary reopened the claim in May 2008.

3. On July 28, 2008 Claimant underwent a repeat right rotator cuff repair. On February 25, 2009 Authorized Treating Physician (ATP) Clement J. Hanson, D.O. determined that Claimant had again reached MMI and assigned him a 6% right upper extremity impairment rating for range of motion deficits. The 6% upper extremity impairment rating converted to a 4% whole person impairment.

4. On March 24, 2009 Respondents acknowledged Claimant's 6% right upper extremity impairment rating and filed a Final Admission of Liability (FAL). Respondents subsequently filed another FAL on July 9, 2009 that awarded Claimant medical maintenance benefits for his right shoulder condition.

5. On July 22, 2009 Claimant visited John J. Aschberger, M.D. for medical maintenance treatment. Dr. Aschberger recounted that he had evaluated Claimant on January 13, 2009 and determined that Claimant suffered from "chronic irritation in the right parascapular area following shoulder surgeries." He noted that Claimant had exhibited trigger points and thus recommended "trigger point injections with followup deep tissue release." Dr. Aschberger noted that Claimant continued to report "persistent irritation well localized at the right parascapular region." Claimant also continued to experience numbness in the fourth and fifth fingers when he leaned back and applied pressure on the scapular area. Dr. Aschberger concluded that Claimant exhibited "persistent myofacial pain at the right parascapular area" and that the symptoms were consistent with previous abnormalities and local irritation. He remarked that Claimant had well-established trigger points and recommended repeat trigger point injections with "more extensive deep tissue release and massage to the affected area."

6. Claimant credibly testified at the hearing in this matter that he suffers functional impairment to the right shoulder area. He explained that he restricts the motion of his right arm because of the pain in his right scapular area that shoots down his right shoulder. Claimant also commented that he has trouble lifting objects to waist height because he experiences pain in the right scapular area.

7. Based on the credible testimony of Claimant and the report of Dr. Aschberger, Claimant experiences pain and discomfort that limits his ability to perform various functions with his right shoulder. Dr. Aschberger reported that Claimant continued to experience "persistent irritation well localized at the right parascapular region." Claimant also exhibited numbness in the fourth and fifth fingers when he applied pressure to the scapular area. Dr. Aschberger noted that Claimant's symptoms were consistent with previous abnormalities and local irritation. Claimant credibly testified that he restricts the motion of his right arm because of the pain in his right scapular area that shoots down his right shoulder. Claimant also noted that he has trouble lifting objects to waist height because he experiences pain in the right scapular area. He has thus produced substantial evidence that he suffers functional impairment proximal to, or above, the arm at the shoulder as a result of his January 6, 2007 industrial injury.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. Section 8-42-107(1)(a), C.R.S. limits medical impairment benefits to those provided in §8-42-107(2), C.R.S. when a claimant's injury is one enumerated in the schedule of impairments. The schedule includes the loss of the "arm at the shoulder." See §8-42-107(2)(a), C.R.S. However, the "shoulder" is not listed in the schedule of impairments. *See Maree v. Jefferson County Sheriff's Department*, W.C. No. 4-260-536 (ICAP, Aug. 6, 1998); *Bolin v. Wacholtz*, W.C. No. 4-240-315 (ICAP, June 11, 1998).

5. When an injury results in a permanent medical impairment not set forth on the schedule of impairments, an employee is entitled to medical impairment benefits paid as a whole person. *See* §8-42-107(8)(c), C.R.S.

6. Because §8-42-107(2)(a), C.R.S., does not define a "shoulder" injury, the dispositive issue is whether a claimant has sustained a functional impairment to a portion of the body listed on the schedule of impairments. *See Strauch v. PSL Swedish Healthcare*, 917 P.2d 366, 368 (Colo. App. 1996). Whether a claimant has suffered the loss of an arm at the shoulder under §8-42-107(2)(a), C.R.S., or a whole person medical impairment compensable under §8-42-107(8)(c), C.R.S., is determined on a case-by-case basis. *See DeLaney v. Industrial Claim Appeals Office*, 30 P.3d 691, 693 (Colo. App. 2000).

7. The Judge must thus determine the situs of a claimant's "functional impairment." *Velasquez v. UPS,* W.C. No. 4-573-459 (ICAP Apr. 13, 2006). The situs of the functional impairment is not necessarily the site of the injury. *Id.* Pain and discomfort that limit a claimant's ability to use a portion of the body is considered functional impairment for purposes of determining whether an injury is off the schedule of impairments. *Eidy v. Pioneer Freightways*, W.C. No. 4-291-940 (ICAP, Aug. 4, 1998).

8. As found, based on the credible testimony of Claimant and the report of Dr. Aschberger, Claimant experiences pain and discomfort that limits his ability to perform various functions with his right shoulder. Dr. Aschberger reported that Claimant continued to experience "persistent irritation well localized at the right parascapular region." Claimant also exhibited numbness in the fourth and fifth fingers when he applied pressure to the scapular area. Dr. Aschberger noted that Claimant's symptoms were consistent with previous abnormalities and local irritation. Claimant credibly testified that he restricts the motion of his right arm because of the pain in his right scapular area that shoots down his right shoulder. Claimant also noted that he has trouble lifting objects to waist height because he experiences pain in the right scapular area. He has thus produced substantial evidence that he suffers functional impairment proximal to, or above, the arm at the shoulder as a result of his January 6, 2007 industrial injury.

ORDER

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

1. Claimant has sustained a 4% whole person impairment rating as a result of his January 6, 2007 industrial injury. Respondents' payments to Claimant shall be calculated based on the formula in §8-42-107(8), C.R.S.

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

3. All issues not resolved by this Order are reserved for future determination.

DATED: December 10, 2009.

Peter J. Cannici

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-784-196

ISSUES

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

FINDINGS OF FACT

1. Prior to January 9, 2009, Claimant suffered from left shoulder, neck and low back conditions. Claimant, as a member of the boilermakers union, was employed by numerous employers in the area of heavy industrial labor. In 1987, Claimant sustained a previous work injury to his left shoulder, neck, and upper back when he was struck by a ladder. As a result of these injuries, Claimant was on social security disability insurance ("SSDI") benefits from approximately January 1988 through 2007.

2. In 1996, claimant underwent a T11-T12 fusion surgery. On April 18, 2007, Dr. Choi performed a C5-C7 two level fusion surgery. The 2007 cervical fusion was successful. On July 17, 2007, Dr. Choi reexamined claimant and noted that he was "improving." Dr. Choi released claimant to return to full activity without restrictions.

3. In September 2007, claimant rejoined the boilermakers union and resumed his employment in heavy industrial labor. Claimant worked several jobs for various employers in Colorado and Wyoming.

4. On February 18, 2008, claimant returned to his personal physician, Dr. Robertson, complaining of dizziness when he turned his head. Claimant continued to suffer left shoulder symptoms since 1987. On March 25, 2008, Dr. Greenhow examined claimant and ordered a magnetic resonance image ("MRI"). The March 31, 2008, MRI showed a biceps tendon tear. Dr. Greenhow recommended surgery for the biceps tendon tear, but claimant deferred surgery because he did not want to lose wages.

5. In June 2008, claimant began work for the Employer in a heavy industrial labor job as a boilermaker.

6. On July 15, 2008, claimant sought treatment from Dr. Knight due to low back pain and radicular symptoms. Dr. Knight ordered an MRI, which showed moderate left and mild right foraminal stenosis at L5-S1 with a moderate sized disk bulge. Dr. Knight administered an epidural steroid injection and prescribed Soma.

7. In October 2008, claimant experienced cardiac problems and underwent angioplasty.

8. On an unknown date, claimant returned to his regular work as a boilermaker for the Employer. This position required a significant amount of heavy lifting and labor. From the time Claimant was hired by the Employer until January 9, 2009, he was able to perform all job duties on a full-time basis without incident or injury.

9. On January 9, 2009, Claimant assisted several other employees to lift a large piece of steel into place using a hoist. Due to a large amount of work going on in the area, numerous air hoses and extension cords were strung out along the ground. Claimant was lightly holding on to a tag line guiding the piece of steel into place when his feet became tangled in some of the air hoses on the ground. Claimant lost his balance and fell to the ground with his feet pinned. Given Claimant's light grip on the tag line, the line slipped through his hands and Claimant fell with full force on his left side. As a result of the fall, Claimant suffered significant injuries to his left shoulder, neck, and low back.

10. On February 13, 2009, claimant reported the injury to his employer and was promptly referred to Dr. Michael Dallenbach. On January 14, 2009, Dr. Dallenbach examined claimant, who reported the history of the work injury with chief complaints of left shoulder, neck and back pain. Claimant extensively described his pre-existing medical conditions relevant to the injured body parts. Dr. Dallenbach noted claimant's history and detailed the existence of the pre-existing conditions. Dr. Dallenbach also performed a physical examination. Dr. Dallenbach concluded that claimant suffered an acute exacerbation of his left shoulder, neck, and low back conditions. Dr. Dallenbach excused claimant from work as a result of the work-related injuries.

11. On February 18, 2009, the insurer filed a general admission of liability ("GAL") for medical benefits and TTD benefits commencing January 16, 2009.

12. On February 24, 2009, Dr. Greenhow examined claimant and recommended an MR arthrogram ("MRA"). The May 8, 2009, MRA showed no changes in the left shoulder.

13. On March 9, 2009, a lumbar MRI showed a disc bulge at L5-S1 with left S1 nerve root impingement. A March 10, 2009, cervical MRI showed the fusion, but no other abnormalities.

14. On April 30, 2009, Dr. Choi administered epidural steroid injections in the cervical spine.

15. On May 26, 2009, the insurer filed an amended GAL to assert an SSDI offset.

16. On June 2, 2009, Dr. Greenhow noted that claimant had a flareup of biceps tendinopathy, for which he recommended arthroscopy.

17. On July 9, 2009, the insurer filed another amended GAL to assert an overpayment.

18. Claimant has continued to obtain treatment from Dr. Dallenbach. On July 7, 2009, Dr. Dallenbach noted that claimant had no change of condition, was still not released to return to work, and was not at maximum medical improvement ("MMI").

19. On August 5, 2009, Dr. Michael Striplin performed an independent medical examination ("IME") for respondents. He concluded that claimant's mechanism of injury would make it medically improbable for serious injury to occur. He concluded that claimant's left shoulder, neck, and low back symptoms preexisted the work injury and that claimant suffered no new injury at work.

20. Dr. Striplin testified at hearing consistently with his IME report. He noted that claimant suffered no new symptoms, but suffered only worsened symptoms that had preexisted. He agreed that such worsened symptoms were possible even without MRI evidence of changes. He concluded that the "majority" of claimant's treatment after the work injury was due to his preexisting conditions. He noted that he disagreed with Dr. Choi's release of claimant to return to work without restrictions and he agreed that claimant was unable to return to work now.

21. Dr. Dallenbach testified at hearing and noted that he diagnosed acute exacerbation of neck, left shoulder, and low back pain. He noted that he had never been provided with copies of claimant's preexisting medical records, even though he had asked for them. He agreed that these medical records would be useful to help determine when claimant had returned to his pre-work injury baseline condition. He noted, however, that claimant had been able to work full time and full duty as a boilermaker before his injury and that was his baseline condition. He agreed with Dr. Striplin that claimant should not have been released to return to such full-duty work because of the risk of new injury, which is precisely what happened.

22. Claimant has proven by a preponderance of the evidence that he suffered an accidental injury to his neck, left shoulder, and low back arising out of and in the course of his employment on January 9, 2009. Claimant clearly fell on the date of injury. He clearly had longstanding neck, left shoulder, and low back problems. He promptly reported his injury and gave a consistent history to Dr. Dallenbach of increased symptoms. Dr. Dallenbach, unfortunately, never had the opportunity to review the preexisting medical records. Nevertheless, Dr. Dallenbach's opinions are credible and persuasive that claimant suffered an acute exacerbation of his preexisting neck, left shoulder, and low back pain. Claimant's ability to return to full duty work as a boilermaker af-

ter July 2007, in spite of his April 18, 2007, two-level cervical fusion, is indicative that his baseline condition permitted considerable functionality. Dr. Striplin and Dr. Dallenbach are persuasive that claimant should not have been released to return to such full duty work. The risk is that he would suffer additional injury, which is precisely what happened in this case.

23. The insurer has failed to demonstrate by a preponderance of the evidence that all future treatment and all TTD benefits should be terminated with the date of this order. Claimant clearly is totally disabled from his work as a boilermaker due to the effects of his work injury. Dr. Dallenbach and his referrals have not determined that claimant is at MMI for the work injury so that he needs no additional medical care for the work injury.

CONCLUSIONS OF LAW

1. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence even if the insurer has previously admitted liability in the claim. *Pacesetter Corp. v. Collett, supra*. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). As found, claimant has proven by a preponderance of the evidence that he suffered an accidental injury to his neck, left shoulder, and low back arising out of and in the course of his employment on January 9, 2009.

2. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). As found, the insurer has failed to demonstrate that all future medical treatment should be terminated with the date of this order. Dr. Dallenbach and his referrals have not determined that claimant is at MMI for the work injury so that he needs no additional medical care for the work injury.

3. As found, claimant is temporarily totally disabled from his usual work as a boilermaker due to the effects of his work injury. Consequently, claimant is "disabled" within the meaning of section 8-42-105, C.R.S. and is entitled to TTD benefits. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999); *Hendricks v. Keebler Company*, W.C. No. 4-373-392 (Industrial Claim Appeals Office, June 11, 1999). Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused claimant to leave work, and claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Respondents have failed to prove by a preponderance of the evidence that any of the terminating events exists in this claim.

ORDER

It is therefore ordered that:

1. The insurer's request to terminate all medical treatment and all TTD benefits as of the date of this order is denied and dismissed.

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

DATED: December 15, 2009 Martin D. Stuber Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-781-380

ISSUES

The issues for determination were compensability, medical benefits, and temporary total disability benefits for December 27, 2008, and from January 3, 2009 to January 16, 2009. The parties stipulated to an average weekly wage of $275.76. Issues not determined by this order are reserved.

FINDINGS OF FACT

1. Claimant suffers from allergies and asthma. These pre-existing conditions make her susceptible to fumes from paint and glue.
2. Claimant appeared for work on Friday, December 26, 2008. When she arrived, she walked through the reception area. The reception area was being repainted and the desk was being resurfaced. There were pain and glue fumes. Claimant told Employer of her susceptibility to these types of fumes. Claimant's badge was recoded so that she could to access her work area through the back door. This lessened Claimant's exposure to the fumes in the reception area.

3. Claimant could see the door from her cubital. Claimant continued to be exposed to some of the fumes from the work going on in the reception area. Claimant developed a sinus infection. She was unable to work on December 27, 2008, due to that infection.
4. Claimant returned to work and worked on December 29, 2008, through December 31, 2008. She was exposed to fumes at work.
5. Claimant began work on her next scheduled day, January 3, 2009. Claimant was exposed to fumes. Claimant's symptoms increased. In the afternoon of January 3, 2009, Claimant sought emergency care at the Sterling Regional MedCenter Emergency Department for sinus pressure and headache. X-rays were taken. Claimant was prescribed a nasal spray. Claimant was directed to OccuMed for follow up. She was released to full duty on January 4, 2009.
6. Claimant followed up with Adam Mackintosh, D.O. with OccuMed on January 5, 2008. Claimant complained of sinus and upper respiratory type symptoms. Dr. Mackintosh's assessment was "upper respiratory infection with apparent trigger secondary to chemical fumes." A Z-Pack and Allegra was prescribed. Claimant was released to return to work on January 7, 2009, with the restrictions that she avoid noxious fumes. Claimant did not return to work as she would have been exposed to fumes.
7. Claimant was examined and treated again by Dr. Macintosh on January 7, 2009. He noted that Claimant had a cough and an URI. He stated, "Suspect this may be due to an exacerbation of her underlying asthma with the history of chemical exposure." Dr. Macintosh again restricted Claimant from noxious fumes. He stated that Claimant could return to work on January 12, 2009, with that restriction.
8. Claimant attempted to return to work on January 12, 2009. Employer directed her to have her physician complete a Return to Work/Status report. Claimant left work and took the form to Dr. Macintosh. Dr. Macintosh completed the form on January 12, 2009. On that form he stated that he last examined Claimant on January 7, 2009. He stated that Claimant was fully recovered with no residual disability.
9. Claimant returned the form to her Employer. Claimant was advised that the form would be reviewed by Employer, and that she would be called and told when she could return to work. Employer called Claimant on January 16, 2009, and directed her to return to work on January 17, 2009. Claimant returned to her usual employment on January 17, 2009.
10. Claimant sought care at the Sterling Regional MedCenter Emergency Department on January 20, 2009. Claimant complained of anxiety attacks for the last four to five years. She was treated on an emergency basis for a panic disorder.
11. Claimant was next examined by Dr. Macintosh on February 9, 2009. Claimant stated that she was feeling better, but still had some cough, sinus pressure, and headaches. Dr. Macintosh stated in his report that the exacerbation was due to paint fumes, and stated that the exacerbation had resolved. He stated that her symptoms were due to her chronic conditions and were not part of the acute exacerbation. She was released from further care for the exacerbation.

CONCLUSIONS OF LAW

Claimant must prove that she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo.App. 2000); *City of Boulder v.*

Streeb, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett,* 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either Claimant or Respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979).

Claimant has established by a preponderance of the evidence that exposure to paint and other fumes at work on December 26, 2008, and several days thereafter aggravated or combined with a preexisting condition so as to produce disability and a need for treatment. The exposure directly and proximately caused the condition for which benefits are sought. The claim is compensable.

An insurer is liable for medical treatment from authorized providers that is reasonably needed to cure and relieve the claimant from the effects of the compensable injury. Sections 8-42-101(1) and 8-43-404(5), C.R.S. Insurer is also liable for emergency care. *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777, (Colo.App. 1990).

Claimant has establish that her treatment on January 3, 2009, at the Sterling Regional MedCenter Emergency Department was an emergency and was reasonably needed to cure or relieve her from the effects of her industrial injury. Insurer is liable for the costs of that care. Dr. Macintosh is the authorized care provider. His examinations and treatment were reasonably needed to cure and relieve Claimant from the effects of the compensable injury. Insurer is liable for the costs of the medical care that Claimant has received from Dr. Macintosh. Liability is limited to the amounts established by the Division of Worker' Compensation. Section 8-42-101(3), C.R.S.

The treatment Claimant received on January 20, 2009, was for a panic disorder, and was not related to this compensable injury. Insurer is not liable for the treatment on January 20, 2009.

If the injury or occupational disease causes disability, a disability indemnity is payable as wages. Section 8-42-103(1), C.R.S. No disability indemnity is payable for the first three days unless the disability lasts more than two weeks. Section 8-42-103(1)(a) & (b), C.R.S. Temporary total disability benefits are payable at the rate of two-thirds of a claimant's average weekly wage. Section 8-42-105(1), C.R.S. Temporary total disability benefits continue until a claimant returns to regular employment or the attending physician gives the claimant a release to return to regular employment. Sections 8-42-105(3)(b) & (c), C.R.S.

Claimant has established by a preponderance of the evidence that she missed work on December 27, 2008, due to this compensable injury. Claimant also missed part

of the work-day on January 3, 2009. Dr. Macintosh released her to return to work on January 4, 2009, and ended this period of temporary disability.

Claimant missed work again as a result of this compensable injury on January 5, 2009. This period of temporary disability ended on January 12, 2009, when Claimant was released to return to work without restrictions by her attending physician. Section 8-42-105(3)(c), C.R.S. requires that temporary disability benefits end upon such a release even when an employer does not permit an injured worker to return until some later date, as was the case here.

Claimant was temporarily disabled as a result of the compensable injury on December 27, 2008, January 3, 2009, and January 5 through January 11, 2009, a period of nine days, less than two weeks. Claimant therefore does not receive compensation for the first three days. Claimant has established that she is entitled to temporary total disability benefits from January 6 through January 11, 2009.

Temporary total disability benefits are payable at the rate of two-thirds of Claimant's average weekly wage. Claimant's average weekly wage is $275.76. Temporary disability benefits are payable at the rate of $183.84 per week. Insurer is liable for interest at the rate of eight percent on all benefits not paid when due. Section 8-43-410, C.R.S.

ORDER

It is therefore ordered that:

1. Insurer is liable for the costs of the medical care Claimant received at the Serling Regional MedCenter Emergency Department on January 3, 2009, and the medical care Claimant received from Dr. Macintosh. Insurer is not liable for the emergency care Claimant received on January 20, 2009. Liability is limited to those amounts established by the Division of Workers' Compensation fee schedule.
2. Insurer is liable for temporary total disability benefits at the rate of $183.84 per week from January 6, 2009, through January 11, 2009. Insurer shall pay interest to Claimant on all amounts of compensation not paid when due.
3. All matters not determined by this order are reserved.

DATED: *December 14, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-701-632

ISSUES

The issues for determination are permanent partial disability benefits, issue preclusion, and penalty against Insurer.

FINDINGS OF FACT

1. Claimant sustained an injury to her back on September 13, 2006, when she lifted a patient. Claimant reached maximum medical improvement on January 21, 2009.
2. Three physicians have provided ratings for Claimant's impairment. Darrell Quick, M.D., an authorized treating physician, rated Claimant's impairment at 27% of the whole person on January 21, 2009. Steven Lindenbaum, M.D. the Division independent medical examiner (DIME), rated Claimant's impairment at 21% of the whole person on April 1, 2009. W. Rafer Leach, M.D., rated Claimant's impairment at 27% of the whole person on September 9, 2009.
3. All three physicians rated Claimant for a specific disorder of the lumbar spine. All three rated the impairment at 7% plus 1% for each additional level. Dr. Quick found one additional level, for a total specific disorder rating of 8%. Dr. Lindenbaum and Dr. Leach each found two additional levels, for a total specific disorder rating of 9% of the lumbar spine. Dr. Lindenbaums rating for a specific disorder of the lumbar spine is supported by the rating of Dr. Leach.
4. All three physicians provided a rating for loss of range of motion. Dr. Lindenbaum's component ratings were each 1% or 2% lower than the ratings of Dr. Quick and Dr. Leach. Dr. Lindenbaum's range of motion impairment was 13%. Both Dr. Quick and Dr. Leach rated Claimant's range of motion impairment at 18%. Dr. Lindenbaum's ratings for loss of range of motion were correctly calculated under the revised third edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment" . It is not highly probable that Dr. Lindenbaum's range of motion impairment is incorrect.
5. Dr. Quick and Dr. Leach each rated Claimant with a 2% impairment for a neurologic impairment for a left S1 radiculopathy. The ratings were made pursuant to the AMA Guides. Dr. Lindenbaum did not rate Claimant for a neurologic impairment. In his January 28, 2008 report he noted that Claimant had decreased sensation over the S1 dermatome distribution. In his DIME report, Dr. Lindenbaum did not comment on any decreased sensation, and did not comment on a neurologic impairment.
6. Dr. Lindenbaum's failure to rate for a neurologic impairment is not supported by the ratings of Dr. Quick and Dr. Leach. Dr. Lindenbaum does not explain his failure to include a rating for a neurologic rating. It is highly probable that the rating of Dr. Lindenbaum is incorrect.
7. Claimant has established by a preponderance of the evidence that she has sustained an impairment of 27% of the whole person.
8. A Findings of Fact, Conclusions of Law, and Order was mailed to the parties on July 21, 2008. The order provided that Insurer was liable for periods of temporary disability benefits after May 31, 2008. The order did not specify the periods or the rate of temporary disability benefits to be paid. This part of the order did not grant or deny a benefit.
9. Claimant filed an Application for Hearing on September 25, 2009. Claimant endorsed penalty as an issue. The Application was withdrawn before a response was filed.

10. After May 31, 2008, Claimant was working for a different employer. The rate of temporary partial disability to be paid could not be ascertained without information as to the wages paid to Claimant by this different employer. Claimant, as the employee receiving the wages, had access to this information. Claimant had also provided Insurer with the name of the employer and a release for that information. Either Claimant or Insurer could have obtained this information.

11. Claimant's counsel obtained the wage information and mailed it on to Respondents' counsel on September 30, 2008. Counsel passed the information to Insurer's adjustor on October 3, 2008. Insurer filed a General Admission of Liability on October 9, 2008, and paid temporary disability benefits to Claimant.

CONCLUSIONS OF LAW

A. Impairment rating:

The DIME physician's finding of medical impairment is binding unless overcome by clear and convincing evidence. Section 8-42-107(8)(c), C.R.S. "Clear and convincing evidence" is defined as evidence that is stronger than a preponderance, is unmistakable and is free from serious or substantial doubt. *DiLeo v. Koltnow*, 200 Colo. 119, 613 P. 2d 318 (1980). In order to overcome the DIME report, there must be evidence which proves that it is highly probable that the DIME physician's opinions are incorrect. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). The question whether the party challenging the DIME physician's determination of maximum medical improvement has overcome the report by clear and convincing evidence is generally one of fact. *McLane Western Inc. v. Industrial Claim Appeals Office*, 996 P.2d 263 (Colo.App. 1999); *Metro Moving and Storage Co. v. Gussert, supra.*

Dr. Quick and Dr. Leach both included a two percent rating for neurologic disorder pursuant to the AMA Guides. Dr. Lindenbaum did not do so, and did not provide an explanation for his failure to do so. Claimant has shown that it is highly probable that the rating of Dr. Lindenbaum, the DIME physician, is incorrect. Claimant has overcome the rating of the DIME physician by clear and convincing evidence.

Claimant has established by a preponderance of the evidence that she sustained a permanent partial impairment of 27% of the whole person. Insurer is liable for permanent partial disability benefits based on that impairment. Sections 8-42-107(8)(c) and (d), C.R.S. Insurer may credit any previous payments of permanent partial disability benefits. Insurer shall pay Claimant interest at the rate of eight percent per annum on any benefits not paid when due. Section 8-43-410, C.R.S.

B. Penalty:

Issue preclusion and claim preclusion apply to administrative proceedings, including workers' compensation claims. *Feeley v. Industrial Claim Appeals Office* 195 P.3d 1154 (Colo. App. 2008). In *Sunny Acres Villa, Inc. v. Cooper*, 25 P.3d 44, 47 (Colo. 2001) the court determined that issue preclusion bars relitigation of an issue if:

> (1) The issue sought to be precluded is identical to an issue actually determined in the prior proceeding;
>
> (2) The party against whom estoppel is asserted has been a party to or is in privity with a party to the prior proceeding;

(3) There is a final judgment on the merits in the prior proceeding; and

(4) The party against whom the doctrine is asserted had a full and fair opportunity to litigate the issue in the prior proceeding.

Factor (2) applies here. However, no hearing was held. Factors (1), (3), and (4) are not present in this case. Issue preclusion does not apply.

Section 8-43-304(1), C.R.S. provides for penalties of up to $500 per day if an insurer fails, neglects, or refuses to obey an order. First, the claimant must prove that the disputed conduct constituted a violation of the statute, rule, or order. *Allison v. Industrial Claim Appeals Office,* 916 P.2d 623 (Colo. App. 1995); *Villa v. Wayne Gomez Demolition & Excavating, Inc.,* W.C. No. 4-236-951 (ICAO, January 7, 1997). If the insurer committed a violation, penalties may be imposed only if the insurer's actions were not reasonable under an objective standard. Reasonableness depends upon whether insurer had a rational argument based in law or fact. *Diversified Veterans Corporate Center v. Hewuse,* 942 P.2d 1312 (Colo. App. 1997); *Pueblo School District No. 70 v. Toth,* 924 P.2d 1094 (Colo. App. 1996). The standard is "an objective standard measured by the reasonableness of the insurer's action and does not require knowledge that the conduct was unreasonable." *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 907 P.2d 676, (Colo. App., 1995).

Claimant has failed to establish that Insurer violated any order. Further, there is no evidence concerning what effort Insurer or its agents made to obtain the wage information before the information was provided by Claimant's counsel. Claimant has not shown that Insurer acted unreasonably under the circumstances. Claimant has failed to establish by the evidence that a penalty should be imposed against Insurer.

ORDER

It is therefore ordered that:

1. Insurer shall pay Claimant permanent partial disability benefits based on an impairment of 27% of the whole person. Insurer may credit any previous payments of permanent partial disability benefits. Insurer shall pay Claimant interest at the rate of eight percent per annum on any benefits not paid when due.
2. Claimant's request for a penalty is denied.

DATED: *December 14, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-753-847

ISSUE

Whether Claimant has established by a preponderance of the evidence that the artificial disc replacement surgery recommended by his Authorized Treating Physicians (ATP) is reasonable and necessary to cure and relieve the effects of his industrial injury.

FINDINGS OF FACT

1. On March 12, 2008 Claimant suffered an admitted industrial injury to his lower back during the course and scope of his employment with Employer. Employer referred Claimant to Concentra Medical Centers in Fort Collins, Colorado for medical treatment. On March 13, 2008 Claimant was diagnosed with lumbosacral and sacroiliac (SI) strains.

2. On April 17, 2008 Claimant underwent an MRI of his lower back. The MRI revealed various abnormalities in his lumbar spine between the L3 and S1 levels.

3. ATP Rosalinda Pineiro, M.D. referred Claimant to Jeffrey A. Wunder, M.D. for an evaluation. On May 7, 2008 Claimant visited Dr. Wunder for an examination. Dr. Wunder remarked that Claimant's MRI findings suggested "mild bilateral L5 radiculopathy." He thus recommended electrodiagnostic studies to ascertain any nerve root involvement and a L5-S1 interlaminar epidural steroid injection.

4. On May 14, 2008 Dr. Wunder performed diagnostic studies on Claimant. The studies produced normal results. However, Dr. Wunder referred Claimant for facet injections to be performed by John T. Sacha, M.D. in order to identify his pain generator.

5. On June 11, 2008 Claimant returned to Dr. Wunder for an evaluation. Dr. Wunder remarked that Claimant's diagnostic response to the injections revealed that his symptoms were discogenic. He commented that Claimant's conservative treatment had been unsuccessful but recommended a psychological evaluation prior to any surgical considerations.

6. On June 23, 2008 Claimant visited Ron Carbaugh, Psy.D. for a psychological evaluation. Dr. Carbaugh noted that Claimant suffered from some anger and resentment toward Employer and the Workers' Compensation system. Nevertheless, he determined that six psychological counseling sessions would be sufficient "to provide [Claimant] cognitive and behavioral strategies for pain, depression, and anger management."

7. Claimant continued to obtain psychological counseling from Dr. Carbaugh through Fall 2008. By October 16, 2008 Dr. Carbaugh remarked that additional diagnostic testing in the form of a discogram had been recommended but not scheduled. He commented that Claimant had become more and more comfortable with psychological treatment and was receptive to discussing relevant issues. Dr. Carbaugh encouraged Claimant to pursue authorization for the discogram and stated that Claimant's follow-up appointments would be "dependent upon his medical treatment course."

8. On November 18, 2008 Dr. Sacha performed provocative discograms at the L2-3, L3-4 and L4-S1 levels. He noted that Claimant's last true disc was located at the L4-L5 level and there was nothing at the L5-S1 level. The procedure at the L4-L5 or L4-S1 level elicited a provocative response and was thus identified as Claimant's pain generator.

9. On November 19, 2008 Claimant returned to Dr. Wunder for an evaluation. Dr. Wunder remarked that the discography performed by Dr. Sacha revealed "concordant pain reproduction and apparent disk disruption at the most inferior disk." He thus referred Claimant to Hans C. Coester, M.D. for an examination.

10. On January 6, 2009 Claimant visited Dr. Coester for an evaluation. Dr. Coester commented that Claimant only had four lumbar vertebrae and noted that Claimant experienced pain at the L4-S1 level when he underwent the discography with Dr. Sacha. He explained that Claimant sought to undergo a disc arthroplasty rather than a lumbar fusion because Claimant was concerned about wear and tear above the fusion. Dr. Coester recounted that he reviewed the risks and benefits of a fusion and a disc arthroplasty with Claimant. He commented that a disc arthroplasty constituted a reasonable consideration based on Claimant's young age. Dr. Coester then referred Claimant to Douglas W. Beard, M.D. to explore whether Claimant constituted a good candidate for a disc arthroplasty.

11. On January 7, 2009 Claimant visited Dr. Beard for an examination. Dr. Beard reviewed Claimant lumbar MRI and discogram. He stated that the lumbar discography reflected "exquisite, concise reproduction" of Claimant's typical pain symptoms. Dr. Beard thus determined that Claimant's L4-S1 level constituted his pain generator. He remarked that he reviewed Claimant's options. Dr. Beard first explained that Claimant could simply undergo a pain management program. Second, Claimant could undergo fusion surgery, but Dr. Beard expressed concerns about possible degenerative changes at the disc above the fusion. Finally, Dr. Beard stated that Claimant could undergo a disc arthroplasty and commented that the procedure was favorable to a single level fusion. Dr. Beard concluded that he wanted to discuss Claimant's condition with Dr. Wunder.

12. On February 25, 2009 Claimant again visited Dr. Beard for a consultation. Dr. Beard recounted that Claimant had already undergone diagnostic studies, a psychological evaluation and a lumbar discography. He explained that he thus did not have much to offer Claimant other than a lumbar disc arthroplasy and Claimant was a suitable candidate for the procedure. Dr. Beard sought authorization to perform the lumbar arthroplasy but Insurer denied authorization on March 11, 2009 based on the opinion of Alfred P. Luppi, II, M.D.

13. Dr. Luppi concluded that a lumbar arthroplasty did not constitute a reasonable and necessary procedure for Claimant. He explained that the Colorado Medical Treatment Guidelines (Guidelines) provide that, for a patient to be considered a candidate for artificial disc replacement surgery, he must first "meet surgical fusion criteria." Dr. Luppi noted that, because Dr. Beard determined that Claimant was not a can-

didate for fusion surgery, disc replacement should not be considered. Furthermore, Dr. Luppi expressed concerns about the longevity of artificial disc replacements. He noted that the Guidelines provide that the "longevity of this prosthetic device has not yet been determined." Dr. Luppi concluded that, because an artificial disc may only last a few years, Claimant would be required to undergo a subsequent back surgery.

14. On October 16, 2009 Dr. Wunder testified through an evidentiary deposition in this matter. Dr. Wunder expressed concerns about fusion surgery because other discs would be placed in jeopardy by the procedure. He stated that, because disc replacement surgery allows patients to retain motion, other discs are not placed in jeopardy. Dr. Wunder noted that Dr. Beard advocated disc replacement surgery. He explained that Dr. Beard had practiced with disc replacement pioneer Dr. Janssen. Dr. Wunder also reviewed Dr. Luppi's report and commented that the Guidelines permit disc replacement surgery under some circumstances. He also noted that there was little long-term data regarding the longevity of artificial disc replacements because the procedure was relatively new. Dr. Wunder finally remarked that Claimant would probably benefit from an artificial disc replacement because of decreased pain and increased function.

15. Claimant's medical records and the persuasive testimony of Dr. Wunder demonstrate that Claimant has established that it is more probably true than not that artificial disc replacement surgery is reasonable and necessary to cure and relieve the effects of his industrial injury. Initially, Claimant underwent a discography that identified the L4-S1 level as the pain generator in his lower back. Because conservative treatment was unsuccessful, Dr. Wunder directed Claimant to undergo a psychological evaluation prior to considering surgical recommendations. Although Claimant initially demonstrated some anger and resentment toward Employer and the Workers' Compensation system, he progressed and became a suitable surgical candidate. Doctors Wunder, Coester and Beard noted that fusion surgery reduces a patient's cervical range of motion. Fusion surgery also creates an increased risk for developing degeneration of the discs above the fused levels because of increased stress. In contrast, disc replacement surgery is beneficial because it permits the patient to enjoy continued cervical range of motion. Moreover, there is decreased risk for degeneration of adjacent discs because of the absence of increased stress. Although Dr. Luppi explained that an artificial disc replacement was not reasonable and necessary for Claimant because the procedure was not justified under the Guidelines, the record reveals that Claimant exhausted conservative treatment, psychological concerns were addressed through counseling and a pain generator has been identified at the L4-S1 level through a discography. Therefore, based on the recommendations of doctors Wunder and Beard, disc replacement surgery is a reasonable and necessary procedure for Claimant.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-

102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). 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).

5. The Guidelines, W.C.R.P. 17, Exhibit 1, relating to Low Back Pain, discuss Artificial Lumbar Disc Replacements in Section F. 9. The indications for surgery include the following:

> Symptomatic one-level degenerative disc disease established by objective testing (CT or MRI scan followed by positive provocation discogram);
>
> Symptoms unrelieved after six months of active non-surgical treatment;
>
> All pain generators are adequately defined and treated;
>
> All physical medicine and manual therapy interventions are completed;
>
> Spine pathology limited to one level;
>
> Psychosocial evaluation with confounding issues addressed.

6. As found, Claimant's medical records and the persuasive testimony of Dr. Wunder demonstrate that Claimant has established by a preponderance of the evidence that artificial disc replacement surgery is reasonable and necessary to cure and relieve the effects of his industrial injury. Initially, Claimant underwent a discography that identified the L4-S1 level as the pain generator in his lower back. Because conservative treatment was unsuccessful, Dr. Wunder directed Claimant to undergo a psychological evaluation prior to considering surgical recommendations. Although Claimant initially demonstrated some anger and resentment toward Employer and the Workers' Compensation system, he progressed and became a suitable surgical candidate. Doctors Wunder, Coester and Beard noted that fusion surgery reduces a patient's cervical range of motion. Fusion surgery also creates an increased risk for developing degeneration of the discs above the fused levels because of increased stress. In contrast, disc replacement surgery is beneficial because it permits the patient to enjoy continued cervical range of motion. Moreover, there is decreased risk for degeneration of adjacent discs because of the absence of increased stress. Although Dr. Luppi explained that an artificial disc replacement was not reasonable and necessary for Claimant because the procedure was not justified under the Guidelines, the record reveals that Claimant exhausted conservative treatment, psychological concerns were addressed through counseling and a pain generator has been identified at the L4-S1 level through a discography. Therefore, based on the recommendations of doctors Wunder and Beard, disc replacement surgery is a reasonable and necessary procedure for Claimant.

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 artificial disc replacement surgery.

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

DATED: December 14, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-015-905

ISSUES

¬ Did claimant prove by a preponderance of the evidence that his cervical fusion procedure in 2009 was reasonable and necessary to cure and relieve the effects of his injuries at employer in 1988 and 1990?

FINDINGS OF FACT

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

1. Claimant's date of birth is July 16, 1946; his age at the time of hearing was 63 years. Claimant worked for employer as a mechanic. Claimant sustained two admitted injuries while working for employer: A lower back injury on January 4, 1988 (W.C. No. 3-889-181); and a right shoulder injury on October 5, 1990 (W.C. No. 4-015-905).
2. At the time of his work-related injury on January 4, 1988, claimant was adjusting the tracking of a conveyor belt, which came loose and knocked him to the floor. Claimant fell a couple of feet to the floor, landing on his back, shoulder, and neck.
3. As a result of his work-related injuries, employer admitted liability for permanent total disability benefits, effective May 5, 1992. On September 10, 1993, the director of the Division of Workers' Compensation entered an order approving a settlement between claimant and employer. The terms of the settlement left open employer's obligation to provide reasonable and necessary medical benefits.
4. Claimant has an extensive history of using alcohol and a 2-pack per day history of smoking cigarettes from approximately age 20 ongoing. Claimant also has had a problem with obesity. Various treating physicians have encouraged claimant to quit smoking, stop drinking, and lose weight.
5. Claimant underwent medical treatment over the years with a number of authorized treating physicians, including Neurologist Peter S. Quintero, M.D. At employer's request, Dr. Quintero reviewed numerous medical records, summarized claimant's treatment, and provided his opinion concerning causation of claimant's cervical symptoms. Dr. Quintero prepared a report dated July 5, 2009, and testified at hearing as a medical expert in the area of Neurology.
6. Physiatrist Gregory Reichhardt, M.D., has been claimant's authorized treating physician since October 15, 2008. Dr. Reichhardt referred claimant to Orthopedic Surgeon Hugh D. McPherson, M.D., for evaluation of his cervical complaints on March 13, 2009. Claimant reported an eight-year history of right-sided neck pain. Dr. McPherson diagnosed the following cervical conditions: Severe cervical spondylosis (arthritis); congenital fusion of the C4 and C5 vertebrae; and stenosis at the C3-4, C5-6, and C6-7 levels of his cervical spine. Dr. McPherson expressed concern that the degenerative disease and arthritic changes in claimant's cervical spine had progressed, such that, even a minor fall could leave claimant paralyzed. Dr. McPherson therefore recommended urgent surgery to fuse claimant's cervical spine from C3 through the C7 levels. Dr. McPherson performed the fusion surgery on April 21, 2009.
7. Claimant believes his work-related injury on January 4, 1988, proximately caused his need to undergo the cervical fusion performed by Dr. McPherson some 21 years after his injury. Claimant's cervical symptoms markedly improved following the surgery.
8. Crediting the medical opinion of Dr. Quintero, the first record evidence of claimant complaining of neck symptoms occurred some 12 years after his injury when Ellen

Price, D.O., examined him on January 10, 2000. At that time, claimant complained to Dr. Price of significant neck pain. Dr. Price referred claimant for a magnetic resonance imaging (MRI) scan of his cervical spine, which revealed cervical stenosis at the C5-6 level due to a broad-based disk, a small disk protrusion at the C6-7 level, and degenerative disk disease (DDD) throughout his cervical spine from C4 to C7. Dr. Price referred claimant for an electro-diagnostic, EMG/nerve conduction study on February 16, 2000, which ruled out cervical radiculopathy.

9. Dr. Price referred claimant for acupuncture treatment, which failed to alleviate his neck symptoms. Dr. Price referred claimant for a CT of his cervical spine, which revealed a congenital, solid fusion of the C4 and C5 vertebrae, multi-level facet disease, osteophyte formation throughout, and stenosis of the neuroforamina. Dr. Price also encouraged claimant to lose weight. By July 23, 2004, Dr. Price reported that claimant had lost some 48 pounds.

10. Dr. Quintero opined that claimant's cervical pathology and need for surgery were unrelated to his lower back and shoulder injuries at employer. Dr. Quintero wrote:

11. Following each of those accidents the claimant had no complaints of neck pain, nor did he have complaints of radiating arm pain. It was **not until** January 10, 2000, over **nine years after the accident, that he first had documentation of neck pain**, as noted by Dr. Ellen Price. It would be my opinion that the development of his neck pain and radiculopathy are due to progressive degenerative arthritis and degenerative disc disease of the cervical spine.

12. (Emphasis added).

13. Dr. Quintero persuasively testified that two of claimant's cervical vertebrae were congenitally fused (the C4 vertebra fused to the C5). In a normal spine, these vertebrae are individual motion segments, allowing motion of the cervical spine. However, the congenital fusion of C4 and C5 eliminated a motion segment, unnaturally increasing motion at the adjoining vertebral segments above and below the fused C4-5 segment. This fusion accelerated progression of the natural degenerative process in claimant's cervical spine.

14. Dr. Quintero further explained that claimant's cervical spine has evidence of facet disease, which involves degenerative changes from arthritis of the facet joints of the spine, and evidence of osteophytes, which are calcium deposits from a build up of calcium. Facet disease and osteophytes indicate a chronic degenerative arthritic process caused or accelerated by age, alcohol consumption, smoking, obesity, and deconditioning. Claimant had all of these factors contributing and accelerating his degenerative arthritic process.

15. Claimant failed to show it more probably true than not that either his lower back or shoulder injuries at employer caused, accelerated, or reasonably aggravated the degenerative arthritis in his cervical spine and his need for surgery by Dr. McPherson. Crediting the medical opinion of Dr. Quintero, the Judge finds: It is medically probable that the degenerative changes in claimant's cervical spine are chronic, and not the result of acute changes from an injury some 21 years earlier. It is more probably true that the chronic degenerative arthritis in claimant's cervical spine was caused, accelerated, or aggravated by his age, alcohol consumption, smoking, obesity, and deconditioning.

CONCLUSIONS OF LAW

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

Claimant argues he has proven by a preponderance of the evidence that his cervical fusion procedure in 2009 was reasonable and necessary to cure and relieve the effects of his injury at employer in 1988. 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. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

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

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

> Every employer … 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.

Respondent thus is 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 that claimant failed to show it more probably true than not that either his lower back or shoulder injuries at employer caused, accelerated, or reasonably aggravated the degenerative arthritis in his cervical spine and his need for surgery by Dr. McPherson. Claimant thus failed to prove by a preponderance of the evi-

dence that Dr. McPherson's surgery was reasonable and necessary to cure and relieve the effects of his injuries at employer.

The Judge credited the medical opinion of Dr. Quintero as persuasive. As found, the degenerative changes in claimant's cervical spine are more likely chronic, and not the result of acute changes from an injury some 21 year earlier. The Judge found it more probably true that the chronic degenerative arthritis in claimant's cervical spine was caused, accelerated, or aggravated by his age, alcohol consumption, smoking, obesity, and deconditioning.

The Judge concludes that employer should not be liable to pay for treatment of claimant's cervical spine disease or for the cervical-fusion surgery performed by Dr. McPherson. Claimant's request for an award of medical benefits for treatment of his cervical spine disease should be denied and dismissed.

ORDER

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

1. Claimant's request for an award of medical benefits to cover treatment of his cervical spine disease is denied and dismissed.

2. Claimant's request for an award of medical benefits to cover the cervical-fusion surgery performed by Dr. McPherson is denied and dismissed.

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

DATED: _December 16, 2009__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-796-329

ISSUES

Whether Claimant sustained a compensable injury to his right knee on June 18, 2009.

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

If compensable, a determination of Claimant's Average Weekly Wage including a determination of Claimant's wages from concurrent employment.

If compensable, whether Claimant is entitled to an award of temporary total disability benefits form the period from June 19 through and including August 25, 2009.

FINDINGS OF FACT

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

1. Claimant was employed as a night foreman for Employer. Claimant's date of hire with Employer was October 13, 2008. In addition to this employment Claimant also worked for the Army/Air Force Exchange Service.

2. Claimant's job as a night foreman for Employer involved unloading of trucks and stocking of shelves in a grocery store. Claimant's job duties required him to bend at the knees, use a step stool and work on his knees. Claimant would typically spend 6 hours of an 8-hour shift stocking shelves.

3. On June 18, 2009 Claimant was leaving the backroom of the King Soopers store to clock-out. Claimant was under instructions from Employer to not work overtime and was rushing to clock out on time. As he was walking up aisle 14 of the store to catch up with another employee, Tim Deveaux, to tell him he had done a good job Claimant stepped hard on his right foot and heard a popping in his right knee.

4. At the time Claimant stepped and experienced a popping in this right knee he did not catch his foot on any object, slip on the floor or move to avoid any obstacle present in the workplace. Claimant was simply trying to catch up with a co-employee when he stepped and experienced the popping in his right knee. After this occurred, Claimant limped to the time clock to clock out.

5. Claimant was referred by Employer for treatment at Concentra Medical Centers and was initially evaluated by Dr. Randall Jones, D.O. on June 18, 2009. Claimant gave a history to Dr. Jones that a the time he felt the pop in the knee he was not twisting and that it was just a normal kind of heel strike and then Claimant felt the pop as he was putting weight on it. The ALJ finds this history to be credible and persuasive.

6. Claimant underwent an MRI of the right knee on July 9, 2009 that revealed a tear of the posterior horn of the medial meniscus of the right knee. Claimant underwent surgical repair of the torn menisus by Dr. Steven Waskow, M.D. on August 5, 2009.

7. Claimant had no problems with his right knee prior to June 18, 2009.

8. Claimant was evaluated by Dr. Timothy Hall, M.D. on August 6, 2009. Dr. Hall opined that Claimant's job duties can create excessive load on the knee and set up the meniscus for injury. Dr. Hall theorized that the excessive loads predisposed Claimant to have an injury that wouldn't normally happen. The ALJ finds Dr. Hall's opinion and theory on causation to be unpersuasive.

9. Claimant has failed to prove by a preponderance of the evidence that a nexus or causal connection exists between his employment and the injury to his right knee. Claimant has failed to prove by a preponderance of the evidence that he sustained a compensable injury to his right knee on June 18, 2009.

CONCLUSIONS OF LAW

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

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

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).

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).

The determination of whether there is a sufficient "nexus" or causal relationship between the claimant's employment and the injury 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).

As found, Claimant has failed to prove the required nexus or causal relationship between his employment with Employer and the injury. Claimant argues that the conditions of his employment placed his knee in a weakened condition that predisposed him to the injury to his knee. Claimant relies upon the report of Dr. Hall in support of this argument. Dr. Hall's opinion that the conditions of Claimant's employment can create excessive load on the knee is unsupported by any persuasive evidence. Claimant had no pre-existing symptoms or problems in his right knee even though he had been performing this work for several months prior to June 18, 2009. There is also no persuasive evidence that Claimant was experiencing any pain or symptoms in the right knee as a result of his work during the work day or immediately prior to stepping down in a normal heel strike fashion and feeling a popping in his knee. No persuasive medical evidence exists in the record of any pre-existing degenerative changes in the right knee that would be evidence of the excessive loading as postulated by Dr. Hall. Dr. Hall's opinion that Claimant's job "can" cause excessive loading is phrased in the nature of a possibility, not a reasonable probability, and represents speculation or conjecture that is unpersuasive and insufficient to meet Claimant's burden of proof.

The ALJ concludes that while Claimant was rushing to clock out to avoid overtime there is no persuasive evidence that Claimant's rushing had any causal effect or relationship to his stepping down and experiencing a popping in his right knee. As Claimant told Dr. Jones, he was walking and with a normal heel strike experienced the popping in the knee. Although Claimant also testified that he stepped hard on his right foot there is no persuasive evidence that this act of stepping hard bore a nexus or causal connection to the injury to his knee.

The ALJ concludes that the facts of this case are analogous to the facts in *Wallis v. Craig Hospital,* W.C. No. 4-627-742 (July 6, 2006) and *Licalzi v. Sky Ridge Medical Center,* W.C. No. 4-661-550 (September 7, 2006). In *Licalzi,* an injury from an unexplained fall was held not to be compensable as it did not arise out of the employment because no direct causal relationship existed between the employment and the claimant's fall. In *Wallis,* claimant's injury to her right knee by merely turning and taking a step toward the front of a wheelchair was held not to be compensable as not arising out of the employment. The claimant's testimony in *Wallis* was that " as I took a step on my

knee, sharp pain and couldn't put weight on my knee". This testimony is substantially similar to Claimant's testimony here as to how his right knee pain began on June 18, 2009. The ALJ concludes that there is no persuasive evidence in the record to explain Claimant's right knee injury other than it occurred simply from the Claimant stepping on his right foot with a normal heel strike and experiencing a popping in his right knee followed by the inability to bear weight on the knee. Although Claimant's injury occurred in the course of his employment the injury did not arise out of the employment and therefore is not compensable.

In light of the ALJ's finding and conclusion that Claimant did not sustain a compensable injury on June 18, 2009 the ALJ does not specifically address the remaining issues concerning medical benefits, average weekly wage or temporary total disability benefits.

ORDER

It is therefore ordered that:

Claimant's claims for compensation and medical benefits for the injury of June 18, 2009 to his right knee are denied and dismissed in their entirety.

DATED: December 16, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-803-135

ISSUES

- Whether Claimant's motor vehicle accident of August 22, 2009, arose out of and in the course and scope of his employment rendering it a compensable injury; and
- Whether Claimant is entitled to medical benefits to treat such injury, including treatment already received through Exempla.

FINDINGS OF FACT

Based on the evidence presented at hearing, the Judge finds as follows:

1. Employer owns and runs 19 franchises for a nationally franchised pizza restaurant.
2. Employer originally hired Claimant in February 2009 as an "insider" which meant that his primary duty was working inside the store making pizzas.

3. The franchise agreement permits only three types of positions for employees: insiders, drivers and management. An employee must have a clean driving record for two years in order to qualify as a driver or manager.

4. Claimant had performed well as an insider and was being considered for other positions. Employer reviewed Claimant's driving record and discovered that his license had been suspended. As such, the Claimant was not qualified to be a driver or manager.

5. In order to encourage and reward employees who performed well, but did not meet the driving record qualifications, Employer created a position entitled, "non-driving intern." Due to Claimant's performance as an insider, Employer promoted Claimant into the position of non-driving intern ("NDI") in early August 2009.

6. The NDI position required the Claimant to act as a manager when the store manager was not present. Claimant's duties included running the shift, managing employees, dealing with customers and handling the money.

7. Claimant typically closed the store in which he worked, which meant that he was required to handle the money in some manner before leaving for the night.

8. Employer's Vice President of Human Resources, Litman, testified that Claimant's job responsibilities did not include making bank deposits. She then testified that Claimant was allowed to make bank deposits provided he followed proper protocol. According to Litman, Claimant had several options regarding how to handle the money. Claimant could make a bank deposit by traveling with an authorized driver to the bank; he could call a manager to take him to the bank; he could walk or ride a bike to the bank with a driver following in a car; or he could have left the money in the safe. Employer offered Claimant several choices with respect to handling the money, but did not specifically prohibit the Claimant from handling the money. Rather, Claimant was required to handle the money in some manner.

9. Claimant signed a non-driving agreement on February 2, 2009, in which he acknowledged that he was not authorized to use a motor vehicle of any kind in the furtherance of the business of Employer. This included making bank deposits.

10. Claimant credibly testified that he was aware that he was prohibited from driving, but that his managers had also told him that they did not want the bank deposit left in the safe overnight. Claimant agreed that it would have been most convenient to leave the deposit in the safe, but he did not feel this was an option based on the conversations he had with his managers.

11. On August 22, 2009, Claimant closed the store and asked a driver to take him to the bank to make the deposit. The driver declined to take Claimant so Claimant took the bank deposit by driving his own vehicle. At approximately 2:00 a.m., while on his way to the bank, Claimant was involved in a motor vehicle accident when a drunk driver ran a red light and struck Claimant's vehicle. Another employee was following Claimant to the bank and witnessed the accident.

12. Claimant initially received treatment in the emergency room of Exempla Lutheran Hospital. Following his discharge from the hospital, Claimant received medical treatment at Exempla Green Mountain Medical Center.

13. Claimant admitted to his Employer that on August 22, 2009, he violated the non-driving agreement, which resulted in termination of his employment.

14. Based on the foregoing, Claimant has established that he was injured in an automobile accident while in the course and scope of his employment with Employer. Employer did not specifically direct Claimant not to handle the money or make bank deposits rather the Employer regulated the manner in which Claimant was to handle the money or make bank deposits. Accordingly, Claimant's act of driving to the bank, a violation of the non-driving agreement, was not outside the sphere of his employment.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Judge makes the following conclusions of law:

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

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

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

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

5. For purposes of determining the compensability of an injury, an employer's direction to an employee falls into one (1) of two (2) categories. The employer's directive may limit the sphere of the employment relationship, or it may simply regulate the employees' conduct while he is engaged in such employment. *Ramsdell v. Horn,* 781 P.2d 150, 152 (Colo. App. 1989). For an employer to limit the sphere of employment, the employer must give a general directive for the employee to cease all activity even if just on a temporary basis. *Id.* at 152. If an employee violates this type of directive, the employee is no longer within the sphere of employment so that any injury occurring to the employee does not arise out of or in the course of her employment. *Id.* at 152. By contrast, an employer's directive may simply regulate the employee's conduct while she is engaged in such employment. The *Ramsdell* Court is clear that if an employee violates this type of directive, the compensability of an injury is not affected. *Id.* at 152.

6. Claimant has established by a preponderance of the evidence that he was in the course and scope of his employment when he was injured in a car accident on August 22, 2009. At the end of each shift, Claimant's job duties required him to handle the money the store had collected over the day. The Employer had never issued a directive to Claimant that prohibited him from making bank deposits or handling the money in one way or another. While it is true that the non-driving agreement prohibited Claimant from driving a vehicle to perform that specific job duty, such directive did not remove Claimant from the sphere of employment. It merely regulated Claimant's conduct while he was engaged in that job duty. Accordingly, Claimant's workers' compensation claim is compensable.

7. Because Claimant's workers' compensation claim is compensable, Claimant is entitled to reasonable and necessary medical treatment related to such claim. Respondents are liable for payment of all such reasonable and necessary treatment, including treatment already rendered subject to the fee schedule.

ORDER

It is therefore ordered that:

1. Claimant's injury occurred in the course and scope of his employment, and therefore, compensable.

2. Respondents shall be liable for all reasonable and necessary medical treatment related to the work injury, including payment for treatment already rendered subject to the fee schedule.
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: December 16, 2009

Laura A. Broniak

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-787-243

ISSUES

The issue to be determined is whether Claimant sustained a compensable injury in or about January of 2009.

FINDINGS OF FACT

1. On or about January 20, 2009, Claimant was performing her duties for the Respondent-Employer as a playground monitor when a student weighing upwards of 195 pounds ran and jumped on her back and neck. She landed on the left side of her body jarring her neck and left shoulder.

2. Initially, Claimant felt a little stiff but did not feel any pain. When Claimant awoke the next morning, she noticed aching in the left neck and shoulder. Over the course of the next day, Claimant's symptoms progressed such that on January 22, 2009 she went to Dr. Tucker, who is a chiropractor in La Junta, Colorado.

3. At the initial visit with Dr. Tucker, Claimant was having left neck pain and left shoulder pain. She advised Dr. Tucker that she had had similar symptoms in the past but her most recent symptoms are related to an accident at work when a young child pulled on her arm and another child jumped on her back. Dr. Tucker noted that the injury happened earlier in the week and that she had been using ice and holding her left arm against her body to relieve symptoms. Dr. Tucker noted that arm movements and head movements provoked left arm pain, hand numbness, and lower neck pain. Claimant treated with Dr. Tucker up through February 10, 2009.

4. Ultimately, at her employer's direction, Claimant presented to James Satt, M.D., on February 10, 2009. Claimant gave Dr. Satt a history of being jumped from behind on schoolyard with her left arm fixed in extension. Dr. Satt diagnosed left shoulder impingement with residual neuropathy and neck pain. Dr. Satt referred Claimant out for an MRI of the cervical spine.

5. On February 10, 2009, an MRI of the cervical spine was done which revealed a mild disc bulge at C4-5, a left sided disc protrusion at the C5-6 level with left sided disc protrusion causing some narrowing of the left neural foramina at both levels, and a disc protrusion at the C6-7 level impressing on the thecal sac, touching the spinal cord without posterior displacement. The rest of the disc levels were within normal limits.

6. At Dr. Satt's referral, Claimant presented to Scott Stanley, M.D. on March 4, 2009. Claimant told Dr. Stanley that she was on playground duty when a student "charged at her." There was a scuffle and another student jumped on her upper back and shoulder region. Claimant told Dr. Stanley that she noted some aching but the next morning her pain had worsened with radicular symptoms down the left upper extremity. Claimant advised Dr. Stanley that she had had a prior rotator cuff injury in 2004 and she initially thought her present symptoms were a recurrence of the prior injury. Claimant described the pain as both aching and stabbing in character in her left arm. Upon examination, Dr. Stanley found limitations in range of motion of the neck, a diminished triceps and brachloradialis reflex in the left side, and some diminished sensation in the lateral aspect of the arm and in the radial aspect of the forearm. Dr. Stanley noted a positive Spurling test on the left side. Dr. Stanley diagnosed a left sided disc herniation at C5-6 and C6-7 along with left shoulder tendinitis. Dr. Stanley prescribed medication, physical therapy, and an epidural steroid injection for the cervical spine.

7. On March 16, 2009, Claimant had an epidural steroid injection in the cervical spine. The injection gave Claimant transient relief but her symptoms returned. In a note dated April 1, 2009, Dr. Stanley mentioned that Claimant continued to have pain in both the C6 and C7 dermatomal distribution. On April 1, 2007, Dr. Stanley recommended Claimant have a C5 through C7 anterior cervical discectomy and fusion. On May 6, 2009, Claimant had a follow-up appointment with Dr. Stanley found an unchanged pain pattern in the C6-C7 dermatomal distribution. Dr. Stanley also found that Claimant had weakness in her left arm, which would respond very quickly to decompression and fusion surgery.

8. On April 2, 2009, Claimant presented herself to David Richman, M.D. On this date, Claimant told Dr. Richman that on January 20, 2009, she was working as a crossing guard and playground aide when a student ran and jumped on her back and neck. Claimant landed on the left side of her body. She told Dr. Richman that initially she felt all right but when she woke up the next morning, she had aching in her left neck and shoulder, which gradually worsened over the ensuing weeks. Dr. Richman made note that Claimant had a history of neck, back, and shoulder problems but was functioning well over the last several years. At this evaluation, Claimant was having aching in the left and posterior head, stabbing, burning, and aching in the neck radiating down into the left shoulder, left arm, and down into the thumb, index, and long fingers. Upon examination, Claimant had significantly decreased range of motion of the cervical spine with a strongly positive Spurling's test for shoulder and arm pain with paresthesia into the hand. Dr. Richman testified that Spurling's test is an indication of a cervical disc injury. Dr. Richman also found some impingement in the left shoulder with pain anteriorly but rotator cuff testing revealed no significant weakness.

9. As part of his evaluation, Dr. Richman reviewed multiple prior medical records including an MRI done on February 10, 2009. Dr. Richman's impression at this visit was a left upper extremity radiculopathy, primarily at the C-6 level, which appears to be trauma related from the work injury of January 20, 2009. Dr. Richman recommended

referral back to Dr. Stanley for consideration of a cervical discectomy and fusion between C5-6 and C6-7.

10. On November 5, 2002, Claimant had undergone a Division Independent Medical Examination ("D.I.M.E.") by Dr. Richman. At this evaluation, Claimant was having pain in her mid back, left shoulder, neck with some aching and numbness down to the left hand. Based upon his evaluation, Dr. Richman gave Claimant the following diagnoses: a thoracolumbar strain and myofascial pain, left shoulder impingement syndrome and bicipital tendinitis, cervical myofascial pain which likely is reactive to the left shoulder with no direct documentation of cervical injury and no mechanism of cervical injury documented, and left SI joint pain/sprain. Dr. Richman gave Claimant a 6% whole person impairment for the thoracic spine, a 10% whole person impairment for the lumbar spine, and a 3% whole person impairment for the left upper extremity. This combined to a 16% whole person impairment. As part of his D.I.M.E., Dr. Richman did not include an impairment of the cervical spine since there was no documented injury and the range of motion deficits were due to reactive myofascial pain emanating from the left shoulder.

11. Subsequent to his D.I.M.E., Claimant continued to have problems with her left shoulder including pain and stiffness radiating into the neck with numbness and tingling down the arm into the hand. She received treatment on a sporadic basis up through approximately 2006. An MRI was done on February 6, 2004, which revealed a C5-6 disc dessication with a small central disc protrusion impinging on the anterior thecal sac touching the spinal cord. All other disc levels including the C6-7 level were normal. There are no medical records that reveal treatment for the left shoulder or neck between 2006 and the date of the injury. Claimant testified that in the approximately two years prior to the January 20, 2009 incident, she had left shoulder pain, which radiated into her neck several times per month. However, the pain was not constant and would subside with over-the-counter medication. Since the January 20, 2009 accident, Claimant's neck pain has been constant in nature. Also, Claimant testified that her pain now emanates from her neck and radiates down into her left shoulder as opposed to pain emanating from the shoulder into her neck.

12. On January 22, 2009, Claimant reported the incident to Debbie Bogner. Claimant was advised that she couldn't report the injury since it had been more than 24 hours since the incident occurred. Claimant made some inquiries and found out that she could still report the injury. Claimant then reported the injury on February 9, 2009 to Judy Davidson, who directed Claimant to Dr. James Satt for treatment.

13. Claimant has continued to work at her usual jobs as a personal care assistant and as a playground aide since January 20, 2009.

14. At request of Respondents, Dr. Mark Paz examined Claimant on June 1, 2009. Dr. Paz reviewed medical records dating back to 2002. Based on the history, his examination of Claimant, and a review of her medical records, Dr. Paz opined that Claimant's current neck and shoulder symptoms are not related to the January 20, 2009 incident. Dr. Paz believes Claimant's present problems are related to Claimant's preexist-

ing degenerative disc disease and prior shoulder problems. Dr. Paz agreed that shoulder problems can cause neck pain and stiffness. Dr. Paz recognized that the incident of January 20, 2009 has the potential to have "aggravated, temporarily or permanently," Claimant's symptoms. In addition, Dr. Paz, unlike Dr. Richman, never evaluated Claimant prior to the January 20, 2009 incident.

CONCLUSIONS OF LAW

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

2. Claimant's unrefuted testimony is that on January 20, 2009, she was involved in an incident while working as a playground aide wherein a large student ran and jumped on her back and neck. Claimant's history as to what happened is corroborated in the histories given the various health care providers who have treated and/or evaluated her since January 20, 2009. Subsequent to being injured on the above date, Claimant has complained of neck pain with radicular symptoms down into the left arm as evidenced in the records of Dr. Tucker, Dr. Satt, Dr. Stanley, and Dr. Richman.

3. Dr. Richman has credibly opined that Claimant sustained a cervical spine injury with a radiculopathy mainly at the C6 level, which appears to be related to the work injury of January 20, 2009. Dr. Richman was aware of Claimant's past medical history, including her problems with her left shoulder and neck and the herniated disc at C5-6. Nonetheless, based in part on the fact that there was no medical records for several years prior to the January 20, 2009 incident reflecting treatment for any neck or shoulder problems coupled with Claimant's history that she was functioning well for the same time period, Dr. Richman concluded that Claimant injured her cervical spine on January 20, 2009. Dr. Richman also based his conclusion on his review of the MRI done on February 10, 2009, which revealed not only the C5-6 disc herniation but also a C6-7 disc herniation, which was impressing on the thecal sac. Dr. Richman felt this showed a change from the 2004 MRI. Finally, Dr. Richman in his report found a strongly positive Spurling's test, which is indicative of a cervical disc injury.

4. It is recognized that Dr. Paz feels that Claimant did not sustain an injury to her cervical spine as a result of the January 20, 2009 incident. Dr. Paz bases his opinion on the fact that Claimant had a prior degenerative disc disease along with neck pain, left shoulder pain, and numbness and tingling down the left extremity. However, Dr. Paz stated in his report that the reported mechanism of injury could have the potential to have aggravated, temporarily or permanently, Claimant's cervical symptoms. Dr. Paz

also admitted that a shoulder injury such as what Claimant had prior to January 20, 2009 can cause cervical symptomatology.

5. The ALJ concludes that Dr. Richman is more credible and persuasive than Dr. Paz. Dr. Richman, unlike Dr. Paz, had the opportunity to evaluate Claimant both before and after the January 20, 2009 incident; the first time being the D.I.M.E. done on November 5, 2002. In his D.I.M.E. of 2002, Dr. Richman opined that Claimant's neck symptoms were reactive in nature and were related to her left shoulder impingement syndrome. Dr. Richman, in his 2002 D.I.M.E., made it clear that there was no injury to Claimant's neck. Dr. Richman credibly testified that Claimant's symptoms are different than what she had prior to the January 20, 2009 incident and this is supported by the 2009 MRI and the other tests done by Claimant's treating physicians.

6. Claimant credibly testified that since the January 20, 2009 incident, she has had ongoing, continuous pain in her neck, which radiates down into her left extremity. Claimant was forthright and straightforward with her doctors as well as in her testimony that she had preexisting neck, shoulder, and arm pain. However, it is clear that she has had no treatment for her neck or shoulder symptoms for at least the two years prior to the incident of January 20, 2009. There is some confusion as to when Claimant reported the injury to her employer. However, Claimant testified that within a few days of injuring herself she tried to report the injury but was rebuffed. Eventually, she was able to report it and was then referred to Dr. Satt. However, as stated above, Claimant has consistently given her treating physicians, including Dr. Tucker, by whom she was seen two days post injury, that she was hurt on January 20, 2009, when a child jumped on her back and neck. Claimant was aware she was injured in the January 20, 2009 incident and therefore, her version of what happened in reporting the incident to her employer is credible and persuasive.

7. Claimant has continued to work and continue with her usual activities in spite of her injury. However, Dr. Richman, unlike Dr. Paz, felt that this was not indicative as to whether or not Claimant sustained an injury. Dr. Richman testified that people can work and continue with their normal activities in spite of being injured.

8. The ALJ concludes that Claimant has established that it is more likely than not that she sustained an injury to her cervical spine on or about January 20, 2009 arising out of and in the course of her employment with the Respondent-Employer and is entitled to benefits under the Workers' Compensation Act of Colorado.

ORDER

It is therefore ordered that:

1. Claimant's claim for benefits under the Workers' Compensation Act of Colorado is compensable.
2. Respondent-Insurer shall pay for all reasonable and necessary medical care to relieve the Claimant from the effects of her work-related injury.
3. Respondent-Insurer shall pay for all reasonable and necessary medical care that Claimant has received to date to relieve the Claimant from the effects of her work-related injury.
4. The insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATE: December 17, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-667-996

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUES

The issues to be determined by this decision concern: penalties against Respondents for failure to pay 17 medical bills associated with Claimant's admitted compensable injury of November 8, 2005, pursuant to a decision of ALJ Barbara Henk, mailed June 16, 2006. Respondents raised lack of jurisdiction of the outset of the first session of the hearing on August 24, 2009. The ALJ finds and concludes that he lacks jurisdiction over International Subrogation Management Company (hereinafter "ISM"), the Swift Newspapers health insurance subrogation company and Swift's health insurance company. Whether or not these two entities were prejudiced by Respondents' failure to timely pay Claimant's workers' compensation medical bills is **irrelevant.** Respondents' also raised the affirmative defense of statute of limitations, for the first time, at the commencement of the first session of the hearing on August 24, 2009. Respondents had not raised statute of limitations in its Response to Application for Hearing, filed April 27, 2009, nor in its Case Information Sheet, filed on August 18, 2009. At the outset of the first hearing, the ALJ ruled that the affirmative defense of statute of limitations was untimely and, therefore, waived and denied.

FINDINGS OF FACT

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

Preliminary Findings

1. This matter involves an originally contested industrial injury that occurred on November 8, 2005 when the Claimant was involved in a car accident returning back to work after purchasing a breakfast burrito at her supervisor's request.

2. As a result of the car accident, the Claimant underwent a cervical fusion, physical therapy, and related diagnostic tests through North Colorado Medical Center (hereinafter "NCMC"), Hans Coester, M.D., and their referrals.

3. Because the claim had been denied by the workers' compensation insurance carrier herein, the Claimant's health insurance – through Swift Newspapers (her husband's health carrier) - paid the majority of the medical bills incurred from the accident on November 8, 2005 until the finding of compensability by ALJ Henk on June 15, 2006.

4. The parties had proceeded to hearing on April 20, 2006 before ALJ Henk. At hearing, the parties stipulated that should the claim be found compensable, the medical treatment Claimant received at Northern Colorado Medical Center and Dr. Coester is reasonably necessary and authorized (*See* Claimant's Exhibit 1, Page 3)."

5. On June 16, 2006, ALJ Henk issued a decision determining the Claimant's injury to be within the scope of her employment and therefore compensable. ALJ Henk's decision states, "Respondents shall pay the medical expenses of North Colorado Medical Center and Dr. Hans Coester and their referrals."

6. On October 11, 2006, Respondents filed a Final Admission of Liability (FAL), admitting for a period of temporary disability, for 26% whole person permanent medical impairment and reasonably necessary authorized medical treatment by Hans Coester, M.D., and his referrals.

The Health Insurance Company Notice to Respondent Insurer on Medical Bills

7. On August 17, 2006, International Subrogation Management Company (hereinafter "ISM"), the subrogation company for Swift Newspapers requested assistance from Claimant's husband in obtaining reimbursement for the medical bills. Following notice that the claim had been found compensable, Sandra Steele, of ISM, notified Laurie Iverson, the adjuster for the Respondent Insurer that ISM intended to recover reimbursement of medical bills paid for the work injury. ISM was essentially acting as an intermediary for the Claimant. Respondents implied argument that the Claimant cannot argue that she was prejudiced because a third-party that was **not** liable for her medical bills paid them sets up a logical fallacy. Claimant was prejudiced when medical provid-

ers ultimately refused to treat her because ISM stopped paying the medical bills after Respondents' adjuster, Laurie Iverson, assured ISM that Claimant's medical bills would be paid and they were not paid.

8. ISM notified Respondent Insurer that medical expenses paid to date were $60,141.96. On September 20, 2006, Steele of ISM wrote Respondent Insurer, "As we discussed today, I have ordered a full payment report plus copies of bills related to the report and will forward them to you when they are received."

9. On September 28, 2006, ISM provided Respondent Insurer the medical bills and the current lien amount of $60,141.96. According to Steele, and as documented by her (*See* Exhibit 14, Page 209), Respondent Insurer "will put bills through their payments center to pay Colorado Fee schedule, will request balance from providers and then will send payment log to me."

10. The September 28, 2006 letter and package of bills sent by ISM to Respondent Insurer was identified, and admitted into evidence, as Claimant's Exhibit 15. Relevant to the issues for hearing, ISM sent Respondent Insurer the following bills for the following dates of service:

Dates of Service
Provider
Amount Billed
Exhibit Reference
11/8/2005
NCMC
$30.55
(Exhibit 14; Pg. 236)
11/8/2005
NCMC
$9,911.20
(Exhibit 14; Pg. 242)
11/28/2005
NCMC
$46,738.43
(Exhibit 14; Pg. 238-239)
2/17/2006
NCMC
$336.15
(Exhibit 14; Pg. 231)
11/11/2005
Dr. Coester
$198.00
(Exhibit 14; Pg. 234)
11/28/2005
Dr. Coester

$9823.00
(Exhibit 14; Pg. 246)
11/28/05
GAS - Anesthesia
$1425.00
(Exhibit 14; Pg. 250)
11/8/05
Diversified Radiology
$603.00
(Exhibit 14; Pg. 252)
11/8/05
Diversified Radiology
$51.00
(Exhibit 14; Pg. 256)
11/28/05
Diversified Radiology
$19.00
(Exhibit 14; Pg. 258

Laurie Iverson, the adjuster for Respondent Insurer, confirmed this understanding on October 10, 2006 by letter to Sandra Steele, "We have agreed that I will forward the bills you have sent through our payment center for payment, then you can go back to the medical providers and ask for the full amount you have paid."

11. That same day, October 10, 2006, Iverson forwarded the above medical bills to the payment-processing center, with the following note: "Please see attached bills for Kathleen Wardell. Please pay as soon as possible so the Health Carrier can ask for reimbursement of their money."

North Colorado Therapy Center Bills

12. Also at issue is Respondent Insurer's failure to pay 7 bills for physical therapy Claimant obtained through North Colorado Physical Therapy (hereinafter "NCTC"). The Claimant treated with NCTC from February 22, 2006 to April 3, 2006. Dr. Coester had referred the Claimant to NCTC for treatment for neck pain due to the 11/8/2005 injury (*See* Claimant's Exhibit 13, Page 168).

13. On June 22, 2006, Claimant's attorney advised NCTC, in writing, that the services performed at their facility were related to an admitted work-related injury. The letter advised NCTC to contact Laurie Iverson, the adjuster. A copy of the Final Admission was attached to the letter. A copy of the letter was sent to Royce Mueller, the attorney for Respondent Insurer (*See* Claimant's Exhibit 13, pp. 165-167).

14. Nancy Hammond, the Reimbursement Analyst for NCTC credibly testified that she faxed the bills to Laurie Iverson three to four times - on June 26, 2006, again on August 21, 2006, and again on November 22, 2006.

15. Hammond called and spoke with Laurie Iverson to obtain payment, and when that failed she called Christine Ford at Carrier Practices, and left messages with Ms. Miller, Iverson's supervisor. (*See* Claimant's Exhibit 13, pp. 162-166).

16. Iverson denied receiving the faxes from Nancy Hammond, and denied any communication with Nancy Hammond. Because of Iverson's interest in this matter, the ALJ infers and finds that she is motivated to **not** be portrayed as mishandling this claim. On the other hand, Nancy Hammond is much more credible than Iverson for the following reasons:

a. Hammond took contemporaneous notes detailing her efforts to receive payment of these medical services.

b. Hammond, unlike Iverson, has no stake in the outcome of this hearing. NCTC bills have been paid, and neither she, nor NCTC, will be affected by this decision.

c. Hammond had no incentive or reason to misrepresent her efforts to obtain payment. Timely payment was her sole objective.

17. When Dr. Coester referred the Claimant for the continued maintenance care of physical therapy, (*See* Claimant's Exhibit 19) in January 2007, the Claimant returned again to NCTC pursuant to Dr. Coester's referral. On January 24, 2007, however, NCTC advised the Claimant that that they would no longer see her for lack of payment. In the letter, Nancy Hammond stated, "The last phone call I made was today and she told me she did not take care of the billing and the number I gave her was not a workers comp ID number. Previously, Ms Iverson had been very cooperative and had me forward (fax) all claims to her. The problem is that we still have not received any payments for physical therapy for dates of service 2/22/06 thru 4/03/06. According to your letter dated 6/22/06, Laurie Iverson was the person I should contact for payment." (*See* Claimant's Exhibit 13, page 164).

18. On July 20, 2007, Professional Finance Company filed a lawsuit against the Claimant and her husband (*See* Claimant's Exhibit 17, page 293-298) for recovery of payment $3,772.98 of medical bills. Of the those bills, $1,591.93 or 42% of the amount sought were for three medical bills that Respondent Insurer received from ISM and should have paid. (*See* counts 11,12,13 – Claimant's Exhibit 17, page 296)

19. Claimant filed an Application for Hearing for Respondent Insurer's failure to pay medical bills on September 12, 2007.

20. Respondent Insurer failed to pay the 17 bills until December 2007 and May 2008. The Exhibits, admitted into evidence, establish the following payments:

Dates of Service
Provider
Amount Billed
CLAIMANT'S EXHIBIT NO.
DATE INSURER PAID
SHOULD HAVE BEEN PAID
R"s NOTICE OF PEN. CL.
DAYS LATE FROM NOTICE
11/8/2005
NCMC
$30.55
3
12/20/07
Page. 24
8/1/06
9-12-07
99
11/8/2005
NCMC
$9,911.20
4
12/31/07
page 37
8/1/06
9-12-07
110
11/28/2005
NCMC
$46,738.43
5
12/19/07
page 64.
8/1/06
9-12-07
98
2/17/2006
NCMC
$336.15
6
12/19/07
page 74
8/1/06
9-12-07

98
11/11/2005
Dr. Coester
$198.00
7
12/19/07
page 92
8/1/06
9-12-07
98
11/28/2005
Dr. Coester
$9823.00
8
12/19/07
page 103
8/1/06
9-12-07
98
11/28/05
GAS - Anesthesia
$1425.00
9
12/20/07
page 116
8/1/06
9-12-07
99
11/8/05
Diversified Radiology
$603.00
10
12/19/07
page 131
8/1/06
9-12-07
98
11/8/05
Diversified Radiology
$51.00
11
12/19/07
page 145
8/1/06
9-12-07
98

11/28/05
Diversified Radiology
$19.00
12
12/20/07
page 157
8/1/06
9-12-07
99
2/22/06 to 4/3/06
North Colorado Therapy Center
$1,860.00
13
4/26/08
page 196
8/1/06

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Although Claimant may be technically correct in arguing that separate penalties should be assessed in each of the 17 instances of Respondents' negligent failure to timely pay Claimant's medical bills, the ALJ finds that Respondents were engaged in a pattern of negligent misconduct for which one penalty should be assessed.

Did Respondent Insurer Fail to Obey ALJ Henk's Decision?

21. ALJ Henk's decision of June 16, 2006 required that "Respondents shall pay the medical expenses of North Colorado Medical Center and Dr. Hans Coester and their referrals." The decision was not appealed.

22. Therefore, Respondents should have paid the medical expenses on or before July 16, 2006. Respondent did not pay the medical expenses until December 12th through the 31st of 2007. The ALJ finds that Respondents willfully or negligently violated ALJ Henk's decision.

Did Respondent Insurer Act Reasonably in Failing to Pay the Medical Expenses Ordered by ALJ Henk.

23. The ALJ infers and finds that Respondent Insurer unreasonably took no active steps to comply with ALJ Henk's decision. In her testimony, Respondent Insurer's adjuster, Laurie Iverson, stated that, in general, the only action she would take following a decision directing her to pay medical expenses from particular providers on a previously contested claim was to make an entry into the computer system that withdrew the hold on payment for those providers. Essentially, Iverson implied that any failures were failures of the payment-processing center. The ALJ infers and finds that this

excuse is analogous to "the dog ate my homework" excuse. It is not a defense to the adjuster for the claim's misfeasance.

24. The ALJ infers and finds that a reasonable workers' compensation insurance carrier should have taken steps and made efforts to ascertain the extent of the medical expenses, obtain billings reflecting those medical expenses, and actually process them and make the appropriate payments within a timely manner. If the function was delegated to the "payment-processing center," then the carrier is responsible for making sure its agent has made the payments.

25. The ALJ finds that Respondent Insurer received the medical bills in question and understood they needed to be paid. Iverson testified that she sent the medical bills she received from Sandra Steele to Respondent Insurer's department (GENEX) for processing and paying medical bills. The ALJ infers and finds that GENEX was nothing more than a mere mechanical agent of the insurance carrier (*See* Respondents' Exhibit C that includes a statement by Iverson, "Please see attached bills for Kathleen Wardell. Please pay as soon as possible so the Health Carrier can ask for reimbursement of their money."

26. The ALJ finds that Respondent Insurer never challenged the sufficiency of the bills it received. To the extent that the bills received are unclear, in improper format, or do not contain sufficient information for the carrier to be able to relate the bill to compensable medical services, the Workers' Compensation Rules of Civil Procedure contain a simple and transparent framework to put providers and the parties on notice that more information is required. [*See* WCRCP (Workers' Compensation Rules of Procedure) 16-11(B) and (C), 7 CCR 1101-3]. Both Steele and Hammond credibly testified that they never received any correspondence or communication that the bills submitted for payment were insufficient. Iverson testified that no such correspondence was ever sent. As previously found, Iverson's denial is not credible.

27. The ALJ finds that Respondent Insurer unreasonably failed to review its own system to see if payments had been made. Iverson testified that she had access to the status of all actions taken by Respondent Insurer's medical payment processing center, including ascertaining what bills had been paid, and what bills were still pending payment. Iverson, however, testified that in this particular claim she never sought out this information. Based on this credible testimony against Iverson's own interest, the ALJ finds that the carrier, through its agent Iverson acted negligently in its failure to fulfill its obligation to pay the ordered medical bills. The ALJ further finds that Respondent Insurer failed to act reasonably in light of ALJ Henk's Order. Respondent Insurer unreasonably failed to review its own system to see if payments had been made. Iverson testified that she had access to the status of all actions taken by Respondent Insurer's medical payment processing center, including ascertaining what bills had been paid, and what bills were still pending payment. Iverson testified, however, that in this particular claim she never sought out this information. The ALJ finds that this further estab-

lishes Respondent Insurer's negligent attitude toward its obligation to pay the ordered medical bills.

28. Respondents argue that ALJ Henk's order was confusing because "ALJ Henk did not order Respondents to pay any specific medical bills. In fact, Claimant submitted no specific medical bills as evidence at the 2006 hearing. Claimant did not claim any medical bills were "outstanding", i.e. not paid, at the 2006 hearing. That is because all of the medical bills documented in Claimant's exhibits, but for NCT, were paid by Claimant's health insurer. ALJ Henk did not order Respondents to pay any specific medical bill. ALJ Henk did not order Respondents to reimburse Claimant's health carrier for bills they paid. ALJ Henk's order merely and cryptically ordered payment of "medical expenses". This phrase was never defined. At either hearing Claimant submitted no credible evidence of any "medical expenses" that existed then or now." (Respondents' Position Statement, page 7). Respondent Insurer employs Laurie Iverson, an adjuster with 19 years experience managing Colorado worker' compensation claims. Respondent Insurer retained the services of a competent law firm with over 20 years experience in workers' compensation law. This claimed confusion, raised for the first time in its position statement, is frivolous

29. Respondent Insurer claims that ALJ Henk "cryptically ordered payment of 'medical expenses.' That phrase was never defined." The ALJ finds this argument wholly without merit. Respondent Insurer now claims that it ignored ALJ Henk's order to pay medical expenses because she failed to direct them to pay specific medical **bills** (emphasis supplied). The Insurer focuses on the word "bill." This argument is ludicrous and entirely without merit.

The Act uses the word "expenses" twice as much as the word "bill." The phrase "expenses" occurs six times associated with medical and hospital expenses, §8-42-101(b), C.R.S. (2009); 8-42-115(a); 8-42-123; 8-46-202(1)(a); 8-46-302(1); and 8-46-303(1). "Bill", as it relates to medical services, occurs only three times and only as it prohibits provider's from seeking payment from the worker, 8-43-207(o); 8-43-501(3)(e) and Pinnacol's ability to sell its service as a medical bill processor. CRS 8-45-101). The Rules use the term "medical expenses." *The Merriam-Webster Dictionary* defines "expenses" as "something expended to secure a benefit or bring about a result; a financial burden or outlay."

Respondent Insurer provided *no evidence* of confusion caused by ALJ Henk's phrase "medical expenses." Respondents' argument is the first and only claim of confusion from ALJ Henk's use of the term "medical expenses. Counsel's argument is not evidence and is accorded no weight. The following took place at hearing:

- Laurie Iverson never testified that she did not understand by the phrase.

- Her adjuster's log fails to indicate any confusion - she indicated in her log that she understood the order requiring her to pay (Claimant's Exhibit 16, pp. 265).

- Respondents never sought to appeal or clarify this claimed ambiguity. Incredibly, Respondent fault Claimant for not seeking clarification.

30. Respondent Insurer's claim that it did not know what medical bills to pay is without merit. Before ALJ Henk, Respondents **stipulated** that the medical treatment Claimant received at Northern Colorado Medical Center (NCMC) and Dr. Coester and their referrals was reasonably necessary and authorized." [Claimant's Exhibit 1, p. 3]. ALJ Henk's Order specifically identifies NCMC and Coester. ALJ Henk also generally ordered payment of the referrals made by these two providers. Respondents criticize ALJ Henk 's Order for not including in her Order specifically that Respondents should pay "specific" bills, or "general" bills, or "Bills paid by the Health Care Insurer" or "outstanding" bills. Despite an absence of any proof, and evidence to the contrary, Respondents ask this ALJ to infer that as a result Respondent had no idea what it should have paid. This claimed ignorance is accorded no weight for the following reasons:

- Iverson never testified that she did not know what bills to pay.. Iverson clearly disavowed any decisions or authority when it came to processing and paying medical bills. Instead, Iverson testified that she acted as a mere intermediary in the transaction - transferring bills from one branch of Respondent Insurer to the medical processing payment center.

- The October 10, 2006 letter from Laurie Iverson to Sandra Steele completely undermines Respondents' argument. Respondent Insurer's position statement ignores the existence of Iverson's letter acknowledging receipt and intention to pay the bills received from Sandra Steele. That letter, along with Iverson's claimed facsimile of the same day (Respondents' Exhibit C) indicate a clear understanding that it would process and pay the bills submitted by Sandra Steele. (Claimant's Exhibit 14; 211).

- Not a single entry exists in the Adjuster's Log documenting this supposed confusion as to what bills should be paid.

- Despite this claim confusion and despite the fact that none of the medical providers (relevant to the penalty dispute) **ever** sent Respondent Insurer a single bill for payment, Respondent Insurer eventually paid all the outstanding bills by April 2008.

31. Respondent Insurer claims that no medical expenses existed at the time of the hearing. Five documented facts contradict this claim:

- medical benefits were at issue at the hearing;
- the parties stipulated that the medical care tendered by NCMC, Coester and their referrals were authorized, reasonable, necessary and related;
- the ALJ Order such medical expenses be paid;
- Respondent Insurer assured Claimant's Health Insurance that it had received the medical bills, would process and pay them; and

- The insurer increased its reserves to cover the potential cost of the medical expenses incurred prior to the hearing.

The Order and the adjuster's log make it clear that the parties understood and agreed that the treatment Claimant underwent prior to the April 2006 hearing was covered in the event compensability was found. Respondent throughout its argument introduces the word "outstanding" bills – as if it can or should be inferred that ALJ Henk sought to limit her order to only those bills no one else had paid. Nothing in the Order suggests ALJ Henk only intended to include "outstanding" bills. The Respondents argument in this regard is without merit. Raised for the first time in its post-hearing brief, Respondent Insurer's claim that it could not understand or comprehend ALJ Henk's Order to obligate it to pay medical expenses stretches reason beyond rationality and common sense and is entirely without merit.

32. Respondent Insurer knew that ALJ Henk ordered it to pay the medical expenses. It knew who the medical providers were and how to contact them. It knew of the bills and had copies of those bills. It knew that the medical providers continued to seek payment from the Claimant. It knew that the Health Insurance Carrier was waiting for it to pay the bills. It knew that medical providers filed suit against the Claimant. Knowing all of this, Respondent Insurer continues to claim that it did nothing wrong until the medical providers tracked them down to seek payment.

Aggravation/Mitigation in Determining Amount of Penalties

33. The Claimant was directly harmed. The payment of medical bills is a critical component of the benefits due to an injured worker. The Claimant was directly harmed as follows: (1) The bills were sent to a collection agency; (2) A lawsuit and judgment was obtained against her for medical bills the carrier should have timely paid; and, (3) the Claimant was denied care with the Physical Treated Center that she had successfully treated with previously.

34. Claimant concedes that the lawsuit would have been filed anyway for other debts, however, those bills, although considered marital debt, pertained to her ex-husband and not to her. In any event, 42% of the money sought to be collected in the lawsuit were due to the carrier's non-timely payment of bills due to Claimant's industrial injury herein.

35. Harm to Claimant's health insurance company is not an appropriate aggravating factor in consideration of aggravation of workers' compensation penalties, although it could not seek reimbursement of nearly $61,000.00 from medical providers until the workers compensation insurance carrier paid the Claimant's medical bills. The Claimant was, in fact, personally prejudiced and denied medical treatment because of Respondents' unreasonable failure to make timely payment of authorized medical bills.

36. The Colorado Workers' Compensation System was harmed. Penalties should serve to dissuade the insurer herein from failing to make reasonable efforts to comply with an ALJ decision to pay medical benefits, or any other benefits. Disobedience of an ALJ's un-appealed order to pay authorized medical bills is **reprehensible** to a significant degree. The disparity between the potential harm to the Claimant and the penalties to deter future misconduct equals at least $61,000.

37. The ALJ infers and finds that Respondents have shown no contrition or understanding of what they failed to do. Respondents' reaction to the situation, as reflected in the evidence, is taken into account: (1) Respondent Insurer misled the health insurance company to the effect that it would promptly and routinely pay the forwarded medical bills; (2) Respondent Insurer never denied the bills, and in fact adjusted its reserves up by $61,000.00, to reflect its obligation to pay; (3) Respondent Insurer has not expressed any contrition or understanding of its wrongdoing. Instead, it has attacked the Claimant for alleged financial mismanagement, and criticized Sandra Steele and Nancy Hammond.

38. After considering the events in this case, four dates stand out:

- **July 16, 2006** – Thirty Days after ALJ Henk's decision was issued, and pursuant to Rule, the date the medical expenses should have been paid. This is the date the carrier should have, after taking reasonable action, paid the medical bills.

- **August 1, 2006** – No timely appeal of ALJ Henk's decision taken and the day the authorized medical bills should have been paid.

- **October 10, 2006** – The date that Respondent Insurer documented receiving the medical bills and acknowledged an obligation to pay those bills. (*See* Claimant's Exhibit 14, Page 211, Respondents' Exhibit C). This is the date that Respondents, after having taken no affirmative steps of its own, nonetheless received copies of all the bills it was to pay, and acknowledged its obligation to pay those bills.

- **September 12, 2007** – The date Claimant filed an Application for Hearing requesting penalties for non-payment of the medical bills at issue. This is the day that Respondent Insurer was put on ultimate notice that it had failed to pay the medical bills and would be called to account for that failure.

Notice/Specificity

39. The latest application for hearing alleges that penalties were sought for failure of the Respondents to pay Claimant's medical bills. Because Respondent Insurer and its adjuster, Laurie Iverson, was an experienced insurer in Colorado for many years, the ALJ finds the notice provided in the application for hearing sufficient. The application provided notice that penalties were sought for the insurer's failure to pay Claimant's medical bills.

Opportunity to Cure

40. Once the Respondent Insurer had notice of claimed penalties on September 12, 2007, it failed to cure its failure to pay Claimant's medical bills within 30-days as provided by statute. Thus, Respondents have failed to prove, by preponderant evidence, that they cured their malfeasance within the time permitted by statute.

Statute of Limitations

41. As found in Finding No. 20 above, Respondents should have paid Claimant's medical bills (expenses) by August 1, 2006, after the time to appeal ALJ Henk's decision had expired. Respondents had notice that penalties were sought as of September 12, 2007. At no time did Respondents raise their proposed affirmative defense of statute of limitations until the beginning of the first session of the hearing herein on August 24, 2009, and they did so verbally at that time. At the threshold, the ALJ denied endorsement of this issue as untimely and waived. Claimant desired to proceed at the time and had no prior notice of a proposed statute of limitations affirmative defense.

Ultimate Findings

42. Claimant has proven, by a preponderance of the evidence that Respondents negligently failed to pay Claimant's outstanding, authorized and reasonably necessary medical bills in a timely fashion. Specifically, Respondents failed to pay 17 medical bills, as illustrated in the table under Finding No. 20 above, in a timely fashion. Respondents should have paid these bills on August 1, 2006. Although Respondents had notice that penalties were being claimed as of September 12, 2007, Respondents did **not** make the first payment, as illustrated in Finding No. 20 above, until December 19, 2007, 98 days had notice that penalties for non-payment were being claimed. Respondents made the last payment on April 26, 2008, 227 days after they had notice that penalties for non-payment were being claimed. The ALJ finds that Respondents' pattern of negligent misconduct spanned the period from August 1, 2006 through April 25, 2008, however, Respondents had notice that penalties were being claimed as of September 12, 2007; and, Respondents made no effort to cure, and failed to cure, their misconduct within thirty days of their notice of the claimed penalties. Under the circumstances, the ALJ finds that Respondents negligent failure to pay Claimant's medical bills in a timely manner was beyond **unreasonable**, based on any objective standard. Respondents did not timely appeal ALJ Henk's decision. They did not contest the authorization, causal relatedness or reasonable necessity of the medical treatment. And, they offered no reasonable excuse, other than adjuster Laurie Iverson's **incredible** denial concerning receipt of the medical bills. Indeed, the insurance carrier made no **rational** argument to explain its failure to pay medical bills on a timely basis.

43. Claimant has proven, by a preponderance of the evidence that Respondents have shown no mitigation for their untimely payment of Claimant's medical bills, as illustrated in Finding No. 20. Moreover, Claimant has proven, by a preponderance of the evidence that aggravating factors, as illustrated in Findings Nos. 28 through 33

above, exist and Claimant was, in fact harmed, and the potential for even greater harm up to the Claimant existed up to the amount of $60,000.00.

44. The ALJ finds that Respondents' aggravated pattern of negligent failure to timely pay Claimant's medical bills was, in fact reprehensible as compared to similar cases of negligent failure to pay medical bills; and the $60,000.00 potential for harm and medical providers ultimate refusal to treat Claimant because of the Respondents failure to pay her medical bills in a timely fashion, compels a severe penalty to vindicate the dignity of ALJ orders to pay and deter insurance carriers from similar negligent misconduct in the future.

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 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, Laurie Iverson, Respondents' adjuster, denied receiving the faxes from Nancy Hammond, Reimbursement Analyst with North Colorado Physical Therapy. Also, as found, Iverson denied any communication with Nancy Hammond. Because of Iverson's interest in this matter, the ALJ infers and finds that she is motivated to **not** be portrayed as mishandling this claim. On the other hand, Nancy Hammond is much more credible than Iverson for the following reasons:

i. Hammond took contemporaneous notes detailing her efforts to receive payment of these medical services.

ii. Hammond, unlike Iverson, has no stake in the outcome of this hearing. NCTC bills have been paid, and neither she, nor NCTC, will be affected by this decision.

iii. Hammond had no incentive or reason to misrepresent her efforts to obtain payment. Timely payment was her sole objective.

Therefore, the ALJ finds Nancy Hammond credible and persuasive and Laurie Iverson unworthy of belief and not credible.

Penalty Standard

b. Penalties may be imposed against an insurer who "(1) violates any provision of the Act; (2) does any act prohibited by the Act; (3) fails or refuses to perform any duty lawfully mandated within the time prescribed by the director or the Panel; or (4) fails, neglects, or refuses to obey any lawful order of the director or the Panel." *Pena v. Industrial Claim Appeals Office,* 117 P.3d 84, 87 (Colo. App. 2004); *see also* § 8-43-304(1), C.R.S. (2009). As found, Respondents negligently failed to pay Claimant's medical bills in a timely fashion.

c. Generally, the imposition of penalties under § 8-43-304(1), C.R.S. (2009), requires a two-step analysis. First, it must be determined whether a party has violated the Act in some manner, or failed to carry out a lawfully enjoined action, or violated an order. If a violation is found, it must be determined whether the violator acted reasonably. *See Allison v. Industrial Claim Appeals Office*, 916 P.2d 623 (Colo. App. 1995). As found, Respondents failed to obey ALJ Henk's order of June 16, 2006 to pay Claimant's authorized medical bills. As further found, Respondents negligent failure to pay Claimant's medical bills in a timely fashion was **beyond unreasonable**.

d. Where a violation is found, the violator is subject to a penalty if the violator's actions were objectively unreasonable. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 907 P.2d 676 (Colo. App. 1995). As found, Respondents failure to timely pay Claimant's medical bills was **unreasonable** by any objective standard. An insurance carrier that fails to obey an order of an ALJ and subsequently fails to take the action that a reasonable insurer would take to comply with the order is acting **unreasonably** by any objective standard. *See Jiminez v. Industrial Claim Appeals Office*, 107 P.3d 965, 967 (Colo. App. 2003). The reasonableness of an insurer's action depends on whether the action was predicated on a rational argument based in law or fact. *Id.* As found, the insurance carrier made no **rational** argument to explain or mitigate its malfeasance. The existence of a violation and the reasonableness of the violator's conduct are issues of fact for determination by the ALJ. *See Human Resource Co. v. Industrial Claim Appeals Office*, 984 P.2d 1194 (Colo. App. 1999).

Burden of Proof

e. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits, including penalties. §§ 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). Also, the burden of proof is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P. 2d 535 (Colo. App. 1992). A "preponderance of the evidence" is that

quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant has sustained her burden of proof, specifically, ALJ Henk's Order of June 16, 2006 required that "Respondents shall pay the medical expenses of North Colorado Medical Center and Dr. Hans Coester and their referrals." Her Order was not appealed. Workers' Compensation Rules of Procedure (WCRCP), Rule 5-6(A), 7 CCR 1101-3, provides that "Benefits awarded by order are due on the date of the order. After all appeals have been exhausted or **in cases where there have been no appeals, insurers shall pay benefits within thirty days of when the benefits are due***.* Any ongoing benefits shall be paid consistent with statute and rule." (Emphasis supplied). Therefore, Respondents should have paid the medical expenses on or before August 1, 2006. As found, Respondent did not pay the medical expenses until December 19, 2007 through April 26, 2008. Respondents violated the ALJ Henk's Order to pay Claimant's medical benefits.

f. Respondent Insurer provided no evidence of confusion caused by ALJ Henk's phrase "medical expenses.**"** "Neither the statute nor the rules require, mandate or even suggest that the adjuster contact healthcare providers to find out whether or not there are any outstanding medical bills and request bills in proper format with documentation. The legislature has not chosen to expand the Workers' Compensation Act to require this. The Director in interpreting the Workers' Compensation Act as promulgated by the legislature has not created rules requiring this. Non-existent provisions cannot be read into the Act or rules." (Respondent's Position Statement, Page 8). If **ignorance** is Respondents' defense, they have failed to prove it by any persuasive evidence.

g. As found, Respondents argue: "Neither the statute nor the rules require, mandate or even suggest that the adjuster contact healthcare providers to find out whether or not there are any outstanding medical bills and request bills in proper format with documentation. The legislature has not chosen to expand the Workers' Compensation Act to require this. The Director in interpreting the Workers' Compensation Act as promulgated by the legislature has not created rules requiring this. Non-existent provisions cannot be read into the Act or rules." (Respondent's Position Statement, Page 8). This argument is wholly without merit.

Did Respondent Insurer act reasonably in failing to pay the medical expenses ordered by ALJ Henk.

h. As found, Respondent Insurer unreasonably took no active steps to comply with the Order. Adjuster, Laurie Iverson, stated that, in general, the **only action** she would take following an Order directing her to pay medical expenses from particular providers on a previously contested claim was to make an entry into the computer system that withdrew the hold on payment for those providers.

i. The Workers' Compensation system requires Insurers to take active reasonable steps to obey an order. A reasonable insurer should have made efforts to ascertain the extent of the medical expenses, obtain billings reflecting those medical expenses, and actually process and make the appropriate payments within a timely manner. For example, when ordered to provide a hot tub, it was previously found that a reasonable insurer would have taken action to contact the claimant, obtain specifications from the treating physician, and provide the physician with the specifications of the hot tub the insurer sought to purchase. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office, supra* [Although the order did not specify the amount of money the insurer was to pay for the hot tub, an ALJ found the insurer violated the order because a reasonable insurer would taken active steps].

j. The Workers' Compensation Act does not require an ALJ to specify every step a party must take in reasonable compliance with an Order. Holding otherwise would frustrate the system and the "remedial and beneficent in purpose of the Act." *See Davison v. Industrial Claim Appeals Office,* 84 P.3d 1023 (Colo. 2004); *Weld County Sch. Dist. RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). It would require the parties and ALJ to spell out in exhaustive detail all of the foreseeable steps and minute actions required to realize the payment of ordered benefits. Suffice it to say, a clear Order, such as ALJ Henk's Order, was sufficient to require the carrier herein to take reasonable steps to ensure timely payment of Claimant's medical bills. Respondent Insurer received the bills and understood they needed to be paid. Laurie Iverson stated that she sent the medical bills she received from Sandra Steele to Respondent Insurer's department (GENEX) for processing and paying medical bills. Respondents' Exhibit C documents this, including a statement by Iverson, "**Please see attached bills for Kathleen Wardell. Please pay as soon as possible so the Health Carrier can ask for reimbursement of their money**." (Emphasis supplied).

k. Respondent Insurer never challenged the sufficiency of the bills it received. To the extent that bills received are unclear, in improper format, or do not contain sufficient information to be able to relate the bill to compensable medical services, the Workers' Compensation Rules of Procedure contain a simple and transparent framework to put providers and the parties on notice that more information is required. *See generally* WCRCP 16-11(B) and (C). As found, both Sandra Steele and Nancy Hammond testified that they never received any correspondence or communication that the bills submitted for payment were insufficient. Iverson denied, incredibly, that such correspondence was ever sent. Respondent Insurer unreasonably failed to review its own system to see if payments had been made. Ms. Iverson testified that she had access to the status of all actions taken by Respondent Insurer's medical payment processing center, including ascertaining what bills had been paid, and what bills were still pending payment. However Ms. Iverson testified that in this particular claim she *never sought out* this information, this further establishes Respondent Insurer's insouciant attitude toward its obligation to pay the ordered medical bills.

l. As found, Respondents argue that ALJ Henk's order was confusing because "ALJ Henk did not order Respondents to pay any <u>specific</u> medical bills. In fact,

Claimant submitted no specific medical bills as evidence at the 2006 hearing. Claimant did not claim any medical bills were "outstanding", i.e. not paid, at the 2006 hearing. That is because all of the medical bills documented in Claimant's exhibits, but for NCT, were paid by Claimant's health insurer. ALJ Henk did not order Respondents to pay any specific medical bill. ALJ Henk did not order Respondents to reimburse Claimant's health carrier for bills they paid. ALJ Henk's order merely and cryptically ordered payment of "medical expenses". This phrase was never defined. At either hearing Claimant submitted no credible evidence of any "medical expenses" that existed then or now." (Respondents' Position Statement, page 7). Respondent Insurer employs Laurie Iverson, an adjuster with 19 years experience managing Colorado worker' compensation claims. Respondent Insurer retained the services of a competent law firm with over 20 years experience in workers' compensation law. This claimed confusion, raised for the first time in its position statement, is frivolous.

m. As also found, Respondent Insurer claims that ALJ Henk *"*cryptically ordered payment of 'medical expenses.' That phrase was never defined." The ALJ finds this argument wholly without merit. Respondent Insurer now claims that it ignored ALJ Henk's order to pay medical expenses because she failed to direct them to pay specific medical **bills** (emphasis supplied). The Insurer focuses on the word "bill." This argument is ludicrous and entirely without merit. The Workers' Compensation ActAct uses the word "expenses" twice as much as the word "bill." The phrase "expenses" occurs six times associated with medical and hospital expenses, § 8-42-101(b), C.R.S. (2009); 8-42-115(a); 8-42-123; 8-46-202(1)(a); 8-46-302(1); and 8-46-303(1). "Bill", as it relates to medical services, occurs only three times and only as it prohibits provider's from seeking payment from the worker, §8-43-207(o); §8-43-501(3)(e) and Pinnacol's ability to sell its service as a medical bill processor. § 8-45-101). The Rules use the term "medical expenses." WCRCP 16.2 (O) defines "Payer" as an insurer, employer, or their designated agent(s) who is responsible for payment of **medical expenses** (Emphasis Supplied). *The Merriam-Webster Dictionary* defines "expenses" as "something expended to secure a benefit or bring about a result; a financial burden or outlay." To argue that the difference between "medical Expenses" and "medical bills" is pivotal is frivolous and entirely without merit.

Respondent Insurer Failed to Act Reasonably

n. Penalties are appropriate in this case. Holding otherwise would frustrate the system and the "remedial and beneficent purpose of the Act." *See Davison v. Industrial Claim Appeals Office,supra; Weld County Sch. Dist. RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). As found, penalties are appropriate herein.

Specificity Requirement

o. §8-43-304 (4), C.R.S. (2009), requires an application for hearing to state with specificity the grounds on which a penalty is being asserted. The fundamental requisites of due process are notice and the opportunity to be heard. *Wecker v. TBL Exca-*

vating, Inc., 908 P.2d 1186 (Colo. App. 1995). The circumstances of each individual case must be examined in determining the sufficiency of notice. It is not acceptable for an experienced workers' compensation insurer to assert **ignorance** of the statutory basis for penalties under the circumstances of this case. *See Lobato v. Taylor,* 70 P.3d 1152 (Colo. 2003). As found, the application for hearing alleges that penalties were sought for failure of the Respondents to pay Claimant's medical bills and the ALJ found this to be adequate notice for an experienced Colorado workers' compensation insurance carrier. *See Carlee Carson v. Indus. Claim Appeals Office* [Court of Appeals No. 03CA0955, October 7, 2004 (not published)].Opportunity to Cure

Opportunity to Cure

p. § 8-43-304 (4), C.R.S. (2009), provides that an alleged violator shall have twenty days after the date of mailing of an application for hearing on penalties within which to cure the violation. As found, September 12, 2007 was the date that Claimant filed her first application for hearing claiming penalties for Respondents' failure to timely pay the Claimant's authorized medical bills (expenses). Respondents failed to cure their violations within twenty days of their notice that penalties were being claimed. As found, the first payment made by Respondents was on December 19, 2007.

Statute of Limitations

q. The statute of limitations is an affirmative defense that must be raised by the insurance carrier and if it is not timely raised it is waived. *Kersting v. Industrial Commission,* 39 Colo. App. 297, 567 P.2d 394 (1977). As found, Respondents had notice that penalties were sought as of September 12, 2007. At no time did Respondents raise their affirmative defense of statute of limitations until the beginning of the first session of the hearing herein on August 24, 2009, and they did so verbally at that time. At the threshold, the ALJ denied endorsement of this issue as untimely and waived. Claimant desired to proceed at the time and had no prior notice of a proposed statute of limitations. Because "statute of limitations" is an affirmative defense, it is not jurisdictional and it must be timely raised, like any other affirmative defense, or it is waived. *See Carlee Carson v. Indus. Claim Appeals Office, supra*.

Mitigation/Aggravation

r. Limited by constitutional constraints, the ALJ's decision regarding the amount of the penalty under § 8-43-304(1), C.R.S. (2009), remains highly discretionary, which implies that the ALJ may consider a wide variety of factors. W.C. No. 4-705-940, [Industrial Claim Appeals Office (ICAO), April 29, 2009]. The following factors may be considered in determining the amount of the penalty assessed: (1) the reprehensibility of the conduct; (2) the disparity between the harm caused by the violation and the penalty; and, (3) the difference between the penalty and civil damages that could be im-

posed in comparable cases. *Associated Business Products v. Industrial Claim Appeals Office of State of Colo.,* 126 P.3d 323, (Colo. App., 2005). Also, an ALJ may apply a progressive amount of penalties according to the length of time. *Case v. Manpower*, W.C. No. 4-688-233 (ICAO, December 20, 2007). As found, there was **no** mitigation or contrition. On the contrary, Respondent Insurer's adjuster, Laurie Iverson, denied receiving the bills, which was contradicted by two very credible and objective witnesses, Sandra Steele of ISM and Nancy Hammond of North Colorado Physical Therapy. This is an aggravating factor.

s. Based on the finding that Respondent Insurer's negligent failure to begin paying the authorized medical bills for 98 days after notice that penalties were being claimed, the ALJ determines that one penalty, instead of 17 separate penalties should be assessed. The maximum daily penalty of $500 per day is warranted, in the aggregate amount of $49,000.00. This is $12,000.00 less than a measure of the potential harm to the Claimant ($61,000.00), but it is the maximum daily penalty permitted by law. This is a measure of mercy to Respondents because the maximum penalty could have been based on 227 days, the day Respondent Insurer paid the last medical bill, for a total of $113,500.00, at $500 per day.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondent Insurer shall pay aggregate penalties of $49,000.00: 75%, or $36,750.00, payable to the Claimant; and, 25%, or $12,250.00, payable to the Subsequent Injury Fund created pursuant to § 8-46-101, C.R.S., Division of Workers' Compensation. These sums are payable retroactively and forthwith.

B. Respondent Insurer shall pay the Claimant and the Subsequent Injury Fund statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

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

DATED this_____day of December 2009.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-782-446

ISSUES

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

2. Whether Claimant has demonstrated by a preponderance of the evidence that the medical treatment she received prior to reporting an occupational disease on November 8, 2008 was authorized.

STIPULATION

The parties agreed that Claimant earned an Average Weekly Wage (AWW) of $520.40.

FINDINGS OF FACT

1. Claimant is a 58 year old female who has worked for Employer since 2003 as a school custodian. Her job duties include cleaning a number of classrooms, bathrooms and modular buildings. Claimant also mopped the gymnasium floor and removed scuffmarks on the floor using a tennis ball connected to a stick.

2. Claimant testified that she began to experience pain in her hands and arms in May 2008. She specifically noted that she had to apply repetitive force in order to remove the scuff marks on the gymnasium floor with the tennis ball attached to the stick. On May 6, 2008 Claimant sent an e-mail to supervisor Tom Beach stating that she was unhappy with two of her coworkers. In the e-mail Claimant mentioned that she might have "carpal tunnel." However, she did not request any medical treatment or otherwise apprise Employer of a work-related claim.

3. In July of 2008 Claimant worked on stripping epoxy or wax from a bathroom floor in the school. A solvent and mechanical stripper were insufficient to remove all of the wax. To remove the remainder of the wax Claimant used a razor blade held in a five inch handle. She switched between her right and left hands while performing the work. Claimant testified that it took her eight hours each day for five days to complete the wax or epoxy removal. She explained that she suffered permanent hand and wrist symptoms subsequent to July 2008. Nevertheless, Claimant continued to perform her full-time janitorial duties.

4. On October 22, 2008 Claimant visited personal physician Kosta M. Zinis, D.O. for an evaluation. Claimant reported bilateral wrist and hand pain over the previous three months. She explained that she experienced pain, numbness and tingling that increased at work. Dr. Zinis noted that Claimant suffered from hypothyroidism. He determined that Claimant suffered from possible bilateral Carpal Tunnel Syndrome (CTS) and ordered an EMG. A subsequent EMG confirmed that Claimant suffered from bilateral CTS.

5. On November 6, 2008 Claimant filed a Workers' Claim for Compensation asserting that she suffered the occupational diseases of CTS and left neck pain as a

result of her job duties for Employer. She contended that "repetitive use of hands cleaning" caused her CTS but did not specifically mention either the removal of scuff marks from the gymnasium floor or the scraping of wax from the bathroom floor.

6. Employer directed Claimant to Authorized Treating Physician (ATP) Robert Massa, M.D. for medical treatment. On November 13, 2008 Claimant visited Dr. Massa for an evaluation. He noted that she suffered from bilateral CTS and a cervical neck strain. Dr. Massa mentioned that he had not been able to review Dr. Zinis' notes. Dr. Massa did not assess the cause of Claimant's symptoms but prescribed removable wrist splints for Claimant's bilateral CTS.

7. On January 22, 2009 Insurer's Physician Advisor Jeff Raschbacher, M.D. reviewed Claimant's request for bilateral CTS release surgery. He noted that Claimant suffered from a thyroid disorder and was a female member of the 50-59 year old age group. Dr. Raschbacher remarked that Claimant thus presented with several risk factors for developing CTS. He commented that none of Claimant's physicians had performed an adequate causation assessment to determine whether Claimant's CTS was related to her duties for Employer. Dr. Raschbacher thus concluded that there was insufficient information to establish that Claimant's bilateral CTS was related to her employment. He thus recommended denial of Claimant's request for bilateral CTS release surgery.

8. Claimant continued to obtain medical treatment from ATP Dr. Massa. On March 2, 2009 Dr. Massa remarked that Claimant's CTS symptoms were much worse on her right side than on the left side. Dr. Massa explained "[i]t is unclear to me based on how this case was presented about the true work relatedness of these injuries." He recommended that Claimant obtain an independent medical examination to ascertain whether her condition was related to her work for Employer.

9. On July 13, 2009 Claimant underwent an independent medical examination with Ronald J. Swarsen, M.D. Dr. Swarsen concluded that Claimant's bilateral CTS and neck symptoms were caused by her job duties for Employer. He noted that Claimant recounted an onset of her symptoms as a result of the forceful, repetitive activity involved in removing wax or epoxy from a school bathroom floor. Dr. Swarsen explained that Claimant developed an "overuse syndrome of her wrist with pain and aching along with the onset of symptoms of carpal tunnel syndrome for which she eventually sought care."

10. On July 16, 2009 Claimant underwent an independent medical examination with F. Mark Paz, M.D. Dr. Paz initially remarked that CTS "may develop as a result of a combination of median nerve compression mechanically and ischemia of the median nerve." He noted that CTS may also be caused by "an abnormal metabolic etiology such as hypothyroidism." Dr. Paz explained that contributing activities to the development of CTS involve repetitive, forceful wrist movements and vibration.

11. In order to ascertain the cause of Claimant's bilateral CTS, Dr. Paz asked Claimant to demonstrate her wrist position when she was scraping wax or epoxy from

the school bathroom floor in July 2008. Claimant then demonstrated the posture and orientation of her wrists. Dr. Paz stated that Claimant's demonstration of her activities did not reveal that her wrists were engaged in flexion or extension. Instead, Claimant's wrists were in a neutral position. Dr. Paz explained that the flexion or extension of the wrists has the potential to "stretch" the median nerve as it passes through the carpal tunnel. Dr. Paz concluded that, based on Claimant's history, his physical examination, and a review of the medical records, a work related cause for Claimant's condition could not be established based on a reasonable degree of medical certainty. He also commented that Claimant's pre-existing CTS was not permanently aggravated by her job duties for Employer. Dr. Paz remarked that Claimant's condition evolved insidiously beginning with night symptoms. He finally explained that Claimant's neck concerns were not caused by her work for Employer because she did not disclose any neck symptoms to Dr. Zinis during her initial evaluation on October 22, 2008.

12. On October 8, 2009 the parties conducted the post-hearing evidentiary deposition of Dr. Paz. He reiterated that Claimant's job duties for Employer did not cause or aggravate her bilateral CTS or neck symptoms. Dr. Paz again explained that Claimant's demonstrated wrist orientation reflected that she did not perform her job duties while in a continuous or predominantly flexed position and thus compromise the blood flow to her median nerve. He noted that hypothyroidism, even if well-controlled, is a risk factor for the development of CTS. Dr. Paz explained that, because Claimant suffers from a very symmetric, bilateral occurrence of CTS, her condition is more likely related to the systemic condition of hypothyroidism than her work for Employer.

13. Claimant has failed to establish that it is more probably true than not that she sustained an occupational disease during the course and scope of her employment with Employer. Claimant's CTS and left neck pain were not caused, accelerated, intensified or aggravated by her job duties for Employer. Initially, ATP Dr. Massa questioned whether Claimant's bilateral CTS and neck symptoms were caused by her job duties for Employer and recommended an independent medical examination. Dr. Raschbacher noted that Claimant possessed risk factors for the development of CTS and there was insufficient information to establish a causal relationship between her bilateral CTS and her employment. Dr. Paz persuasively concluded that Claimant's bilateral CTS and neck symptoms were not caused or aggravated by her custodial duties. He stated that Claimant's demonstration of her work activities in removing wax or epoxy from a school bathroom floor did not reveal flexion or extension of the wrists. Instead, Claimant's wrists remained in a neutral position. Dr. Paz explained that the flexion or extension of the wrists has the potential to "stretch" the median nerve as it passes through the carpal tunnel. He also persuasively commented that hypothyroidism, even if well-controlled, is a risk factor for the development of CTS. Dr. Paz remarked that, because Claimant suffers from a very symmetric, bilateral occurrence of CTS, her condition is more likely related to the systemic condition of hypothyroidism than her work for Employer. In contrast, Dr. Swarsen's opinion that Claimant's bilateral CTS and neck pain were caused by her work for Employer is not persuasive. He failed to consider Claimant's CTS symptoms prior to scraping wax or epoxy in July 2008, her wrist position while engaged in scraping. Dr. Swarsen also did not address CTS risk factors including hypothyroidism,

older age and female gender as delineated in the Guidelines. Therefore, Claimant's CTS and left neck pain cannot be fairly traced as a proximate cause to her employment with Employer.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. 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. 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. as:

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

6. A claimant is required to prove by a preponderance of the evidence that the alleged occupational disease was directly or proximately caused by the employment or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251, 252 (Colo. App. 1999). Moreover, §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.*

7. The DOWC CTS Medical Treatment Guidelines (Guidelines) provide that the highest risk occupational factors associated with the development of CTS involve the combination of “high exertional force” and “high repetition.” The presence of a “concurrent disease does not negate the work relatededness of any specific case.” However, the Guidelines provide that hypothyroidism in older females is a risk factor for the development of CTS.

8. As found, Claimant has failed to establish by a preponderance of the evidence that she sustained an occupational disease during the course and scope of her employment with Employer. Claimant’s CTS and left neck pain were not caused, accelerated, intensified or aggravated by her job duties for Employer. Initially, ATP Dr. Massa questioned whether Claimant’s bilateral CTS and neck symptoms were caused by her job duties for Employer and recommended an independent medical examination. Dr. Raschbacher noted that Claimant possessed risk factors for the development of CTS and there was insufficient information to establish a causal relationship between her bilateral CTS and her employment. Dr. Paz persuasively concluded that Claimant’s bilateral CTS and neck symptoms were not caused or aggravated by her custodial duties. He stated that Claimant’s demonstration of her work activities in removing wax or epoxy from a school bathroom floor did not reveal flexion or extension of the wrists. Instead, Claimant’s wrists remained in a neutral position. Dr. Paz explained that the flexion or extension of the wrists has the potential to “stretch” the median nerve as it passes through the carpal tunnel. He also persuasively commented that hypothyroidism, even if well-controlled, is a risk factor for the development of CTS. Dr. Paz remarked that, because Claimant suffers from a very symmetric, bilateral occurrence of CTS, her con-

dition is more likely related to the systemic condition of hypothyroidism than her work for Employer. In contrast, Dr. Swarsen's opinion that Claimant's bilateral CTS and neck pain were caused by her work for Employer is not persuasive. He failed to consider Claimant's CTS symptoms prior to scraping wax or epoxy in July 2008, her wrist position while engaged in scraping. Dr. Swarsen also did not address CTS risk factors including hypothyroidism, older age and female gender as delineated in the Guidelines. Therefore, Claimant's CTS and left neck pain cannot be fairly traced as a proximate cause to her employment with Employer.

ORDER

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

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

DATED: December 17, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-789-836

ISSUES

The issues for determination are compensability, medical benefits, and temporary disability benefits, including responsibility for termination.

FINDINGS OF FACT

1. Claimant was hired by EP as a truck driver. EP's company had a lessee contract with Employer to pick up and deliver perishable food items. Claimant was a salaried employee of EP, receiving his paychecks directly from him. Claimant's average weekly wage was $925.00.
2. On May 16, 2008, Claimant was in Illinois unloading a truck when he slipped, fell and hit his right elbow on the floor. Claimant continued to work immediately after the injury but his elbow swelled. Dispatch referred him to obtain medical treatment from Concentra. Claimant has received treatment from Concentra and from other medical care providers.
3. As an employee of a common carrier, Claimant was covered by an accident policy. Claimant was off work from July 29 to August 19, 2008. Claimant was paid by Zurich

$2,358.86 in wage replacement benefits. Claimant's medical bills and wages for lost time were paid by Zurich.

CONCLUSIONS OF LAW

Claimant was hired by EP to drive trucks. EP was a lessee of Employer, picking up and delivering perishable food items for Employer.

Section 40-11.2-102(5)(a), C.R.S., provides that any lease executed pursuant to the statutory section shall provide for coverage under workers' compensation or a private insurance policy that provides similar coverage. Similar coverage means disability insurance for on and off the job injury, health insurance and life insurance, with benefits comparable to the benefits offered under the workers' compensation system.

Claimant admitted that he was covered by a Zurich accident insurance policy and that it paid for his medical benefits and time off work. It is Claimant's burden to prove that the benefits were not similar such that he would no longer be construed to be an independent contractor. Claimant has failed to do so. Claimant's medical bills were paid in full. Claimant's wage replacement was paid. Claimant's average weekly wage was $925.00 per week. Claimant was off work from July 29, 2008 to August 19, 2008. Under workers' compensation, he would have been entitled to $1,938.10 in temporary total disability benefits. He received a total of $2,358.86 from Zurich for wage replacement benefits. Claimant received similar benefits to workers' compensation benefits.

The facts in this case are almost identical to the facts in *FFE Transportation Services, Inc. v. Industrial Claim Appeals Office*, 93 P.3d 630 (Colo.App. 2004). As in the *FFE* case, Claimant was an employee of a trucking company that had a lease with Employer, a contract carrier. EP and Claimant, through Employer, had an accident policy. The fact that Claimant is not a party to the lease agreement between EP and Employer is immaterial. He is a truck driver working "under" a lease agreement.

Section 8-41-401, C.R.S., is inapplicable to any person excluded from the definition of employee pursuant to Section 8-40-301(5), C.R.S. That person excludes any person who is working as a driver under a lease agreement pursuant to Section 40-11.5.102, C.R.S., with a common carrier or contract carrier. As concluded by the Court of Appeals in *FFE, supra*, Section 8-40-301(5), C.R.S., specifically refers to drivers as opposed to independent contractors. This is in sharp contrast to Section 40-11.5-102, which prescribes how lease contracts between contract carriers and their common carrier independent contractors may use assistants. Had the General Assembly intended to exclude only independent contractors from the definition of statutory employee, it would not have allowed independent contractors to use assistants. *FFE, supra.* Likewise, Had the General Assembly intended to limit the exclusion of Section 8-40-301(5), C.R.S., to only independent contractors in direct contractual privity with the contract carrier, there would have been no need to add the provisions of Section 8-40-301(6), C.R.S., relating to drivers, because in that event the two provisions would be redundant in the "driver" and "independent contractor" would be interchangeable terms.

FFE, supra. As in *FFE*, "here, the interest of providing insurance to workers is severed because a policy was in force that paid benefits to the injured claimant." *FFE, supra*.

Claimant's arguments regarding control of Claimant by Employer are irrelevant. Section 40-11.5-102, C.R.S., specifically provides that there can be control over both the independent contractor (lessee) and the driver. This does not change the applicability of Section 40-11.5-102, C.R.S., to Claimant.

This injury is not compensable under the Workers' Compensation Act of Colorado. Other issues are not reached.

ORDER

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

DATED: *December 18, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-798-365

ISSUES

The issues for determination are compensability, medical benefits, authorized medical care providers, average weekly wage, and temporary total or temporary partial disability benefits.

FINDINGS OF FACT

1. Claimant is employed by Employer as a Transportation or Court Services Deputy. The parties have stipulated that he earns an average wage of $780.98 per week in that employment. Claimant has been employed with Employer since January 2003.
2. Claimant's primary duties with Employer entail transporting inmates between the Detention Center and the County Courts. Employer uses a Ford Expedition, Ford Crown Victorias, vans, and a modified van called a High Risk Transport Vehicle ("HRTV"). Throughout his employment with Employer, every one to two months Claimant's shift has rotated between a "set-up" shift from 5:00 a.m. to 1:00 p.m., and the transport shift that begins at 7:30 a.m. and ends at 3:30 p.m.
3. Claimant is also concurrently employed as a Certified Nurses Assistant (CNA). Claimant began part-time work as a CNA in June 2009. Claimant is paid hourly for the in-home healthcare he provides to his autistic son. Claimant's wage records reflect that

the hours worked as a CNA have varied from month to month, both before and after July 13, 2009. This variation resulted from the differing demands of his work for Employer.

4. When his shifts with Employer allow, Claimant works as a CNA from 5:00 a.m. to 7:00 a.m. on weekdays. Claimant works as a CNA for a few hours in the evening and on the weekends. When his hours at Employer prevent him from providing care for his son, his wife performs those services. Claimant is paid weekly as a CNA, with checks issued six days after the weekly pay period ends.

5. In the ten weeks prior to his injury, Claimant earned $454.74 in his work as a CNA, an average of $45.47 per week.

6. On July 13, 2009, as part of his duties with Employer, Claimant was transporting several inmates in the HRTV between the Detention Center and the County Courts. After court proceedings had finished, the inmates were loaded into the HRTV. While a fellow officer was loading some inmates into the side door of the HRTV, Claimant climbed into the HRTV, grabbing the steering wheel with his left hand, and stepping onto a step with his left leg. The step in the HRTV was just inside the driver's side door of the HRTV.

7. After Claimant stepped onto the step, Claimant testified that he turned to see if the vehicle parked behind the HRTV had moved. He testified that, as he turned, he felt a burning sensation in his left knee. He then sat down and drove the inmates back to the Detention Center.

8. Upon his return to the Detention Center, Claimant informed his supervisor that he had injured his knee. The supervisor promptly referred Claimant to Dr. Holthouser at Occupational Health Services.

9. Dr. Holthouser saw Claimant on July 13, 2009, and took a history from him. Claimant told him that he was climbing into the HRTV when he "twisted his left knee under full weight and felt a stinging pain…." Based upon this history, Dr. Holthouser concluded that Claimant suffered a work-related injury.

10. After this initial visit, a phone conversation took place between Dr. Holthouser and a representative of Employer. The representative questioned whether Claimant suffered a particular injury arising out of his employment or whether climbing into the HRTV was similar to performing the usual activities of daily living.

11. After the phone call, Dr. Holthouser requested that Claimant bring the HRTV to his office on July 14, 2009. Dr. Holthouser asked Claimant to "climb into the van as he did the day he was injured, as closely as possible…" Claimant told the doctor that he was not interacting with any inmates at the time nor performing any duties unique to his position with Employer. On July 14, 2009, Claimant did not tell Dr. Holthouser that he twisted as he got into the HRTV. Claimant did give a history of twisting to Dr. Holthouser on July 13, 2009. Typically, when a person twists to look behind him, the person will twist at the torso, not at the knee.

12. Claimant demonstrated that he stepped as he would on regular stairs at home, grasping the steering wheel with his left hand, walking up and sitting down in the large driver's seat of the HRTV. There was a "small amount of twisting required" as Claimant fixed his foot on the floorboard and swung sideways to sit down. Dr. Holthouser explained that there was a massive, big door to the HRTV and regular steps stepping up to it with a very large seat. Based upon the doctor's observations on July 14, 2009, he

concluded that there was no mechanism of injury and that Claimant suffered no trauma to his knee as he climbed into the van. Dr. Holthouser issued a report on July 14, 2009, reflecting his conclusion that Claimant did not suffer from any work-related condition. He noted that Claimant's movements in ascending the stairs into the HRTV would be the same as climbing the stairs at home.

13. At the hearing, Claimant testified that his knee was painful on July 14, 2009, and he was not sure whether he duplicated the way that he got into the HRTV on the date the injury allegedly occurred. He understood that this was the purpose of this demonstration to Dr. Holthouser and could not recall whether he told the doctor that he was not able to completely duplicate the maneuver.

14. Claimant testified that, as he was getting into the HRTV at the time of the incident, he looked behind him and twisted. Claimant mentioned twisting to Dr. Holthouser on July 13, 2009, to Dr. Schtleben on July 17, 2009, and to Dr. Hughes on October 26, 2009. The testimony of Claimant that he twisted as he was stepping into the HRTV on July 13, 2009, is credible and persuasive.

15. On July 14, 2009, Dr. Holthouser referred Claimant to see his primary care physician for an MRI of the left knee and appropriate treatment depending on the findings. Claimant sought care at the Orthopedic Center of the Rockies. He was treated by Dr. Trumper and Dr. Sachtleben.

16. An MRI was done of Claimant's left knee on July 22, 2009. This showed a "horizontal cleavage tear of the posterior horn and body of the medial meniscus with a parameniscal cyst measuring 7x4 mm." Claimant underwent outpatient surgery on August 25, 2009, and returned to work for Employer on September 11, 2009. On September 18, 2009, he was released to full duty.

17. After the injury, Employer placed Claimant on the set-up shift from 5:00 a.m. to 7:00 a.m., until he underwent surgery to repair his left knee on August 25, 2009. Claimant was never disabled from performing services as a CNA. His wages at Employer were not reduced except during the period of time when he was completely off work between August 25 and September 11, 2009.

18. In approximately mid 2008, Claimant began to experience pain in his right knee. He suffered no specific injury but simply awoke one night with severe pain.

19. Claimant consulted Dr. Steven Yemm on March 6, 2009. An MRI scan of the right knee was done on March 11, 2009. This showed a "horizontal cleavage tear of the posterior horn and body segment of the medial meniscus with associated parameniscal cyst."

20. Claimant underwent surgery to his right knee on April 21, 2009, and was released to return to full duty one week later.

21. Dr. Holthouser testified that degenerative joint disease is hereditary and tends to be symmetrical. He was asked to compare the MRI reports concerning the studies of both of Claimant's knees. Based upon that comparison, he concluded that the tear to the medial meniscus on the left knee pre-existed the events of July 13, 2009.

22. With degenerative changes such as this, the simple act of walking may be sufficient to cause a medial meniscus tear to become symptomatic. Dr. Holthouser reached his opinions concerning causality by exercising his independent medical judgment.

23. Claimant retained Dr. John Hughes to perform an evaluation. He issued a report dated October 26, 2009. Claimant told Dr. Hughes that he experienced pain after he

“twisted his left knee under full weight.” Based upon that history, Dr. Hughes concluded that this event aggravated the degenerative medial meniscus tear in Claimant’s left knee. Dr. Hughes did not observe Claimant climb into the HRTV. He did not comment about Dr. Holthouser’s opinions of July 14, 2009.

24. The opinions expressed by Dr. Hughes are credible and persuasive. It is found that the incident on July 13, 2009, aggravated Claimant’s pre-existing condition and accelerated the need for treatment.

CONCLUSIONS OF LAW

A. Compensability:

A compensable injury is one that arises out of and in the course of employment. Section 8-41-301(1)(b)-(c), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origin in an employee's work-related functions, and be sufficiently related thereto so as to be considered part of the employee's service to the employer. The Supreme Court has stated that "[a]n activity arises out of and 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, although the activity itself is not a strict employment requirement and does not confer an express benefit on the employer." *Price v. Industrial Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996). There is no presumption that an injury that occurs in the course of a worker's employment also arises out of the employment. *Finn v. Industrial Commission,* 165 Colo. 106, 437 P.2d 542 (1968); *See also Industrial Commission v. London & Lancashire Indemnity Co.,* 135 Colo. 372, 311 P.2d 705 (1957) (mere fact that the decedent fell to his death on the employer's premises did not give rise to presumption that the fall arose out of and in course of employment). Additionally, it is a claimant's burden to prove by a preponderance of the evidence that there is a direct causal relationship between the employment and the injuries. Section 8-43-201, C.R.S. 2007; *Ramsdell v, Horn,* 781 P.2d 150 (Colo.App. 1989). Further, the respondents are liable if employment-related activities aggravate, accelerate, or combine with a pre-existing condition to cause a need for medical treatment. Section 8-41-301(1)(c), C.R.S.; *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo.App. 1997).

The determination of whether there is a sufficient "nexus" or causal relationship between a claimant's employment and the injury is generally one of fact, which the ALJ must determine based on the totality of the circumstances. *In Re Question Submitted by the United States Court of Appeals,* 759 P.2d 17 (Colo. 1988); *Moorhead Machinery & Boiler Co. v. Del Valle,* 934 P.2d 861 (Colo.App. 1996).

Special rules apply in the event an injury is "precipitated" by some preexisting condition brought by a claimant to the workplace. Where the precipitating cause of an injury is a pre-existing condition suffered by a claimant, the injury is not compensable unless a "special hazard" of the employment combines with the pre-existing condition to cause or increase the degree of injury. *See National Health Laboratories v. Industrial Claim Appeals Office*, 844 P.2d 763 (Colo.App. 1992). This principle is known as the "special hazard" rule. *Ramsdell v. Horn,* 781 P.2d 150 (Colo.App. 1989). In addition, to be considered an employment hazard for this purpose, the employment condition must not be a ubiquitous one; it must be a special hazard not generally encountered. *See Ramsdell*

v. Horn 781 P.2d 150 (Colo.App. 1989) (high scaffold constituted special employment hazard to worker who suffered epileptic seizure and fell); *Gates Rubber Co. v. Industrial Commission, supra* (hard level concrete floor not special hazard because it is a condition found in many non-employment locations). The rationale for this rule is that unless a special hazard of employment increases the risk or extent of injury, an injury due to a claimant's pre-existing condition does not bear sufficient causal relationship to the employment to "arise out of" the employment. *Gates v. Rubber Co. v. Industrial Commission*, 705 P.2d 6 (Colo.App. 1985); *Gaskins v. Golden Automotive Group, L.L.C.,* W.C. No. 4-374-591 (August 6, 1999) (injury when pre-existing condition caused the claimant to stumble on concrete stairs not compensable because stairs were ubiquitous condition).

It is concluded that the special hazards doctrine is inapplicable to the facts in this case. As noted, our courts have held that the existence of a preexisting disease or infirmity does not disqualify a claimant from receiving compensation "if the employment aggravates, accelerates, or combines with the disease or infirmity to produce the disability for which workers' compensation is sought." *H & H Warehouse v. Vicory,* 805 P.2d 1167, 1167 (Colo.App. 1990). Moreover, there is no requirement that a particular activity of employment which aggravates the preexisting condition be unique to the employment, or that it constitute a "special hazard" of the employment. To the contrary, the special hazard requirement applies only where the precipitating cause of an injury is a preexisting non-industrial condition that a claimant brings to the workplace. In such cases, the special hazard requirement provides the requisite causal connection between the injury and the employment. *National Health Laboratories v. Industrial Claim Appeals* Office, 844 P.2d 1259 (Colo.App. 1992); *Ramsdell v. Horn,* 781 P.2d 150 (Colo.App. 1989); *Sheldon v. Pinnacol Assurance,* W.C. 4-724-391 (ICAO, 2008).

Here, it is expressly found that Claimant aggravated his preexisting left knee condition when he stepped into the HRTV. The opinion of Dr. Hughes that Claimant aggravated his preexisting condition is credited. The opinion of Dr. Hughes supports the determination that Claimant sustained a compensable injury. Dr. Holthouser's observation that the injury could have happened at work is correct. However, the incident happened at work and the incident aggravated Claimant's preexisting condition and accelerated the need for medical care. Because of that finding, it is concluded that Claimant sustained a compensable injury on July 13, 2009. This issue of whether there was a special hazard is not reached. *See Sheldon, supra.* This conclusion is not based on a presumption that an injury that occurs in the course of a worker's employment also arises out of employment. Based on the totality of the circumstances, a sufficient nexus or causal relationship is found between Claimant's employment and the injury.

B. <u>Authorized Medical Care Providers and Liability for Medical Care:</u>

Employer referred Claimant to Dr. Holthouser, and Dr. Holthouser is authorized. Section 8-43-404(5)(a), C.R.S. After stating that the incident was not compensable, Dr. Holthouser referred Claimant to his primary care physician. Claimant's primary care physicians were at the Orthopaedic Center of the Rockies. Claimant was treated for this injury there by Thomas R. Sachtleben, M.D., and Rocci V. Trumper, M.D., who are also authorized. *Cabela v. ICAO*, 198 P.3d 1277, (Colo.App. 2008). The treatment Claimant received from these authorized providers was reasonably needed to cure and relieve

Claimant from the effects of the compensable injury. Section 8-42-101(1), C.R.S. Insurer is liable for the costs of such care, in amounts not to exceed the Division of Workers' Compensation fee schedule. Section 8-42-101(3), C.R.S.

C. Average Weekly Wages and Temporary Disability Benefits:

The parties stipulated that Claimant earned $780.98 per week in his job for Employer. Claimant concurrently earned $45.47 as a CNA. Claimant average weekly wage at the time of his injury was $826.45.

Claimant did not miss any work as a CNA as a result of the compensable injury. Claimant only lost wages when he was off work from August 25, 2009, to September 11, 2009. Temporary disability benefits end when a claimant returns to work. Section 8-42-105(3)(b), C.R.S. He lost wages at the rate of $780.98 per week. Temporary partial disability benefits are payable for that period at the rate of $520.65 per week. Section 8-42-106, C.R.S.

Insurer is liable for interest at the rate of eight percent per annum on all benefits not paid when due. Section 8-43-410, C.R.S.

ORDER

It is therefore ordered that:

1. Insurer shall pay for the medical care Claimant has received for this injury from Dr. Holthouser, Dr. Sachtleben, and Dr. Trumper, in amounts not to exceed the Division of Workers' Compensation fee schedule.
2. Insurer shall pay Claimant temporary partial disability benefits at the rate of $520.65 per week from August 25, 2009, to September 11, 2009. Insurer shall pay Claimant interest on any benefits not paid when due.
3. All matters not determined herein are reserved for future determination.

DATED: *December 17, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-759-947

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that he sustained an injury to the left knee arising out of and in the course of his employment?

¬ Did the claimant prove by a preponderance of the evidence that he is entitled to an award of temporary total disability benefits as a result of the alleged injury?

¬ Did the respondents prove by a preponderance of the evidence that the claimant's right to receive temporary total disability benefits, if any, was terminated because the claimant was responsible for his termination from employment?

¬ Did the claimant prove by a preponderance of the evidence that Dr. Isaacs is an authorized treating physician, and that the treatment provided by Dr. Isaacs was reasonable and necessary for purposes of curing or relieving the alleged injury?

¬ Are the respondents entitled to imposition of a penalty for the claimant's failure timely to report the injury in writing?

FINDINGS OF FACT

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

1. The claimant seeks compensation for a left knee injury allegedly sustained on April 30, 2008. On that date the claimant was employed as a technician specializing in the repair and maintenance of medical equipment. The claimant had been employed in this field for quite some time, but had only worked for this employer for approximately 7 months.
2. The claimant worked in a shop that contained equipment and tools used in the repair of the medical equipment. The claimant typically performed his duties at a workbench and was seated on a stool. The stools were similar to "bar stools" and their height could be adjusted. There was a footrest or "ring" near the bottom of the stool.
3. The claimant had a significant history of left knee problems prior to April 30, 2008. On February 26, 2008, the claimant sought treatment with P.A. Marnie Ceazan, a physician's assistant at Broomfield Family Practice. At that time the claimant complained of left knee pain and reported a history of intermittent left knee pain for 15 years with removal of a bursal sac eight years previously. The claimant stated that he had been experiencing night pain for two weeks. P.A. Ceazan assessed a probable meniscal tear and ordered an x-ray. She advised the claimant that he would probably need an orthopedic consult.
4. The claimant testified he believed the February 2008 injury occurred when he jumped out of his truck.
5. On March 3, 2008, the claimant underwent an MRI of the left knee. The MRI report indicated the presence of a posterior horn medial meniscus tear. Also reported was, "Tendinosis distal patellar tendon without partial tear and with deep infrapatellar bursitis and mild bony degenerative change in the tibial tuberosity."
6. On March 14, 2008, Dr. Christopher Isaacs, D.O., performed a left knee arthroscopy and partial medial meniscectomy. The operative report notes that the camera passed through the patellofemoral compartment, "which revealed the articular surfaces to be free from defect." Dr. Isaacs' office note from March 14, 2008, states that, except for the meniscal tear, "the remainder of the knee was in good condition."
7. On April 3, 2008, Dr. Isaacs reported the claimant had not been strong enough to return to work at full duty despite an earlier release. Dr. Isaacs commented the claimant had been given a "new release returning him to work next Friday."

8. The claimant testified that he did return to work after the March 2008 surgery, but that his knee was "weak" and painful. He believed that he was under restrictions that prohibited him from squatting and lifting heavy items.
9. The claimant testified that on Wednesday, April 30, 2008, he was going to perform his duties at a workstation that ordinarily belonged to "Trish." The claimant explained that Trish was not in the shop and her workstation had the testing equipment necessary for his duties. According to the claimant Trish adjusted her stool so that it was unusually high. The claimant recalled that he pushed off the stool's foot ring with his left leg and felt a sharp pain in his knee. The claimant stated that the pain was different than he experienced previously in that it burned badly and caused him trouble sleeping at night.
10. The claimant testified that at the time of the injury on April 30, 2008, his coworker, Mr. Billy Jefferson, was training him. The claimant recalled that Mr. Jefferson was very near and that after the incident the claimant asked, "did you hear that?" The claimant further stated that he told Mr. Jefferson about the pain in his knee.
11. The claimant further testified that he believes he aggravated the knee problem later the same day when pushing carts of heavy materials up a steep ramp in the shop.
12. The claimant testified that on the morning of May 1, 2008, he had a conversation with Trish and told her about the knee injury. According to the claimant, Trish was the technical "lead" person and he considered her to be his supervisor. The claimant recalled that Trish replied, "So now it's all about my chair," and stated she would report the injury to "Jim," the overall department manager.
13. Mr. Billy Jefferson testified that he was present in the shop on April 30, 2008, and working within three feet of the claimant. Mr. Jefferson stated that he did not recall seeing any incident involving the claimant, and did not hear the claimant complain about any knee pain. Mr. Jefferson is now retired from the employer.
14. On Monday, May 5, 2008, the claimant sought treatment from Dr. Isaacs for the injury allegedly sustained on April 30. The claimant elected to go to Dr. Isaacs on his own and the employer did not refer the claimant to Dr. Isaacs.
15. The May 5, 2008, notes of Dr. Isaacs state the following:
16. [Claimant] called over the weekend complaining of severe pain in his knee suddenly for the last week. He was hoisting himself up onto a bar stool with that leg when he felt a sudden stabbing pain in the anterior aspect of the knee.
17. On May 5, 2008, Dr. Isaacs diagnosed a strain versus partial tear of the patellar tendon of the left knee, and prescribed an MRI. On May 6, 2008, Dr. Isaacs telephoned the claimant and advised him that the MRI showed a partial tear of the patellar tendon and a stress fracture of the medial femoral condyle. Dr. Isaacs indicated the claimant could perform full weight bearing, but should diminish his activity "as pain allows."
18. The employer eventually referred the claimant to Concentra where Dr. Yvonne Nelson, M.D. examined him on May 20, 2008. The claimant gave Dr. Nelson a history that he experienced pain in the left knee "after stepping onto the railing of stool and pushing self up into elevated chair." Dr. Nelson noted that Dr. Isaacs had diagnosed a patellar tendon tear and stress fracture. Dr. Nelson stated that she needed to obtain the MRI results and the notes of Dr. Isaacs. Dr. Nelson opined that causation was "questionable" because it is "very unlikely to cause stress fracture with patellar tendon tear pushing self up onto stool." However, Dr. Nelson also stated that she would "defer to

ortho for causality." Dr. Nelson stated the claimant had agreed to "follow up with PCP for all non-work related complaints." She imposed restrictions of no squatting, kneeling and climbing.

19. Following the alleged injury of April 30, 2008 the claimant returned to work, although he was under some restrictions to avoid pain-causing activity.

20. Mr. James Grissom testified for the respondents. Mr. Grissom is the maintenance account manager for 2 hospitals, including the one where the claimant was employed. Mr. Grissom was the claimant's superior. Mr. Grissom stated the claimant reported the injury to him on Monday, May 5, 2008. Mr. Grissom stated that he instructed the claimant to complete "paperwork" so that Mr. Grissom could sign it and initiate the procedure to obtain medical treatment for the claimant. Mr. Grissom stated that once he signed the paperwork designation of the medical provider was the responsibility of the insurance adjuster in Colorado Springs. Mr. Grissom also stated that it was his policy that if any of the workers' were injured on the job they could immediately report to the hospital emergency room for treatment.

21. On May 22, 2008, the respondents filed a Notice of Contest with respect to the alleged injury.

22. Mr. Grissom testified that on May 23, 2008, he asked the claimant to come to a meeting with the claimant's immediate supervisor, a Mr. Rhodes, concerning some performance issues that had come to Grissom's attention. Mr. Grissom had no intention of discharging the claimant, and in fact considered the claimant to be very competent in technical matters. Less than a minute after the meeting began the claimant announced that he "did not fit in this environment" and resigned his position with the employer.

23. Mr. Grissom testified that prior to May 23, 2008, the employer had accommodated the claimant's restrictions. For instance, Mr. Grissom had directed that other employees, including Mr. Jefferson, were to assist the claimant in such tasks as pushing carts up the ramp. Mr. Grissom testified that employer could have continued to accommodate the claimant's restrictions had he not walked off of the job.

24. On three occasions from May 14, 2008, to August 26, 2008, the claimant sought treatment from PA Ceazan. None of these visits concerned the left knee, although one concerned right knee pain of 4 days' duration.

25. On September 16, 2008, the claimant returned to Dr. Isaacs. The claimant reported that a "couple of days ago" he was coming down from a ladder, stepped awkwardly and injured his left knee. Thereafter the claimant experienced pain and swelling. Dr. Isaacs noted effusion and recommended an aspiration, which was completed. He also recommended a repeat MRI.

26. On September 18, 2008, Dr. Isaacs notified the claimant of the MRI results. Dr. Isaacs recorded that the MRI showed a stress fracture in the medial compartment, evidence of a prior meniscectomy, and moderate to severe tendonitis and partial thickness tearing of the patellar tendon. Dr. Isaacs reported that these findings were consistent with the claimant's "previous MRI."

27. The claimant returned to Dr. Isaacs on September 24, 2008, and reported that his knee was feeling better. Dr. Isaacs observed the effusion was gone. Dr. Isaacs recommended a cortisone injection, which was performed.

28. The claimant proved it is more probably true than not that on April 30, 2008, he sustained an injury to his left knee arising out of and in the course of his employment.

The ALJ credits the claimant's testimony that he experienced a sharp pain in the left knee when he hoisted himself up on the Trish's stool, and that this pain was different in quality than that he had experienced before. The ALJ finds the claimant's testimony is significantly corroborated by the note of Dr. Isaacs dated May 5, 2008, in which the claimant reported "severe pain" in the anterior aspect of the leg after "hoisting himself up onto a bar stool." Moreover, Mr. Grissom testified that the claimant notified him of the injury on May 5, 2008, relatively soon after the event and well before the claimant was called to the conference to discuss the "performance issues." Although Mr. Jefferson does not recall the incident, the ALJ does not find this to be particularly persuasive evidence since the claimant was already having knee difficulties as a result of the February 2008 injury, and the ALJ concludes that Mr. Jefferson was probably not disposed to consider it significant if the claimant mentioned some new pain on April 30, 2008.

29. The ALJ further finds that the medical evidence is most consistent with the claimant having sustained an injury to his knee on April 30, 2008. The MRI performed in March 2008 demonstrated a meniscal tear, as well as degenerative changes of the patellar tendon *without* a tear, and bony degenerative changes of the tibial tuberosity. Dr. Isaacs noted that, except for the meniscal tear, the knee was in good condition when he operated in March 2008. However, the MRI in May 2008, after the alleged incident of April 30, showed a partially torn patellar tendon and a stress fracture of the femoral condyle. The new pathology demonstrated on the May 2008 MRI substantially coincides with the alleged injury of April 30, 2008, and the ALJ finds this temporal relationship to be persuasive evidence that the injury occurred as the claimant testified.

30. The ALJ recognizes that Dr. Nelson expressed doubt that the alleged mechanism of injury was sufficient to cause a partially torn patellar tendon and stress fracture. However, the ALJ does not find Dr. Nelson's opinion to be persuasive evidence that the alleged mechanism of injury was not the cause of the torn patellar tendon and stress fracture. Dr. Nelson's May 20, 2008, office note expressly states that she had not reviewed the MRI results, and that she desired to see them together with the notes of Dr. Isaacs. The ALJ infers from these statements that Dr. Nelson's opinion concerning causation was tentative and subject to change with additional information, including the MRI results. The ALJ is unable to determine whether Dr. Nelson might have reached a different conclusion concerning the sufficiency of the mechanism of injury if she had known the claimant had pre-existing degenerative changes of the patellar tendon. There is no credible or persuasive evidence that Dr. Nelson was ever shown the MRI results for the purpose of determining her final opinion on the causation question.

31. Conversely, on May 5, 2008, Dr. Isaacs diagnosed a strain versus partial tear of the patellar tendon of the left knee. Implicit in this diagnosis is his opinion that the alleged mechanism of injury (the claimant's action of "hoisting" himself onto the "bar stool") was sufficient to cause a partial tear of the patellar tendon. The MRI then confirmed the presence of a partial tear. The ALJ is persuaded by the reports of Dr. Isaacs that the alleged mechanism of injury was sufficient to cause the pathology noted on MRI.

32. The ALJ finds the claimant failed to prove it is more probably true than not that he sustained any injury while pushing a heavy cart up the ramp on the employer's premises. Although the claimant may have experienced some symptoms while pushing a cart, the May 2008 the medical records do not show that he reported pushing a cart as

the mechanism of injury to Dr. Nelson or Dr. Isaacs. Neither of these physicians has opined that the claimant sustained any injury pushing a cart.

33. The ALJ finds the claimant failed to prove entitlement to TTD benefits prior to May 23, 2008. The claimant returned to work following the injury on April 30, 2008. There is no credible or persuasive evidence that the claimant lost any time from work prior to May 23, 2008, nor is there any credible or persuasive evidence that he lost any wages prior to May 23, 2008.

34. The ALJ finds the respondents proved it is more probably true than not that the claimant acted volitionally when he resigned his employment on May 23, 2008, and that he exercised substantial control over the circumstances that led to his resignation. The ALJ credits the testimony of Mr. Grissom that on May 23 he called the claimant into discuss some performance issues, but had no intention of terminating the claimant's employment. However, the claimant immediately resigned his employment stating that he did not "fit" in the environment. The ALJ does not find any credible or persuasive evidence that the claimant was harassed or otherwise forced to resign because he filed a workers' compensation claim, or because he was experiencing any limitations resulting from the injury or the March 2008 surgery. The claimant's testimony that he was transferred to a bench where water was "leaking" does not persuade the ALJ that the claimant was the subject of harassment or any attempt to force him to resign because of his physical condition. Indeed the claimant did not tell Mr. Grissom that he was resigning because of harassment or because he had been transferred to a defective workstation. The ALJ is persuaded that Mr. Grissom tried to help the claimant process the paperwork necessary for the claim and to obtain treatment, and did not initiate or direct any campaign to force the claimant's resignation.

35. The ALJ further finds that Mr. Grissom credibly testified that the employer would have continued to accommodate the claimant's restrictions had he not resigned. Therefore, even though Dr. Isaacs placed the claimant on a two-week non-weight bearing status in September 2008, this is not a case in which the claimant proved a worsened condition sufficient to reestablish a causal connection between the injury and the wage loss. The worsening of the claimant's condition in September 2008 would not have precluded the claimant from working had he not quit the employment in May 2008.

36. Moreover, the claimant failed to prove that any worsening of his condition in September 2008 is causally related to the industrial injury. The medical records of Dr. Isaacs establish the claimant aggravated his knee condition when climbing down from a ladder. The claimant's testimony that he has no recollection of this event is not persuasive evidence that it did not occur. Moreover, the claimant had not sought any treatment for the left knee throughout the summer of 2008. Under these circumstances the ALJ finds the worsening of the claimant's left knee condition in September 2008 was the result of an intervening injury that occurred when the claimant stepped awkwardly while descending a ladder.

37. The claimant credibly testified that he understood Trish was his immediate supervisor, and that when he told her about the injury on May 1, 2008, she did not immediately refer him to a physician or direct him to go to the emergency room in the hospital. Although Mr. Grissom stated that Trish had resigned as a supervisor earlier in the year, the ALJ credits the claimant's testimony that on April 30, 2008, he still understood Trish to be in a supervisory role. The ALJ further finds that the employer played a substantial

role in causing the claimant's belief since Mr. Grissom acknowledged that Trish had been the claimant's supervisor in the past. Further the respondents did not present any credible or persuasive evidence tending to establish that the claimant knew that Trish was not his supervisor, or one of his supervisors, on the day of the injury.

38. The ALJ finds the right of selection passed to the claimant because Trish did not immediately refer the claimant to any medical provider or providers. The ALJ finds that the claimant selected Dr. Isaacs as the authorized treating physician (ATP) for the injury he sustained on April 30, 2008.

CONCLUSIONS OF LAW

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

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

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

COMPENSABILITY OF ALLEGED INJURY

The claimant argues that he proved by a preponderance of the evidence that on April 30, 2008, he sustained a compensable injury to his left knee when he placed pressure on it while raising himself up on the foot ring of the work stool. Additionally the claimant argues that he "aggravated" his condition while pushing heavy carts up a ramp. The ALJ concludes the claimant proved it more probably true than not that he sustained a compensable injury when lifting himself up on the stool.

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 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 his employment and during an activity that had some connection with his work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The "arising out of " element is narrower and requires claimant to show a causal connection between the employment and the injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *See Triad Painting Co. v. Blair*, *supra.* The mere fact that an injury occurs at work does not establish the requisite causal relationship to demonstrate that the injury arose out of the employment. *Finn v. Industrial Commission,* 165 Colo. 106, 437 P.2d 542 (1968).

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). Causation may be established by evidence that the duties of the employment placed stresses on the body that resulted in an injury. *See Cabela v. Industrial Claim Appeals Office,* 198 P.3d 1277 (Colo. App. 2008). The question of whether the claimant met the burden of proof to establish an injury is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

The claimant must prove causation to a reasonable probability. Lay testimony alone may be sufficient to prove causation. However, where expert testimony is presented on the issue of causation it is for the ALJ to determine the weight and credibility to be assigned such evidence. *Rockwell International v. Turnbull,* 802 P.2d 1182 (Colo. App. 1990).

As determined in Finding of Fact 27, the ALJ concludes the claimant proved it is more probably true than not that on April 30, 2008, the claimant sustained an injury to his left knee arising out of and in the course of his employment as a medical equipment technician. Specifically, the ALJ credits the claimant's testimony that while performing his duties in the employer's shop, he used his left leg to put pressure on a foot ring and raise himself up onto a high work stool. This action occurred within the time and place limits of the employment and was causally related to the performance of the claimant's duties as a medical equipment technician.

As determined in Findings of Fact 27 through 30, the ALJ concludes claimant's action of raising himself up on the stool proximately caused left knee injuries including a partially torn patellar tendon and stress fracture of the femoral condyle. The ALJ credits the claimant's testimony that he sustained sharp pain in the knee when he raised himself up on the work stool. The ALJ finds that the claimant's testimony is consistent with the report of injury to Dr. Isaacs, as well as the May 2008 MRI results showing new pathology (partially torn patellar tendon and stress fracture of femoral condyle) when com-

pared to the March 2008 MRI. Moreover, the ALJ credits the implicit opinion of Dr. Isaacs that the alleged mechanism of injury was sufficient to cause the new pathology. The ALJ is not persuaded by the contrary opinions expressed by Dr. Nelson because they are not based on review of the MRI results and appear to be tentative in nature. Moreover, the evidence does not demonstrate that Dr. Nelson was afforded an opportunity to review the MRI results and change her opinion if necessary.

As determined in Finding of Fact 31 the claimant failed to prove it is more probably true than not that he sustained any injury while pushing a cart.

TEMPORARY TOTAL DISABLITY BENEFITS

The claimant seeks an award of temporary total disability (TTD) benefits commencing on the date of injury and continuing until terminated by law or order. The respondents contend that the claimant failed to prove that he sustained any compensable disability. In any event, the respondents contend the evidence establishes the claimant voluntarily resigned his employment on May 23, 2008, and is not entitled to TTD benefits after that date. The ALJ agrees with the respondents that under the facts of this case the claimant is not entitled to any award of TTD benefits.

To prove entitlement to TTD benefits, the 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); *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 637 (Colo. App. 1997). Section 8-42-103(1)(a), C.R.S., requires the 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*.

However, the industrial injury need not be the sole cause of a disability or need for medical treatment if the injury is a significant, direct, and consequential factor in causing a disability or need for treatment. See *Subsequent Injury Fund v. Industrial Claim Appeals Office,* 131 P.3d 1224 (Colo. App. 2006); *Joslins Dry Goods Co. v. Industrial Claim Appeals Office,* 21 P.3d 866 (Colo. App. 2001); *Seifried v. Industrial Commission,* 736 P.2d 1262 (Colo. App. 1986). Our courts have held that if the industrial injury leaves the body in a weakened condition and the weakened condition plays a causative role in producing disability or the need for additional medical treatment then the treatment is a compensable consequence of the industrial injury. *Standard Metals Corp. v. Ball,* 172 Colo. 510, 474 P.2d 622 (1970); *Price Mine Service, Inc. v. Industrial Claim Appeals Office,* 64 P.3d936 (Colo. App. 2003); *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082 (Colo. App. 2002). However, disability and the need for treatment are not compensable if they were caused as the direct result of an independent intervening cause. *Owens v. Industrial Claim Appeals Office,* 49 P.3d 1187 (Colo. App. 2002). The question of whether a disability and need for treatment were caused by the industrial injury or an intervening event is one of fact for the ALJ. *Owens v. Industrial Claim Appeals Office, supra.*

As determined in Finding of Fact 32, the claimant failed to prove that he lost time from work prior to May 23, 2008, or that he sustained any wage loss prior to May 23, 2008. Consequently, the claimant failed to prove that he left work as a result of the injury and that he sustained any wage loss prior to May 23, 2008. The ALJ concludes the claimant failed to prove any entitlement to TTD benefits from April 30, 2008, through May 23, 2008, since he has not proven an injury-related wage loss for that period of time.

Section 8-42-103(1)(g), C.R.S., and § 8-42-105(4), C.R.S., (termination statutes) provide that if a temporarily disabled employee "is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury." Because these statutes provide a defense to an otherwise valid claim for TTD benefits, the respondents shoulder the burden of proof by a preponderance of the evidence to establish each element of the defense. *Gilmore v. Industrial Claim Appeals Office,* 187 P.3d 1129 (Colo. App. 2008); *Brinsfield v. Excel Corp.,* W.C. No. 4-551-844 (I.C.A.O. July 18, 2003).

In *Colorado Springs Disposal v. Industrial Claim Appeals Office*, 58 P.3d 1061 (Colo. App. 2002), the court held the term "responsible" as used in the termination statutes reintroduces the concept of fault as it was understood prior to the Supreme Court's decision in *PDM Molding, Inc. v. Stanberg,* 898 P.2d 542 (Colo. 1995). Consequently, the concept of fault used in the unemployment insurance context is instructive. Fault requires a volitional act or the exercise of some control in light of the totality of the circumstances. *Padilla v. Digital Equipment Corp.,* 902 P.2d 414 (Colo. App. 1994), *opinion after remand*, 908 P.2d 1185 (Colo. App. 1995); *Brinsfield v. Excel Corp., supra.* The claimant acts volitionally and is responsible for the termination from employment if he voluntarily resigns employment within his capacity to perform. See *Gilmore v. Industrial Claim Appeals Office,* 187 P.3d 1129 (Colo. App. 2008). Ultimately, the question of whether the claimant was responsible for the termination is one of fact for determination by the ALJ. *Gilmore v. Industrial Claim Appeals Office, supra.*

As determined in Finding of Fact 23, the evidence establishes the claimant voluntarily resigned his employment on May 23, 2008. The claimant's decision to resign was volitional and demonstrates that he exercised control over the circumstances leading to the separation. As found, the ALJ is not persuaded that the claimant was forced to resign either because he filed a claim for benefits or because he was limited in the performance of his duties. To the contrary, the ALJ has found that the employer was willing and able to accommodate the claimant's restrictions, and had assisted him in filing the claim and completing the necessary paperwork. Consequently, the respondents have proven that even assuming the claimant was "disabled" at the time of he resigned on May 23, 2008, the claimant was "responsible" for the termination within the meaning of the termination statutes and he is disqualified from receiving TTD benefits after May 23, 2008.

The ALJ further concludes that this is not a case in which the claimant sustained a post-injury and post-separation worsening of condition sufficient to reestablish the causal connection between the injury and the wage loss. *See Anderson v. Longmont Toyota v. Industrial Claim Appeals Office,* 85 P.3d 548 (Colo. 2003). As determined in Finding of Fact 34, the evidence establishes that the employer would have accommodated the no weight bearing restriction imposed by Dr. Isaacs in September 2008, had the claimant not voluntarily resigned his employment May 2008. Therefore, the claimant's wage loss in September 2008 remained the result of the industrial injury within the meaning of the termination statutes.

In any event, the ALJ concludes the worsening of the claimant's condition and the increase in his disability, if any, was the result of an efficient intervening cause, not the industrial injury. As determined in Finding of Fact 35 the medical records of Dr. Isaacs and the claimant's failure to seek any medical treatment for the left knee throughout the summer of 2008 establish that any worsening of the claimant's condition in September 2008 was related to a non-industrial intervening event that occurred when the claimant aggravated his knee coming down a ladder. In such circumstances any increased disability and subsequent wage loss were caused by the intervening event, not a worsening of the industrial injury.

MEDICAL BENEFITS

The claimant contends that Dr. Isaacs is an authorized treating physician and that the respondents are liable to pay for treatment rendered by Dr. Isaacs. The ALJ agrees.

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. 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).

As noted above, the claimant is required to prove a direct causal relationship between the injury and the need for medical treatment. Medical treatment is not compensable if the need for it is the direct result of an independent intervening cause. *Owens v. Industrial Claim Appeals Office, supra*.

Section 8-43-404(5)(a)(I)(A), C.R.S. gives the respondents the right in the first instance to designate the providers authorized to treat the claimant. 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 selected the claimant may not ordinarily change physicians or employ additional physicians without following one of the

designated statutory procedures or 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)(I)(A), applicable to this 2008 injury and claim for benefits, provides that:

> "In all cases of injury, the employer or insurer shall provide a list of at least two physicians or two corporate medical providers or at least one physician and one corporate medical provider, where available, in the first instance, from which list an injured employee may select the physician who attends said injured employee."

The statute further provides that if "the services of a physician are not tendered at the time of injury, the employee shall have the right to select a physician or chiropractor."

This statute affords the employer the right to designate at least two physicians and/or corporate providers that are deemed authorized to provide medical treatment. Consistent with the version of § 8-43-404(5)(a) that was amended in 1997, the current version provides that the employer's right to designate the authorized providers may be lost and the right of selection passed to the claimant if medical services are not tendered "at the time of injury." *See Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565 (Colo. App. 1987).

As determined in Finding of Fact 36 the claimant proved it is more probably true than not that he notified Trish of the injury on May 1, 2008, and that the claimant reasonably understood Trish to be one of his supervisors. Further Trish did no refer the claimant to any medical provider, and no physician was designated in accordance with the Act. Therefore, the right of selection passed to the claimant and he selected Dr. Isaacs as the ATP for the injury of April 30, 2008.

The ALJ concludes based on the medical records that the medical treatment provided by Dr. Isaacs in May 2008 was reasonable, necessary and related to the injury the claimant sustained on April 30, 2008. Therefore the respondents are liable to pay for this treatment.

The ALJ further concludes based on the medical records that the medical treatment that Dr. Isaacs provided for the claimant's left knee in September 2008 was caused by the intervening injury that occurred while the claimant was coming down the ladder. Thus, the ALJ concludes the respondents are not liable for the treatment that Dr. Isaacs rendered to the claimant in September 2008. Of course the ALJ does not find, and should not be understood to find, that the need for any *future* treatment of the claimant's left knee would be the result of the intervening injury rather than the compensable injury of April 30, 2008. That issue remains open if further treatment is determined to be necessary.

LATE REPORTING PENALTY

The respondents seek the imposition of a late reporting penalty under § 8-43-102(1)(a), C.R.S. Section 8-43-102(1)(a) provides that an employee that sustains an injury from an accident "shall notify the said employee's employer in writing of the injury within four days of the occurrence of the injury." If the employee fails to report the injury in writing "said employee may lose up to one day's compensation for each day's failure to so report." Because the statute uses the word "may," imposition of a penalty for late reporting is left to the discretion of the ALJ. *LeFou v. Waste Management,* W.C. No. 4-519-354 (ICAO March 6, 2003).

Here, the ALJ has determined that the claimant is not entitled to any TTD benefits. Therefore, the ALJ concludes that imposition of any penalty for late reporting is inappropriate. Indeed, there is no compensation for the claimant to lose.

ORDER

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

1. The claimant sustained a compensable injury of the left knee on April 30, 2008.

2. The claimant's request for an award of temporary total disability benefits is denied and dismissed.

3. Dr. Christopher Isaacs, D.O., is an authorized treating physician for the injury of April 30, 2008.

4. The respondents shall pay for the medical services rendered by Dr. Isaacs and his referrals for evaluation and treatment of the claimant's left knee in May 2008.

5. The respondents are not liable to pay for the treatment of the claimant's left knee that Dr. Isaacs rendered in September 2008.

6. The respondents' request for the imposition of a late reporting penalty is denied and dismissed.

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

DATED: December 17, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-790-512

ISSUES

The following issues were raised for consideration at hearing:

1. Whether Claimant is an employee of the Respondent or an independent contractor;
2. Whether Claimant suffered a compensable back injury;
3. What is Claimant 's average weekly wage (AWW);
4. Whether Claimant is entitled to temporary disability benefits;
5. Whether Claimant is entitled to medical benefits; and
6. Whether Claimant is entitled to an order awarding penalties.

FINDINGS OF FACT

Based on the evidence presented at hearing, the following Findings of Fact are entered.

1. Claimant entered into an agreement with Respondent entitled "Independent Contractor and Lease Agreement, Lease Driver –Denver". The effective date of the agreement was January 8, 2008. (Exhibit C). The Lease Agreement refers throughout to Claimant, Tsega Baye, as "Driver"

2. Denver Yellow Cab is an intrastate for hire common motor carrier operating under authority of the Colorado Public Utilities Commission (PUC). Denver Yellow Cab is a division of Colorado Cab Company, LLC.

3. Under the terms of the Lease Agreement, Claimant leased a vehicle from Respondent specially equipped and painted to be utilized exclusively as a taxicab. (Exhibit C, paragraph A.).

4. The Lease Agreement, at paragraph E, recites that 'Driver' understands that as a driver contracting with Denver Yellow Cab, he was operating under regulations enforced by the Colorado PUC.

5. In the Lease Agreement, both parties acknowledge and agree that Driver is an Independent Contractor as that term is applied pursuant to state law (Lease Agreement, Exhibit C, paragraph M).

6. The Lease Agreement entered into between Claimant and Respondents was a lease between a motor carrier and an independent contractor.

7. At the time of the alleged injury, the subject of the above captioned claim, Claimant was working as a driver under a lease agreement with a common carrier. The provisions of the Lease Agreement required the Claimant as 'Driver' to agree to personally provide 'the transportation services contemplated by the Agreement.' (Exhibit C., paragraph R).

8. The Lease Agreement between Claimant and Respondent was a lease agreement pursuant to Section 40-11.5-102, C.R.S. and Claimant was working as a driver under that lease agreement.

9. Claimant was covered by an occupational accident insurance policy written by National Union Fire Insurance Company of Pittsburg, PA. (Exhibit D). Claimant accessed this coverage through AIG Claims Services. This insurance had a weekly benefit cap on lost wages of $350.00 per week with a waiting period of seven days and a maximum benefit period of fifty-two weeks; a limitation on medical treatment of fifty-two weeks; no benefits for permanent partial disability; and no form of disability benefits after fifty-two weeks past the accident.

10. The Lease Agreement placed upon the Driver the obligation to obtain, at the Driver's expense, coverage under workers' compensation or other private insurance that provides similar coverage. (Exhibit C paragraph M(f)). Under the terms of the Lease Agreement, Claimant was not offered workers' compensation insurance coverage by Pinnacol Assurance or similar coverage.

11. The occupational accident policy did not provide coverage that was at least comparable to the coverage offered under the workers' compensation system. The occupational accident policy contains limitations on the length of time wage loss benefits can be received (52 weeks), a cap on the weekly amount of wage loss benefits, which was lower than the maximum temporary total disability benefits rate available under the workers' compensation system, and limitations on medical benefits, which are not comparable to the benefits available in the worker's compensation system.

12. It is found that Claimant established by clear and convincing evidence that he was an employee of the Respondent on the date of the work injury, on August 9, 2008. The insurance coverage provided to Claimant under the occupational accident policy, administered by AIG, did not provide coverage similar to or comparable to the benefits provided by the workers' compensation system consistent with the requirements of Sections 8-40-301(6) and 40-11.5.102 (5)(a) and (b), C.R.S. In the absence of such similar coverage, Claimant is considered to be an employee of Respondent, the motor carrier.

13. Claimant had two prior accidents, a 1989 right shoulder problem for which he had surgery, and a 2003 motor vehicle accident. Claimant underwent an independent medical evaluation performed by Dr. Marc Steinmetz, M.D. on September 25, 2009. Claimant testified at hearing that since Dr. Steinmetz did not specifically ask him about either incident, Claimant did disclose these accidents to the doctor.

14. Claimant missed two years from work as a consequence of the 1989 work injury. After receiving almost $60,000.00 in medical benefits, indemnity benefits, and permanent partial disability benefits, Claimant entered a full and final settlement of the work injury claim totaling $35,000.00 in 1991. (Exhibit E)

15. After the August 9, 2008, work injury, Claimant was in a cast for between three and four months. He was able to resume driving once the cast was removed.

16. Claimant earned $500.00 per week with the Respondent. Claimant 's AWW is $500.00.

17. Claimant asserts that, in addition to the wrist injury, he suffered a back injury in the August 9, 2008, work injury and he seeks workers' compensation benefits for this injury. Respondent contest this claim and maintains that Claimant did not suffer a back injury in the August 9, 2008 accident.

18. Claimant testified that he was unable to work after the accident until obtaining a part time job as a security guard on September 12 or September 13, 2009 for Frontline Security. He works 13-20 hours a week and is paid $9.00 per hour.

19. Claimant was transported to Denver Health Medical Center after the August 9, 2008, work injury. At the hospital, he reported left wrist pain and "0 pain anywhere else". He denied back pain. Claimant was x-rayed and splinted.

20. Dr. Lawrence Varner, M.D. saw Claimant on referral from Dr. Bruce Latta and examined him on August 19, 2008. Dr. Varner took a history from Claimant, which noted a prior right shoulder surgery and a current injury to the left wrist. Dr. Varner diagnosed a "closed left distal radial styloid fracture in satisfactory alignment". No history was obtained of a back problem.

21. Claimant returned to Dr. Varner on October 15, 2008. The cast was removed and replaced with a Velcro wrist splint. Claimant wore the Velcro wrist splint for approximately one month. Claimant reported "minimal" left wrist pain and no other problems. Dr. Varner discharged Claimant from care.

22. Dr. Varner saw Claimant on January 12, 2009. Claimant presented with a healed left distal styloid fracture and left symptomatic deQuervain's disease for which Dr. Varner prescribed a left first dorsal compartment tenovaginotomy.

23. On September 10, 2008, Dr. Douglas Hammond, M.D. saw Claimant. At that time, Claimant complained of middle and lower back pain, but did not state when that pain began. He said he had no prior trauma to the neck or back, had type II diabetes, and was involved in a motor vehicle accident during 2003 with neck and back injuries. Claimant told Dr. Hammond that the neck and back problems from the 2003 accident had resolved. On examination, Claimant complained of tenderness over the mid thoracic to lumbar spine with good range of motion at the waist. Dr. Hammond diagnosed

thoracic and lumbar sprain/strain. He prescribed Vicodin and Soma as well as recommending chiropractic and massage therapy. He did not impose any work restrictions at that time.

24. Claimant returned to Dr. Hammond on September 24, 2008. No additional history was obtained and Claimant stated that his low back pain was getting worse. Dr. Hammond continued prescription medication and recommended chiropractic manipulation with some traction. Dr. Hammond made no reference to work restrictions or limitations on September 24, 2008. Dr. Hammond saw Claimant on October 8, 2008 and December 15, 2008. No additional history was obtained during either visit and no work restrictions or limitations imposed. The treatment modalities were continued and injections were contemplated.

25. Claimant returned to Dr. Hammond on April 1, 2009. Claimant stated that he was unable to work and that he had two lumbar spine epidurals from a Dr. Huser. Dr. Hammond mentioned a surgical consultation if there was no improvement after two more injections. Dr. Hammond did not otherwise change the diagnosis or impose work restrictions or limitations. The same findings and diagnosis were found when Dr. Hammond examined Claimant on June 22, 2009 and August 4, 2009.

26. Dr. Hammond testified at the November 13, 2009, hearing in this matter and was deemed less credible and persuasive than Dr. Marc Steinmetz, M.D., Respondent's IME.

27. Claimant was seen by Dr. Gregory Ingram at the Latta Chiropractic Clinic on August 14, 2008. Claimant complained of left arm, left shoulder and right knee pain. He did not complain of back pain. He disclosed that he was diabetic and had right shoulder surgery approximately 11 years earlier due to a motor vehicle accident. Dr. Ingram tested Claimant's range of motion in the cervical, thoracic and lumbar spines. All were noted as "WNL" (within normal limits). Dr. Ingram found no need for specific restrictions.

28. Dr. Latta himself saw Claimant on August 19, 2008. Treatment was given to the shoulder. There were no back complaints or additional history. The same treatment and lack of back complaints is discernable from Dr. Latta's August 21, 2008, and August 26, 2008, notes.

29. Claimant first mentioned back pain when he saw Dr. Latta on August 28, 2008. He reported that his lower back was flaring up with some pain if he sat or stood for longer than an hour. On examination, Dr. Latta found palpable tenderness and joint restrictions in the cervical, thoracic and lumbar spines. Dr. Latta did not comment on the etiology of Claimant's back complaints.

30. After numerous visits with Dr. Latta, on December 11, 2008, Claimant reported a doubling of his pain complaints, telling Dr. Latta that his back pain flared in response to snow shoveling and increased activity.

31. Dr. Latta saw Claimant 14 more times between December 15, 2008 and March 24, 2009. Dr. Latta's notes contain no mention of work restrictions or limitations. They contain no comment on the etiology of Claimant's complaints. Despite Claimant's varying subjective pain reports, Dr. Latta's notes contained identical phrasing. The doctor noted Claimant's condition as, "palpable tenderness and joint restrictions found in the cervical, thoracic , and lumbar spine" as well as "frequent flare-ups with increased activity".

32. Claimant visited Dr. Latta for the last time on April 1, 2009. Dr. Latta stated that Claimant was nearing MMI and offered his opinion that Claimant's injuries and symptoms were directly related "to the accident of record" although he did not explain the basis of his opinion. Dr. Latta's opinion was not deemed credible.

33. Dr. Steinmetz examined Claimant at Respondents' request on September 25, 2009, authored a report, and provided credibly testimony at hearing. The doctor reviewed medical records, which are summarized in his report prior to the exam. He spent one hour and forty minutes with Claimant, taking a history and conducting a physical examination.

34. Claimant told Dr. Steinmetz that he was treated for injuries to his left wrist and knee, acknowledging that back pain was not present until some time after the accident.

35. Claimant denied any injuries of any kind before or after the subject accident. He also denied any prior surgeries of any kind, though Claimant had surgery with the prior injuries. Claimant told Dr. Steinmetz that he was not working and that he was looking for sedentary employment.

36. Claimant's spinal exam with Dr. Steinmetz displayed a lack of tenderness with normal range of motion. While he complained of low back tenderness, Dr. Steinmetz was unable to appreciate any trigger points or spasms. The back range of motion was inconsistently demonstrated. Claimant had good range of motion while distracted by a task such as tying his shoes, but claimed an inability to flex during testing.

37. Dr. Steinmetz concluded that Claimant sustained a fractured left wrist on August 9, 2008. Dr. Steinmetz further concluded that Claimant did not injure his back in that accident. This conclusion, in part, was based on the absence of reported back pain for nearly three weeks, the denial of low back pain to various providers, inconsistent medical histories, inconsistent exam findings, and the description of Claimant's back condition as having "flare-ups", which suggested a preexisting condition.

38. Claimant misrepresented his condition to Dr. Steinmetz. Claimant told Dr. Steinmetz that he never had a prior work injury, never missed work on account of injury, and had no neck, back or arm problems before the subject work compensation injury. Further conflicting information provided Dr. Steinmetz revealed that Claimant's performance on the straight leg raise testing was inconsistent. During the doctor's exam, Claimant

was negative while sitting and positive while lying down. The doctor credibly testified that the two tests should have been uniform as they required exertion of the same nerves and muscles. Dr. Steinmetz observed Claimant 's musculature and gait and found that everything was normal, a finding inconsistent with reported back pain and inactivity. Dr. Steinmetz observed scarring on both shoulders, which was consistent with surgery, but Claimant denied prior surgeries. Claimant's range of motion tests yielded inconsistent results. He exhibited pain behaviors and little motion on testing, while displaying a greater range of motion and no pain behaviors while distracted. The doctor's experience in treating motor vehicle accident victims lead him to concluded that if Claimant injured his back in the motor vehicle accident, it would have been apparent during his initial treatment phase for the accident.

39. Dr. Steinmetz opined that Claimant injured his left upper extremity in the August 9, 2008, accident and that he was able to resume normal driver activities after the cast was removed. In terms of the back, Dr. Steinmetz concluded that Claimant had a pre-existing degenerative back problems based on MRI findings, which were only intermittently symptomatic or limiting and this condition was not related to the August 9, 2008, accident.

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 8-40-102(1), C.R.S. A claimant in a workers' compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.,* 104 P.3d 273, 275 (Colo. App. 2004). The facts in a workers' compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S.

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 contend that Claimant was an independent contractor who performed services for Employer. The dispute in this matter thus involves the construction of Sections 8-40-202, 8-40-301 and 40-11.5-102, C.R.S. Courts must construe Colorado's Workers' Compensation Act as a whole to give consistent, harmonious and sensible effect to all of its parts. *Monfort Transportation v. ICAO*, 942 P.2d 1358, 1360 (Colo. App. 1997). Section 8-40-202(2)(c), C.R.S. provides that "[n]othing in this section shall be construed to conflict with section 8-40-301 or to relieve any obligations imposed pursuant thereto." Section 8-40-301(5), C.R.S. states that "'[e]mployee' excludes any person who is working as a driver under a lease agreement pursuant to 40-11.5-102 C.R.S., with a common carrier or contract carrier". Section 8-40-301(6), explains that "[a]ny person working as a driver with a common carrier or contract carrier as described in this section shall be eligible for and shall be offered workers' compensation insurance coverage by Pinnacol Assurance or similar coverage consistent with the requirements set forth in Section 40-11.5-102(5), C.R.S". Section 40-11.5-102(5)(a), states that '[a]ny lease or contract executed pursuant to this section shall provide for coverage under workers' compensation or a private insurance policy that provides similar coverage." "'[S]imilar coverage' means disability insurance for on and off the job injury . . . [and] such insurance coverage shall be at least comparable to the benefits offered under the workers' compensation system." Section 40-11.5-102(5)(b).

5. Because Employer is a common carrier or contract carrier and Claimant worked for Employer as a driver pursuant to Section 40-11.5-102, C.R.S. he is excluded from the definition of "employee." He is thus presumed to be an "independent contractor" in the absence of clear and convincing evidence. *See Gebrekidan v. MKBS, LLC,* W.C. No. 4-678-723 (ICAO, May 10, 2007). However, pursuant to Section 40-11.5-102(5)(a), C.R.S. a lease agreement that excludes a driver from the definition of "employee" must provide workers' compensation coverage or a private insurance policy that offers similar coverage.

6. In *USF v. Industrial Claim Appeals Office,* 111 P.3d 529 (Colo. App. 2005) the Colorado Court of Appeals addressed the issue of whether a claimant's failure to secure complying insurance coverage changed his status from an independent contractor to an employee. In reviewing the statutory scheme, the Court reasoned that the exclusion of leased drivers as employees in Section 8-40-301(5) only takes effect when the lease agreement includes complying coverage. *Id.* at 533. The Court of Appeals determined that the alleged independent contractor agreement and the insurance coverage made available to the driver violated the requirement that the common carrier must provide either Workers' Compensation coverage or similar coverage for the driver. *Id.* Because the required coverage was not provided, the Court determined that the claimant was automatically an "employee" of USF who was eligible for Workers' Compensation benefits directly through USF. *Id.* at 533-34. The Court of Appeals specifically noted:

> Accordingly, we conclude that claimant could establish his status as an "employee" of respondent for purposes of the Act either by overcoming the presumption created under section 40-11.5-102(4) with clear and convincing proof or by showing that he was not offered coverage that satisfied the requirements set forth in section 40-11.5-102(5). Because claimant established that the policy negotiated through respondent did not comply with those requirements, we need not reach the issue of whether he otherwise established the existence of an employment relationship.

Id. at 533-34.

7. In *Aligaze v. Colorado Cab Co./Veolio Transportation,* W.C. No. 4-705-940 (ICAP, Apr. 29, 2009), the Panel considered whether a taxicab driver was an independent contractor or employee. Addressing *USF,* the Panel noted that a driver can establish his status as an employee either by overcoming the presumption of independence in Section 40-11.5-102(4), C.R.S. or showing that he was not offered coverage that satisfied the requirements of Section 40-11.5-102(5), C.R.S. The Panel reviewed the driver's insurance policy and concluded that it did not provide benefits "comparable to the benefits under the Workers' Compensation system" because the policy limited medical benefits and compensation.

8. As found in this case, Claimant was an employee while working as a taxi driver for Employer on August 9, 2008. The AIG Policy covering Claimant did not provide benefits that were "at least comparable" to the benefits available under Colorado's Workers' Compensation system. The Policy provided a weekly accident indemnity benefit of up to $350.00 for a maximum of one year after a seven-day waiting period. Moreover, the AIG Policy limited medical benefits to $300,000 for a maximum period of one year. In contrast, Colorado's Workers' Compensation system has no aggregate limit on indemnity or medical benefits. The preceding differences are sufficient to establish that the AIG Policy does not provide coverage "comparable" to Colorado's Workers' Compensation system within the meaning of Section 40-11.5-102, C.R.S. and Section 8-40-301, C.R.S. Therefore, it is unnecessary to address whether Claimant was an employee under the criteria set forth in Section 8-40-202, C.R.S.

9. Claimant asserts a compensable August 9, 2008, work injury, including the Claimant's back. Respondent maintains that Claimant did not suffer a work injury affecting the back. The totality of the credible and persuasive evidence presented at hearing established that Claimant did not suffer a back injury in the August 9, 2008, work injury. Dr. Steinmetz medical opinion was found to be more credible and persuasive than the reports of the other doctors referenced in these findings.

10. Since the medical records reflect that Claimant was released from care on October 15, 2008, and that no restrictions were imposed on Claimant as a result of the

work injury, it is found and concluded that Claimant is not entitled to additional workers' compensation benefits.

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ORDER

It is therefore ordered that:

1. Claimant is an employee of the Respondent with regard to the August 9, 2008, work injury.

2. Claimant's claim for a back injury caused by the August 9, 2008, work injury is denied and dismissed.

3. Claimant's claim for penalties is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: December 17, 2009

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-797-897

ISSUES

The sole issue determined herein is jurisdiction. The parties held the issue of whether claimant's injury arose out of and in the course of employment and all benefit issues for later determination after hearing.

FINDINGS OF FACT

1. Claimant has lived in Colorado for about six years. Claimant previously worked for other over-the-road truck driving companies.

2. The employer operates a transportation business that involves over-the-road truck drivers. The employer owns facilities only in Dallas, Texas. The employer has no facilities in Colorado, but does have some cooperative agreements with other businesses to provide each other with secure parking lots in their respective states.

3. On approximately October 7, 2008, claimant responded to a newspaper advertisement for driving jobs with the employer. He completed a brief application for

employment over the internet. He also called Mr. Wilson, a recruiter for the employer, to discuss the nature of the job. Claimant advised Mr. Wilson that he wished to obtain a driving position wherein he could continue to reside in Colorado. Claimant and recruiter discussed the fact that the employer regularly delivered goods in Colorado. Mr. Wilson had no authority to hire employees, but had authority to invite applicants to travel to Dallas, Texas to go through the application process.

4. The employer paid claimant's expenses for him to attend orientation and testing in Dallas from October 19 through 22, 2008. Claimant attended a class of about 30 prospective driver employees. Claimant was not paid any wages for his participation in this process. He completed a lengthy paper application for employment. He underwent a D.O.T. physical examination and a drug test. He had to pass written and driving tests. He had to await successful verification of his background and employment history.

5. On October 22, 2008, the employer offered claimant employment as an over-the-road truck driver. Claimant accepted and completed his contract of hire. Claimant was then placed on the payroll and began approximately a three-week training program of driving trucks. He brought his belongings with him from Colorado and did not return to Colorado prior to starting his truck driving employment.

6. The employer makes regular scheduled deliveries in Colorado delivering Kraft™ products to Colorado warehouses for King Sooper's, Wal-Mart, and Albertson's. Many of the products were food products. Because Colorado is not a major food producing state, the employer more often delivered goods to Colorado and then had its employees "dead-head" an empty tractor to a neighboring state to pick up the next load. The employer has obtained the rights to use secured lots in Colorado Springs and Denver, Colorado where all of its trucks must park when not on the road.

7. In his 8 months of employment, claimant was dispatched into or out of Colorado on 22 occasions of 308 total dispatches. He was paid to deadhead from a secure Colorado Springs lot to his next loading point. He was not paid to deadhead from his last delivery site to a secure Colorado Springs lot in order to go home. He only went home 3 times during his 8 months of employment because he was only eligible for one day off work for each week he had been gone from home. Nevertheless, he drove inside Colorado more than in any other state. He made at least one delivery to Colorado each month through May 2009. On June 15, 2009, he loaded in Denver and then made deliveries to Pennsylvania and Maryland.

8. Claimant suffered a heart attack on June 28, 2009 in Loma Linda, California.

9. Claimant has proven by a preponderance of the evidence that he was regularly employed in Colorado and suffered an injury on June 28, 2009, in California, within six months after last leaving the state of Colorado.

CONCLUSIONS OF LAW

1. Claimant has proven by a preponderance of the evidence that Colorado has jurisdiction for claimant's extraterritorial injury. Whether an employee was hired in Colorado is a contract question generally governed by the same rules as other contracts. *Denver Truck Exchange v. Perryman*, 134 Colo. 586, 407 P.2d 805 (1957). The essential elements of a contract are competent parties, subject matter, legal consideration, mutuality of agreement, and mutuality of obligation. *Aspen Highlands Skiing Corp. v. Apostolou*, 866 P.2d 1384 (Colo. 1984). The place of contracting is generally determined by the parties' intention, and is usually the place where the offer is accepted or the last act necessary to the meeting of the minds or to complete the contract is performed. *Aspen Highlands Skiing Corp. supra; Denver Truck Exchange v. Perryman, supra.* Despite the application of the general law of contracts to this issue, in some circumstances it is only necessary that the "fundamental elements" of a contract be present. One must consider the purpose for the determination. When that purpose is determining the application of workers' compensation law, a technical application of the "contract of hire" requirement is not appropriate. A contract of hire may be deemed formed even though not every formality attending commercial contractual arrangements is observed, as long as the fundamental elements of contract formation are present. *Moorhead Machinery & Boiler Co. v. Del Valle*, 934 P.2d 861 (Colo. App. 1996), *abrogated on other grounds Horodyskyj v. Karanian*, 32 P.3d 470 (Colo. 2001). As found, claimant's contract of hire was made in Texas rather than in Colorado. Mr. Wilson did not make an offer of employment; he merely invited claimant to the employer's offices in Dallas, Texas, to complete the application process commencing October 19, 2008. In Texas, claimant received a conditional offer of employment, subject to passing a physical examination, drug screen, background verification, and written and driving tests. On October 22, 2008, the employer made an offer of employment, which claimant accepted and began to earn wages.

2. As found, claimant has proven by a preponderance of the evidence that he was regularly employed in Colorado and suffered an injury on June 28, 2009, in California, within six months after last leaving the state of Colorado. Section 8-41-204, C.R.S., establishes the exclusive grounds under which Colorado may take jurisdiction of an injury that occurs outside of the state. *Rodenbaugh v. DEA Construction*, W. C. No. 4-523-336 (ICAO, December 20, 2002). The claimant must either be hired in Colorado and sustain an injury within six months of leaving the state, or be regularly employed in Colorado and sustain an injury within six months of leaving the state. There is no mathematical formula for determination of "regularly employed." Claimant drove inside Colorado more than in any other state. He made at least one delivery to Colorado each month through May 2009. Claimant was dispatched into or out of Colorado on 22 occasions of 308 total dispatches. On June 15, 2009, he loaded in Denver and then made deliveries to Pennsylvania and Maryland before suffering an alleged work-related heart attack on June 28, 2009. Colorado has jurisdiction over the workers' compensation claim.

ORDER

It is therefore ordered that:

1. No benefits were requested and none are ordered herein. All matters not determined herein are reserved for future determination.

2. This decision of the administrative law judge 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: December 18, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-590

ISSUES

- Whether Claimant is entitled to medical benefits, specifically payment of three medical bills.
- Whether penalties should be imposed against Respondents for its failure to pay said medical bills.

FINDINGS OF FACT

Based on the evidence presented at hearing, the Judge finds as follows:

1. Claimant sustained an injury on April 12, 2008, for which Respondents admitted liability. Accordingly, Respondents provided medical treatment to the Claimant.
2. On April 28, 2008, Claimant underwent chest x-rays at St. Anthony North. Colorado Imaging Associates billed Claimant $33 as result. The primary insurer listed on this bill dated October 17, 2008, is Aetna US Healthcare.
3. Claimant also had lab work on August 15, 2008, upon the orders of authorized treating physician, Mark Failinger, M.D. Quest Diagnostics performed the lab work and sent a bill to the Claimant. A bill dated October 14, 2008, indicates that the remaining balance is $86. It further indicates that the claim was filed with the Department of Labor, that the Employer is "Ventury Clean" and that the Group Name is "Wasau Sierra."
4. Claimant underwent knee surgery on August 19, 2008, at St. Anthony's North. Claimant returned to St. Anthony's later that day due to complications that arose from the surgery. Claimant received a bill dated October 31, 2008, reflecting a balance due of $1620 and that his primary insurer was Aetna.

5. All three of the aforementioned medical bills were incurred as a result of authorized, reasonable and necessary medical treatment related to the Claimant's work injury. Respondents presented no evidence to the contrary.
6. Claimant's private health insurance carrier at the time was Aetna which explains that Aetna appears as the primary insurer on two of the bills.
7. There is insufficient evidence that the providers sent the bills to the Insurer within 120 days of the date of service; however, extenuating circumstances exist. The provider was not informed of where to send the bills as evidenced by the incorrect insurer information on each of the bills.
8. Claimant filed an Application for Hearing on April 13, 2009 which endorsed payment of the St. Anthony's North bill as an issue for hearing. A hearing on that application for hearing was scheduled for August 6, 2009; however, Claimant agreed to vacate that hearing because he believed that Respondents were going to pay all three bills.
9. Based on the evidence presented, the Judge infers that the Insurer received notice of the St. Anthony North bill following the Application for Hearing filed on April 13, 2009. There is insufficient evidence as to whether Insurer received the actual bill on or around April 13, 2009.
10. The Judge also infers that the Insurer received notice of the Quest Diagnostics and Colorado Imaging Associates bills following the filing of the August 5, 2009, Application for Hearing. Again, there is insufficient evidence as to whether the Insurer received the actual bills on or around August 5, 2009.
11. Claimant has received calls from collection agencies regarding the unpaid medical bills which has caused him stress, depression and lack of sleep. Claimant is concerned that his credit is now damaged.
12. The Insurer undoubtedly was aware of these unpaid medical bills by the time of the hearing scheduled for August 6, 2009; however, there is no persuasive evidence that the Insurer was in receipt of the actual bills by that date. Moreover, there was no persuasive evidence that the Insurer willfully failed to pay such medical bills even if it had received them.
13. Based on the foregoing, Claimant has established that the three medical bills in question were incurred as a result of authorized, reasonable and necessary medical treatment related to his work injury. Accordingly, Claimant has established that Insurer is responsible for the payment of all three medical bills.
14. Claimant has failed to establish that penalties should be imposed against Insurer. There was no persuasive or credible evidence of when, if at all, Insurer received the three medical bills in question.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Judge concludes as follows:

The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of

the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

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

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

Payment of the medical bills

Insurer is liable for the medical care Claimant receives from authorized providers that is reasonably needed to cure and relieve Claimant from the effects of the compensable injury. Section 8-42-101(1), C.R.S. WCRP Rule 16-11, is entitled "Payment of Medical Benefits." Subsection (1) states, "Providers shall submit their bills for services rendered within one hundred twenty (120) days of the date of service. Bills first received later than 120 days may be denied unless extenuating circumstances exist. Extenuating circumstances may include but not be limited to delays in compensability being decided or the provider has not been informed where to send the bill."

As found, extenuating circumstances existed for any delay in the providers submitting the three bills to the Insurer. Insurer is not entitled to deny payment for that reason. It is undisputed that the medical bills in question were incurred as result of authorized, reasonable and necessary medical treatment. Respondents, therefore, are responsible for payment of the bills described in paragraphs two, three and four in the Findings of Fact above.

Penalties

As pertinent here, WCRP 16-11(A)(2) provides that all bills submitted by a provider are due and payable within 30 days after receipt of the bill by the payer unless contested. Receipt is presumed to occur three days after the date the bill was mailed to the payer's correct address. Claimant seeks penalties based upon the allegation that the Insurer received the three medical bills, but failed to pay them within 30 days. There is no persuasive evidence as to the date on which the Insurer received the three medical bills. As such, it cannot be determined that the Insurer failed to pay the bills within 30

days. Claimant has, therefore, failed to establish that penalties should be imposed against Respondents for failure to timely pay the three bills discussed herein.

ORDER

It is therefore ordered that:

1. Insurer shall pay the St. Anthony's North bill for treatment rendered on August 19, 2008; the Colorado Imaging Associates bill for treatment rendered on April 28, 2008; and the Quest Diagnostics bill for treatment rendered on August 15, 2008.
2. Claimant's claim for penalties pursuant to §§ 8-43-401(2)(a) and 8-43-304(1), C.R.S., for Respondents' failure to timely pay the three medical bills is hereby 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.

DATED: December 18, 2009

Laura A. Broniak
Administrative Law Judge

STATE OF COLORADO,
OFFICE OF ADMINISTRATIVE COURTS
W. C. No. 4-764-343

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUES

The issues to be determined by this decision concern the Claimant's request for a penalty pursuant to § 8-43-304(1), C.R.S. (2009)), due to an alleged violation of § 8-42-107.2(4) and Workers Compensation Rule of Procedure (WCRP), Rule 5-5(C). 7 CCR 1101-3 [allegedly not filing another admission after the filing of the DIME Report stating the Claimant was not at maximum medical improvement although Respondents continued its willingness to pay pre-MMI medical benefits and there was **no** termination or reduction in indemnity benefits]. The Claimant also requests a change of physician due to his residence in Phoenix, Arizona.

FINDINGS OF FACT

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

1. The Claimant had sustained a compensable occupational disease as of July 23, 2008, when he developed pain in the neck and left arm over a period of time while working as an over the road truck driver. Marc Steinmetz, M.D., and Lawrence A. Lesnak, D.O., treated the Claimant. Both are authorized treating physicians ((ATPs). The Claimant was eventually referred as well to Lon Noel, M.D., who also was authorized.

2. The Respondents filed a General Admission of Liability (GAL) on December 19, 2008, which stopped the payment of temporary benefits as of December 16, 2008, based upon a written release to regular duty provided to the Claimant by ATP Dr. Steinmetz on December 16, 2008. Dr. Steinmetz reiterated the return to regular duty in a report dated January 22, 2009. On March 31, 2009, Dr. Lesnak, an ATP, also provided a return to regular duty release as of December 16, 2008.

3. Dr. Steinmetz determined the Claimant was at MMI as of December 16, 2008. The Claimant had this determination reviewed through a Division Independent Medical Exam (DIME), performed by John E. Tobey, M.D., on June 2, 2009. Dr. Tobey determined that the Claimant was not at MMI. Dr. Tobey recommended cervical epidural steroid injections. Depending on the response to these injections, Dr. Tobey then suggested the consideration of medial branch blocks, and possible radiofrequency denervation. A final consideration mentioned was a surgical consultation. In September of 2008, Dr. Lesnak had discussed epidural steroid injections with the Claimant, but it was decided to defer them at that time.

4. After the submission of Dr. Tobey's report, the Claimant did not contact Dr. Steinmetz, Dr. Lesnak or Dr. Noel about further treatment. He did not contact the insurance carrier in regard to further treatment. The carrier did not deny any requests for further treatment. Respondents did not timely challenge Dr. Tobey's DIME determination that Claimant was not at MMI.

Penalties

5. The Claimant's ATP provided him with a written return to regular duty release. The payment of temporary disability benefits ceased at that point. DIME Dr. Tobey states at the conclusion of his Discussion "No formal work restrictions are necessary. The ALJ finds that Claimant has failed to prove, by a preponderance of the evidence that Respondents did not obey a statute, rule or order, as further amplified in the Conclusions of Law.

Change of Physician

6. The Claimant no longer works as an over the road truck driver. His residence is in Phoenix, Arizona. As a result, it is now difficult for him to get to Denver for treatment. He requests the designation of a physician in the Phoenix area to provide

treatment. Claimant has proven, by a preponderance of the evidence that a change of physician to a physician in the Phoenix, Arizona area is warranted.

CONCLUSIONS OF LAW

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

Burden of Proof

a. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the entitlement to benefits, including penalties. §§ 8-43-201 and 8-43-210, C.R.S. (2008). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant has failed to sustain his burden with respect to penalties. As further found, Claimant has sustained his burden with respect to a change of physician.

Penalties

b. The Claimant argues the Respondents have violated WCRP, Rule 8-5 (C), by not filing another General Admission of Liability after the date of the determination of the DIME physician that the Claimant was not at MMI. The assertion is that since the Respondents are not contesting the non-MMI finding of the DIME, they are necessarily resuming medical benefits. Rule 5-5 (C) states:

> Admissions shall be filed with supporting attachments immediately upon termination or reduction in the amount of compensation benefits. An admission shall be filed within 30 days of resumption or increase of benefits.

The Claimant reasons the last sentence in this Rule requires another General Admission be filed. The ALJ is not persuaded by this contention of the Claimant. This was not the interpretation of the Division of Workers' Compensation (DOWC) when drafting the Rules. The Claimant was provided a written return to regular duty release by his authorized treating physician. Pursuant to § 8-42-105(3)(c), C.R.S. (2009), temporary benefits cease at that point. As found, even the DIME physician states at the conclusion of his Discussion "No formal work restrictions are necessary." Rule 5-5 (f) sets forth the Director's rule in regard to the need to file a new admission after a Division IME report. That section states a new admission is necessary in the situation where there is

an "IME's report determining medical impairment." This excludes the situation where the DIME determines that a claimant is not at MMI. Rule 5-5 (C) then provides that a new admission may be necessary when there is a termination of "compensation benefits (this means indemnity benefits **not** medical benefits)." The following sentence states a new admission is also required when there is a "resumption or increase of benefits". It is clear, however, that this reference to "benefits" is to the same benefits mentioned in the preceding sentence. Those, of course, are "compensation benefits (indemnity benefits as distinguished from medical benefits)." To interpret the rules otherwise would result in an absurd situation. At every point when there is a dispute over a medical recommendation, a new admission would need to be filed once it is resolved. In some cases, this would lead to a new admission every few weeks.

The Director, in fact, has specified in WCRP, Rules 16-9, 16-10 and 16-11, the procedures the parties are to follow when a recommended medical benefit is disputed and then resolved.

c. The imposition of penalties is governed by an objective standard of negligence. *See Pueblo School Dist. No. 70 v. Toth,* 924 P. 2d 1094, 1097 (Colo. App. 1996). As found, by any objective standard of negligence, Respondents were **not** negligent because they did not disobey a statute or rule. There was no negligent violation of any order, statute or rule by the Respondents. The DOWC specified in WCRP, Rules 16-9, 16-10 and 16-11, the procedures that parties are to follow when a recommended medical benefit is disputed and then resolved. These Rules do not require a new admission be filed upon resolution of a dispute. The ALJ concludes that in the case where indemnity benefits are not to be resumed as a result of an DIME determination that MMI has not been reached, the Respondents are not in violation of the Workers Compensation Act or the WCRP when **no** new general admission is filed. The Claimant has failed to prove a penalty by a preponderance of the evidence.

Change of Physician

d. § 8-43-404 (5) (a) (VI), C.R.S. (2009), provides that upon a proper showing, an employee may procure permission to have a physician of the employee's selection treat the employee. The ALJ concludes that Claimant living in Phoenix, Arizona, as opposed to Denver where his present ATPs are, is a proper showing for a change of physician. The ALJ concludes that It is reasonable for the Claimant to have a new doctor located in the Phoenix, Arizona area designated to treat him as opposed to requiring the Claimant to return to Denver to receive treatment from his Denver ATPs.

ORDER

A. The Claimant's request for the assessment of a penalty pursuant to § 8-43-304(1), C.R.S. (2009) is hereby denied and dismissed.

B. The Claimant's request to authorize a change of physician is granted. Both parties shall agree to a list of three doctors in the Phoenix, Arizona area. Each party may then strike one of the doctors. The remaining doctor shall be authorized to treat the Claimant for his work injury.

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

DATED this ____ day of December 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-697-330

ISSUES

1. Respondent's attempt to overcome the Division Independent Medical Examination ("DIME") of Dr. Jade Dillon.

2. Authorization of a partial right knee arthroplasty for Claimant, as recommended both by Dr. Dillon and by Dr. Michael Feign.

FINDINGS OF FACT

1. Claimant suffered a work-related injury to her right knee while assisting a patient on August 28, 2006. The claim was admitted.

2. Claimant underwent arthroscopic surgery on her knee on December 18, 2006 that was unsuccessful in relieving the pain, swelling, or weakness in Claimant's right knee, which she had experienced since her work injury of August 28, 2006.

3. Claimant underwent a second arthroscopic surgery on her knee on September 26, 2007. The pain, swelling, and weakness in Claimant's right knee persisted following this surgery as well.

4. An MRI was performed on Claimant's right knee on November 12, 2007 that revealed that Claimant's work injury had led to a rare condition called avascular necrosis.

5. On April 1, 2008, Dr. Pak, Claimant's authorized treating physician placed Claimant at maximum medical improvement. However, Claimant continued to experience pain and weakness in her right knee.

6. On referral from Dr. Pak, Claimant saw Dr. Michael Feign, an orthopedic surgeon, on January 7, 2009. Dr. Feign stated in his report that the "only option to relieve [Claimant's] pain is to proceed with a partial knee replacement."

7. On February 23, 2009, Dr. Wayne Gersoff performed an independent medical examination at the request of Respondent. After examining Claimant, Dr. Gersoff concluded that based in part on the diagnosis of avascular necrosis, "[Claimant] would best be treated with a medial compartment unicompartmental knee replacement."

8. On April 30, 2009, Dr. Gersoff, without examining Claimant and without explanation, changed his diagnosis of Claimant.

9. On May 26, 2009, Dr. Jade Dillon performed a Division of Worker's Compensation Independent Medical Examination ("DIME") of Claimant. Relying upon the opinion of Dr. Feign, the initial opinion of Dr. Gersoff, and her own examination, Dr. Dillon noted that Claimant was not at MMI, and would require a partial right knee arthroplasty to bring her to MMI.

10. Respondents took a deposition of Dr. Gersoff on October 14, 2009. During this deposition, Dr. Gersoff changed his diagnosis of Claimant a second time without examining Claimant or performing any diagnostic tests. Ultimately, the ALJ finds Dr. Gersoff's opinion's to be equivocal, and not such that they would establish that Dr. Dillon's opinions were clearly wrong.

11. In a deposition of Dr. Jade Dillon, taken on September 14, 2009, Dr. Dillon addressed her opinion as to whether Claimant was at maximum medical improvement ("MMI") when she examined Claimant on May 26, 2009. Dr. Dillon acknowledged that Claimant's condition seemed to be improving, and that she was appropriately placed at MMI on April 1, 2008; however, she ultimately opined that on the date of her examination of the Claimant, Claimant's condition had deteriorated such that she was no longer at MMI.

12. Dr. Dillon opined that with this "type of pathology, it can advance with time, and I believe that it is possible that it was related to the original injury with – with a good deal of medical certainty."

13. With respect to Claimant's need for knee surgery, Dr. Dillon opined "it is very reasonable to proceed with the next indicated medical procedure, which is a partial arthroplasty."

14. The ALJ finds Dr. Dillon's opinion that the Claimant was not at MMI has not been overcome by clear and convincing evidence. The ALJ finds that Dr. Dillon's opinions

concerning Claimant's need for knee surgery to correct the consequences of her work-related injury knee pathology, and the underlying facts, establish that Claimant's knee surgery is reasonable, necessary and related to her work injury. Dr. Dillon's opinions more credible than any contrary evidence introduced.

CONCLUSIONS OF LAW

1. The opinion of a physician who has conducted a division independent medical examination (DIME) can only be overcome by clear and convincing evidence with respect to a Claimant's status concerning maximum medical improvement. C.R.S. §§ 8-42-107(8)(b)(II) and (c).

2. Clear and convincing evidence represents evidence that is stronger than a preponderance. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo.App. 1995). Clear and convincing evidence is a standard which refers to evidence that is highly probable and free from substantial doubt. *Id.*

3. Respondent has failed to show, by clear and convincing evidence, that the opinion of Dr. Dillon, who performed a DIME on Claimant, is incorrect. Dr. Dillon's testimony is credible and supported by the opinion of an orthopedic specialist, Dr. Feign, whose diagnosis of Claimant relies upon medical evidence and has remained constant throughout. Dr. Gersoff's diagnoses are equivocal. Therefore, the ALJ finds Dr. Gersoff's opinions fail to establish the requisite clear and convincing evidence necessary to overcome Dr. Dillon's opinion.

4. An employer and its insurance company must furnish surgical treatment that is reasonably necessary to cure and relieve the employee from the effects of a work-related injury. C.R.S. § 8-42-101(1)(a).

5. The duty of an employer and its insurance company to furnish treatment extends to treatment for conditions that represent a natural development of the work-related injury. *Owens v. Indus. Claim Appeals Office of the State of Colorado*, 49 P.3d 1187, 1188 (Colo.App. 2002).

6. The record must, however, clearly reflect the medical necessity of the treatment required to cure and relieve an injured employee from the effects of the work-related injury. *Public Service Co. of Colorado v. Indus. Claim Appeals Office*, 979 P.2d 584, 585 (Colo.App. 1999).

7. Both Dr. Jade Dillon, who performed a DIME of Claimant, and Dr. Feign, an orthopedic specialist to who examined Claimant on referral from her ATP, have stated in their reports that Claimant requires a partial right knee arthroplasty to cure and relieve the pain associated with her August 28, 2006, work-related injury. Therefore, the ALJ concludes that the record clearly reflects the medical necessity of a partial right knee

arthroplasty for Claimant and that Respondents have a duty to furnish this treatment for Claimant.

ORDER

It is therefore ordered that:

1. Respondents challenge of the DIME physician's opinion with respect to Claimant's MMI status is denied and dismissed..

2. Respondents shall furnish for Claimant a partial right knee arthroplasty, the necessity of which is clearly reflected in Claimant's medical records.

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: December 22, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-805-281

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?
¬ Did claimant prove by a preponderance of the evidence that he is entitled to medical benefits?
¬ Did insurer prove by a preponderance of the evidence that it had properly canceled employer's policy of workers' compensation insurance prior to the time of claimant's injury?

FINDINGS OF FACT

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

1. Employer is in the business of producing wood millwork and molding. Claimant's primary language is Spanish. Claimant worked for employer operating machinery for

shaping wood. Crediting his testimony, claimant sustained an injury while working for employer on July 2, 2009, when the router he was operating rebounded into his left hand.

2. Claimant showed it more probably true that he sustained an injury arising out of the course and scope of his employment on July 2, 2009. Crediting the testimony of David Heller, employer does not dispute claimant's injury.

3. Claimant was taken to University Hospital where he received emergent medical treatment on July 2, 2009. Employer also referred claimant to Concentra Medical Centers for follow-up care. University Hospital and Concentra are authorized medical providers. The medical treatment claimant received at University Hospital and Concentra was reasonable and necessary to cure and relieve the effects of claimant's work-related injury.

4. Jeff Bunn, underwriter for insurer, credibly testified that the policy of workers' compensation insurance insurer issued to employer had been cancelled due to non-payment of premium, effective 12:01 a.m. April 14, 2009. Crediting Mr. Bunn's testimony and the exhibits, insurer properly mailed employer the notice of cancellation via certified mail on March 26, 2009, which employer received on March 30, 2009. The notice of cancellation advised employer that the policy would be canceled if employer failed to pay the premium due in the amount of $4,732.00 on or before April 13, 2009. Employer failed to pay the premium by April 13th, and insurer issued a letter to employer notifying it that coverage had been canceled. Employer later obtained a new policy of insurance from insurer, effective July 29, 2009.

5. Employer was non-insured for workers' compensation coverage on the date of claimant's injury on July 2, 2009. Insurer thus is not liable for providing claimant workers' compensation benefits under the Workers' Compensation Act.

CONCLUSIONS OF LAW

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

A. Compensability:

Claimant argues he has proven by a preponderance of the evidence that he sustained an injury arising out of the course and scope of his employment. The Judge agrees.

The purpose of the Workers' Compensation 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), *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. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Here, the Judge found claimant showed it more probably true that he sustained an injury arising out of the course and scope of his employment on July 2, 2009. Claimant thus proved by a preponderance of the evidence that he sustained a compensable injury.

B. Insurance Coverage:

Insurer argues it is not liable for claimant's benefits because it proved by a preponderance of the evidence that it had properly canceled employer's policy of workers' compensation insurance prior to the time of claimant's injury. The Judge agrees.

Insurer showed it more probably true that it complied with §8-44-110, supra, in canceling employer's insurance policy as of April 14, 2009.

The Judge concludes that insurer is not liable for claimant's benefits under the Workers' Compensation Act. Claimant's claim against insurer should be denied and dismissed.

C. Medical Benefits:

Claimant argues he has proven by a preponderance of the evidence that he is entitled to medical benefits. The Judge agrees employer is liable for claimant's medical benefits under the Workers' Compensation Act.

Once he has established a compensable work injury, claimant is entitled to a general award of medical benefits, and respondents are liable to provide all reasonable and necessary medical care to cure and relieve the effects of the work injury. Section 8-42-101, *supra*; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). As such, claimant has established that he is entitled to any and all reasonable, necessary, and related medical benefits for the compensable left hand injury suffered on July 2, 2009.

As found, the treatment claimant received at University Hospital and Concentra was authorized and reasonably necessary to cure and relieve claimant of the effects of his injury at employer.

The Judge concludes that employer should pay, pursuant to fee schedule, the medical bills from University Hospital and Concentra for the medical treatment claimant received for his compensable injury.

ORDER

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

1. Claimant's injury at employer on July 2, 2009, is compensable.

2. Claimant's claim against insurer is denied and dismissed.

3. Employer shall pay, pursuant to fee schedule, the medical bills from University Hospital and Concentra for the medical treatment claimant received for his compensable injury.

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

DATED: _December 22, 2009___

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-792-517

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered a compensable left knee injury during the course and scope of his employment with Employer.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his left knee condition.

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 May 15, 2009 until terminated by statute.

STIPULATION

The parties agreed that Claimant earned an Average Weekly Wage (AWW) of $1079.89.

FINDINGS OF FACT

1. Claimant has worked for Employer as a Route Sales Representative (RSR) since August 2007. His duties involved delivering products from Employer's warehouse to various retail locations. Claimant specifically unloaded products using a dolly or cart and stocked the products on shelves. He engaged in kneeling, squatting, crouching and bending to complete his job duties.

2. On April 26, 2009 Claimant was delivering products to Hays Market in Johnstown, Colorado. He testified at the hearing in this matter. Claimant explained that at the end of a 12-hour shift he was walking from a back room to the sales floor when his left knee gave out. He remarked that he experienced some discomfort in his left knee but caught himself before falling. Claimant completed his work shift but awoke the next morning with a lump on his left knee.

3. On April 27, 2009 Claimant reported to Employer that his left knee gave out while walking. He completed an injury report and noted that he was "just walking when the pain occurred."

4. Claimant has a history of knee dislocations. The medical records reveal that Claimant's left knee simply collapsed while techno-dancing in 2003. Claimant subsequently underwent surgery for his left knee condition. He also experienced a right knee dislocation while playing softball.

5. Employer referred Claimant to Concentra Medical Centers for treatment. On April 28, 2009 Rosalinda Pineiro, M.D. evaluated Claimant. He reported that he had injured his knee while walking in a backroom. Dr. Pineiro diagnosed Claimant with a left knee strain. She concluded that Claimant suffered "an aggravation of a preexisting condition" and that his knee condition was related to his work for Employer.

6. Claimant subsequently underwent physical therapy and other conservative medical treatment for his left knee condition. He consistently reported that he was simply walking when his left knee gave out. Claimant also noted that he began to experience pain and discomfort in his right knee as a result of physical therapy.

7. On June 2, 2009 Claimant reported to Garth C. Nelson, M.D. that he was "walking on a flat surface and for no apparent reason [my] left leg gave way." Dr. Nelson noted that Claimant had undergone an MRI of his left knee. The MRI revealed "an irregularity of the junction of the body and the posterior horn of the lateral meniscus which may be postsurgical." Dr. Nelson also remarked that Claimant had "moderate patellofemoral chrondrosis" and that the PF joint exhibited more wear than the average 29-year old.

8. On June 29, 2009 Claimant told Thomas R. Sachtleben, M.D. that he was "walking at work at the end of his shift and felt his knee buckle and give out." Claimant remarked that he was "not carrying anything at the time." Dr. Sachtleben diagnosed Claimant with left "patellofemoral chondromalacia" and a possible "left lateral meniscus tear."

9. Claimant testified that he did not remember whether he was simply walking or pushing a cart at the time his left knee gave out at Hays Market. However, Claimant explained that Hays Market employee Daniel Gehrig informed him in a telephone conversation several months after the incident that he may have been pushing a cart or dolly when his left knee gave out.

10. Mr. Gehrig testified at the hearing in this matter. He stated that he was working in the backroom of Hays Market when Claimant's left knee gave out on April 26, 2009. Mr. Gehrig commented that he was uncertain whether Claimant was pushing a dolly or cart when his left knee gave out. Nevertheless, he remarked that Claimant told him at the time of the incident that "my knee just went out on me."

11. On October 6, 2009 Gregory Reichhardt performed an independent medical examination of Claimant. Dr. Reichhardt also testified at the hearing in this matter. He noted that Claimant suffers from recurrent patellar subluxation or dislocation of the kneecap. Dr. Reichhardt persuasively concluded that Claimant did not suffer either a left knee injury on April 26, 2009 or an occupational disease to his left knee during the course and scope of his employment with Employer. He also determined that Claimant did not sustain an injury to his right knee while undergoing physical therapy for his left knee condition.

12. Dr. Reichhardt commented that Claimant did not sustain an acute injury on April 26, 2009 because there was a lack of evidence in the medical records that Claimant was doing anything other than walking when his left knee gave out. He remarked that Claimant was not pushing or pulling anything that was mechanically more challenging than the normal activity of walking. Dr. Reichhardt thus concluded that Claimant's left knee problem constituted the natural progression of his pre-existing left knee recurrent patellar subluxation.

13. Dr. Reichhardt also explained that Claimant did not suffer an occupational disease to his left knee because patellar subluxation is not a cumulative trauma condition. As demonstrated by Claimant's pre-existing knee problems, Dr. Reichhardt noted that Claimant simply suffers from a propensity to develop knee dislocations. Dr. Reichhardt remarked that Claimant's previous knee injuries have resulted in a compromised knee structure. He concluded that walking is a normal activity of daily living and does not constitute a hazard "to which one is not equally exposed outside of the workplace."

14. Dr. Reichhardt also did not attribute Claimant's right knee complaints to the physical therapy that he underwent for his left knee condition. He stated that the medical records did not reveal any right knee complaints as a result of physical therapy.

Notably, Claimant did not assert that he suffered a right knee injury during physical therapy prior to November 11, 2009.

15. Claimant presents three theories of compensability. He first contends that he suffered an acute injury to his left knee on April 26, 2009 while completing his job duties at Hays Market. Second, Claimant asserts that he sustained an occupational disease as a result of his job duties for Employer. Finally, he argues that he injured his right knee while undergoing physical therapy for his left knee. However, Claimant has failed to demonstrate that it is more probably true than not that he suffered a compensable injury during the course and scope of his employment for Employer. Moreover, Claimant's knee conditions were not caused, accelerated, intensified or aggravated by his job duties for Employer.

16. Claimant consistently reported in the medical records that he was simply walking when his left knee gave out. He did not mention that he was pushing a cart or dolly at the time of his injury on April 26, 2009. Mr. Gehrig informed Claimant in a telephone conversation several months after the incident that he may have been pushing a cart or dolly when his left knee gave out. However, Mr. Gehrig was uncertain at the hearing about whether Claimant had been pushing anything at the time of the incident. Dr. Reichhardt persuasively commented that Claimant did not sustain an acute injury on April 26, 2009 because there was a lack of evidence in the medical records that Claimant was doing anything other than walking when his knee gave out. Dr. Reichhardt thus concluded that Claimant's left knee problem constituted the natural progression of his pre-existing left knee recurrent patellar subluxation.

17. Dr. Reichhardt also explained that Claimant did not suffer an occupational disease to his left knee because patellar subluxation is not a cumulative trauma condition. As demonstrated by Claimant's pre-existing knee problems, Dr. Reichhardt noted that Claimant simply suffers from a propensity to develop knee dislocations. He remarked that Claimant's previous knee injuries have resulted in a compromised knee structure. Dr. Reichhardt noted that walking is a normal activity of daily living and does not constitute a hazard "to which one is not equally exposed outside of the workplace." He also did not attribute Claimant's right knee complaints to physical therapy because the medical records did not reveal any right knee complaints. Notably, Claimant did not assert that he suffered a right knee injury during physical therapy prior to November 11, 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. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The

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

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

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

4. As found, Claimant presents three theories of compensability. He first contends that he suffered an acute injury to his left knee on April 26, 2009 while completing his job duties at Hays Market. Second, Claimant asserts that he sustained an occupational disease as a result of his job duties for Employer. Finally, he argues that he injured his right knee while undergoing physical therapy for his left knee. However, Claimant has failed to demonstrate by a preponderance of the evidence that he suffered a compensable injury during the course and scope of his employment for Employer. Moreover, Claimant's knee conditions were not caused, accelerated, intensified or aggravated by his job duties for Employer.

Acute Injury

5. 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.

6. 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).

7. As found, Claimant consistently reported in the medical records that he was simply walking when his left knee gave out. He did not mention that he was pushing a cart or dolly at the time of his injury on April 26, 2009. Mr. Gehrig informed Claimant in a telephone conversation several months after the incident that he may have been pushing a cart or dolly when his left knee gave out. However, Mr. Gehrig was uncertain at the hearing about whether Claimant had been pushing anything at the time of the incident. Dr. Reichhardt persuasively commented that Claimant did not sustain an acute injury on April 26, 2009 because there was a lack of evidence in the medical records that Claimant was doing anything other than walking when his knee gave out. Dr. Reichhardt thus concluded that Claimant's left knee problem constituted the natural progression of his pre-existing left knee recurrent patellar subluxation.

Occupational Disease

8. 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. 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.

9. 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.*

10. As found, Dr. Reichhardt also explained that Claimant did not suffer an occupational disease to his left knee because patellar subluxation is not a cumulative trauma condition. As demonstrated by Claimant's pre-existing knee problems, Dr. Reichhardt noted that Claimant simply suffers from a propensity to develop knee dislocations. He remarked that Claimant's previous knee injuries have resulted in a compromised knee structure. Dr. Reichhardt noted that walking is a normal activity of daily

living and does not constitute a hazard "to which one is not equally exposed outside of the workplace." He also did not attribute Claimant's right knee complaints to physical therapy because the medical records did not reveal any right knee complaints. Notably, Claimant did not assert that he suffered a right knee injury during physical therapy prior to November 11, 2009.

ORDER

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

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

DATED: December 21, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-766-142

ISSUES

1. Whether Claimant can prove by a preponderance of the evidence that he sustained a sudden, compensable noise-induced hearing loss in the course and scope of his employment?

2. Whether a hearing aid would cure or relieve the effects of the injury or improve Claimant's hearing, and should be awarded as a specific medical benefit in this case?

FINDINGS OF FACT

1. The Claimant has been employed by the Respondent-Employer for over 22 years. He is now 60 years old. He was employed at the time of his injury as the lead man for a pipe gang, a position that often involves jackhammering as part of the job duties. Claimant used a jackhammer approximately two-to-three times a week in his job.

2. On April 14, 2008, the Claimant was jackhammering, starting at about 7:30 in the morning. The surface that the Claimant was working on was especially dense and hard. The surface was composed of three layers of asphalt, red slag, and cement that the crew had to jackhammer through. The hardness of the material resulted in the crew having to switch to a heavy jackhammer, as well as switch the bit on the jackhammer.

3. There were five men on the crew that morning, each taking turns running the jackhammer. The Claimant was wearing foam earplugs while he was jackhammering. The Claimant was in the vicinity of the truck, the compressor and the jackhammer throughout the morning. The compressor was mounted on the bed of the truck. Throughout the morning, the jackhammer was running and the compressor was running. The jackhammer and the compressor were turned off about 10:30 in the morning. At that point, after about three hours of exposure to the noise, the Claimant removed his foam earplugs and realized he could not hear his co-workers.

4. The Claimant reported the injury to his supervisor, George Woods later that same day. Initially the Claimant thought that maybe the earplugs had pushed wax down into his ears.

5. The next morning Claimant's supervisor, Mr. Woods, told the Claimant the injury was not work-related and told him to see his personal physician. Dr. Ramos is the Claimant's personal physician and Claimant was seen by Dr. Ramos' assistant that day. The Claimant did not have any signs of infection, virus, he was not running a fever, he did not have pain, dizziness, or vertigo. Dr. Ramos' office referred the Claimant to Dr. Dodds, an Otolaryngologist.

6. Dr. Dodds first saw the Claimant on May 5, 2009. At Dr. Dodds' office, Dr. Daugherty did an audiogram which Dr. Dodds reviewed before he prepared his report. Dr. Dodds notes that the hearing loss was worse in one ear.

7. Dr. Dodds' report also notes that the Claimant had been jackhammering at work for three days in a row and that the onset of the hearing loss was acute after the jackhammer work on the date of injury. He diagnosed the hearing loss, tinnitus, and noted there were no vestibular symptoms. Dr. Dodds did evaluate Claimant for non-work related symptoms prior to arriving at his conclusion that the hearing loss was work-related.

8. Dr. Dodds noted that the Claimant was wearing sponge earplugs on the date of injury. Dr. Dodds also reviewed the Claimant's health summary. Based upon his evaluation, Dr. Dodds' impression was that the noise exposure and the vibrations associated with the jackhammering, caused the hearing loss.

9. When the Claimant's hearing did not improve after several days, Claimant again requested to be seen by a worker's compensation physician. Dr. Nanes finally saw the Claimant on May 6, 2008, 22 days after his injury and one day after his appointment with Dr. Dodds that was arranged through Dr. Ramos' office. Dr. Nanes noted bilateral hearing loss and tinnitus and noted in his report that the Claimant had been jackhammering for three days in a row prior to the injury. Dr. Nanes reviewed an audiogram that had been performed in Dr. Dodds' office confirming the hearing loss. Dr. Nanes performed an examination and determined that in his opinion, the injury was work-related, returning Claimant to work with restrictions of no jackhammering.

10. Dr. Dodds referred the Claimant to his audiologist Dr. Daugherty to be fitted for hearing aids. Dr. Dodds expressed his concern that continued exposure to Jackhammering and/or loud noise could cause additional hearing loss. He did state that he felt that maybe if the Claimant were fitted with special earplugs and then wore heavy earmuffs, that he might be OK to work on his jackhammer crew. In his final report of June 5, 2008, he reiterates his opinion that the hearing loss is due to injury, acoustic and vibrotactile. He recommends monitoring with continued audiometric testing to make sure the hearing does not get worse.

11. Dr. Dodds examined and consulted with the Claimant on three occasions. Dr. Daugherty, the audiologist in his office, performed the audiology and fitted the Claimant for the special earplugs (earmolds) and the hearing aids.

12. Dr. Dodds testified at hearing. He is an Otolaryngologist and testified as an expert in that field. Dr. Dodds was aware that noise induced hearing loss was normally symmetrical, or the same in both ears. Even though he realized that was not the case for the Claimant, he believed that the hearing loss is related to the jackhammering. He believes that the vibration from the jackhammer could also be contributory. He has used a Jackhammer in the past and knows the vibratory force is significant.

13. Dr. Dodds' is of the opinion that it is reasonable and necessary and related for Claimant to have hearing aids to relieve the Claimant from the effects of his work injury.

14. Dr. Dodds testified that the bill for the hearing aids obtained by the Claimant were $5,750.00 and that it remained unpaid to date.

15. Dr. Jacobson, who is an audiologist, examined Claimant at the request of the Respondents and performed audiograms on the Claimant. His opinion was that the hearing loss was not work-related, primarily because the hearing loss was asymmetrical, or not the same in each ear and also because of the specific range of the hearing loss as shown in the audiogram.

16. At the request of Respondents, the Claimant went to an appointment with Dr. Shaw, a specialist in Otolaryngology but, before he would see the Claimant, Dr. Shaw had the Claimant see his associate, Dr. Olson.

17. Neiland R. Olson, M.D., an Otolaryngologist, did the "Initial Consultation/History and Physical" of the Claimant on February 24, 2009. On that same day, his office did an audiogram. He noted possible retrocochlear pathology, asymmetrical hearing loss and recommended additional testing.

18. Additional vestibular testing was done on the Claimant on April 8, 2009, including Electrostagmography that was performed by Dr. Cameron Shaw's office.

19. After the initial consultation and exam, the specialist, Dr. Cameron Shaw saw the Claimant on April 14, 2009, one year after the injury. He notes: "He has a history of on

the job noise induced severe to profound hearing loss in his right ear. It happened exactly a year ago after switching off a compressor and could no longer hear in his right ear. He has done this for decades previously."

20. After his first examination, Dr. Shaw recommended an MRI "because of the severity of his asymmetry. Also on that date, the Claimant got another audiogram. Dr. Shaw did an examination and noted "examination reveals no defect, deformity, or effusion."

21. An MRI was done per Dr. Shaw's recommendation on April 27, 2009. The MRI was interpreted by Dr. Karl Wolff. Dr. Wolff found "No acoustic neuroma or other imaging abnormality of the internal auditory canal regions identified."

22. 23. Dr. Shaw's final report is dated May 27, 2009. At this examination, he states: 'I had seen him for a hearing loss that was work-related as well as tinnitus, and the hearing loss was asymmetric". He states that he had reviewed the MRI and "there is no evidence of acoustic neuroma or other retrocochlear lesion."

23. The ALJ finds Claimant to be credible in his explanation of the events detailed above.

24. The ALJ finds Dr. Dodds' medical opinions to be credible and carry the greater weight when compared to medical evidence to the contrary, specifically that of Dr. Jacobsen. Dr. Dodds' opinions are corroborated by other medical doctors.

CONCLUSIONS OF LAW

1. A worker's compensation claimant must prove by a preponderance of the evidence that he or she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301, C.R.S.*; 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.2d 1230 (Colo.App. 2001). The facts in a worker's compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. Claimant bears the burden of proof by a preponderance of the evidence that his or her employment bears a direct causal relationship to the injury. *Finn v. Industrial Commission of Colorado,* 437 P.2d 542 (Colo. 1968), *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251 (Colo.App. 1999); *Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo.App. 1997). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979).

2. In determining credibility, the ALJ should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or un-

reasonableness of testimony and actions, the probability or improbability of testimony and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or evidence, and any bias, prejudice or interest in the outcome of the case. COLORADO JURY INSTRUCTIONS, CIVIL, 3:16.

3. It is Claimant's burden to prove by a preponderance of the evidence that his hearing loss occurred in the course and scope of his employment. 8-41-301(1)(b), C.R.S.; *Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). Claimant must demonstrate circumstances indicating to a reasonable probability that the disabling condition resulted from the employment. See *Industrial Commission v. Riley*, 441 P.2d 3 (Colorado, 1968). There is preponderant evidence as detailed above, establishing that it is more likely than not that Claimant suffered a job related hearing loss arising out of and in the course of his employment with the Respondent-Employer. Several medical doctors, including an Otolaryngologist are of the opinion that Claimant's hearing loss is job related. The contrary evidence is insufficient to overcome the evidence that the hearing loss is work-related.

4. Pursuant to 8-42-101(1)(a), C.R.S., Respondents are obligated to provide medical benefits to "cure and relieve" the effects of the industrial injury. *Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). 8-42-101(1)(b), C.R.S., as in effect on the date of injury, provides that "[i]n all cases where the injury results in … loss of vision or hearing … the employer shall furnish … a hearing aid … and any other external prosthetic device … which are reasonably required … to improve the employee's … hearing." Claimant bears the burden of proof to establish the right to specific medical benefits. *HLJ Management Group, Inc. v. Kim,* 804 P.2d 250 (Colo. App. 1990).

5. As found above the preponderant evidence establishes the requisite reasonable, necessary and related criteria.

ORDER

It is therefore ordered that:

1. Claimant's request for benefits pursuant to the Workers' Compensation Act of Colorado for his work-related hearing loss is granted. Claimant's claim is compensable. Respondents shall pay for all reasonable and necessary medical care to cure or relieve the Claimant from the effects of his work-related hearing loss.

2. Respondents are responsible for the cost of Claimant's hearing aids in accordance with the fee schedule.

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: December 23, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-609-184

ISSUES

¬ Where the Industrial Claim Appeals Office remands a case to the ALJ with instructions to "conduct appropriate proceedings, including a hearing if necessary, to resolve respondent's request for attorney fees," may the ALJ order that a hearing be set and conducted without first requiring the respondent to file an application for hearing raising the issue of attorney fees?

¬ Did the respondent prove by a preponderance of the evidence that claimant's counsel is subject to attorney fees because he filed a petition to review and brief in support seeking review of an order that did not award or deny any benefits or penalties?

FINDINGS OF FACT

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

1. This matter concerns a request for the imposition of attorney fees against claimant's counsel pursuant to § 8-43-301(14), C.R.S.
2. This matter was before the ALJ on a previous occasion. On February 26, 2009, the ALJ entered Findings of Fact and Conclusions of Law (FFCL) with respect to the issue litigated on February 3, 2009. The ALJ's order details the history of the case and is incorporated in this order. Specifically, the ALJ notes that on two prior occasions the claimant failed to establish that she ever sustained a compensable injury.
3. In the February 26, 2009, FFCL the ALJ explicitly found that at the February 2009 hearing, "claimant's counsel represented that the only real issue for determination is whether, if the claimant applies for a hearing on the issue of permanent total disability (PTD) benefits, the respondents' [sic] "defenses" of issue preclusion, claim preclusion and claim closure would impose a legal bar to adjudication of the PTD claim."
4. In the February 26, 2009 FFCL, the ALJ concluded that the issue presented by the claimant was not "ripe" for adjudication because the question of whether the defenses "would bar entry of an award of PTD benefits is purely hypothetical." Specifically, the ALJ concluded that the issue of the validity of the defenses was not "ripe" because the claimant had "not presented any claim for PTD benefits, and [had] not raised any such claim by filing an application for hearing seeking PTD benefits." Finally, the ALJ concluded that because the issue presented was not ripe for hearing, the claimant's "application for hearing should be dismissed without prejudice."
5. At the conclusion of the FFCL the ALJ included the following paragraph:

6. This decision of the administrative law judge 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.

7. On or about March 17, 2009, claimant's counsel filed a Petition to Review the February 26, 2009, FFCL. Counsel electronically signed the petition.

8. On April 17, 2009, claimant's counsel filed a Brief in Support of Position [sic] for Review. Counsel electronically signed the brief. In this brief counsel for the claimant stated the following:

9. The Order does not award or deny a benefit and therefore may not be reviewable. *See Natkin & Co. v. Eubanks,* 775 P.2d 88 (Colo. App. 1989). Further, the order must determine the amount of benefits to be awarded before it is final and appealable. *See United Parcel Service, Inc. v. Industrial Claim Appeals Office,* 988 P.2d 1146 (Colo. App. 1999).

10. The claimant's brief further stated that, "to the extent the order is found to be reviewable, the Order is in error in that finds [sic] that Respondents [sic] have not raised the defenses of claim closure and issue preclusion." The brief further states that the "Response to Application for Hearing raises those issue [sic]." The brief requested that the matter be remanded to the ALJ for the purpose of determining whether the claimant "is barred from seeking permanent total disability by the doctrines of case closure and issue preclusion."

11. The respondent filed a Brief in Opposition to Petition to Review. The respondent argued that the FFCL did not constitute a final order subject to Industrial Claim Appeals Office (ICAO) review under § 8-43-301(2), C.R.S., because it did not award or deny any benefits or penalties. The brief further argued that, because the FFCL did not constitute a final order subject to appeal, the ICAO should assess attorney fees against claimant's counsel under § 8-43-301(14). The respondent reasoned that because the appeal did not award or deny benefits or penalties it was "not warranted by existing law."

12. On July 2, 2009, a panel of the ICAO issued an Order resolving the issues presented by the claimant's petition to review and brief in support. The ICAO noted that, contrary to the assertion contained in the claimant's brief, the ALJ "specifically found that the respondent filed a response to application for hearing listing several other issues including issue preclusion, claim preclusion, and claim closure." The ICAO further held, based on § 8-43-301(2), that there "has been no award or denial of benefits: rather, the ALJ has declined to offer an opinion involving certain issues that might be raised in hypothetical future litigation involving claimed PTD benefits." Therefore the ICAO concluded the "matter is not reviewable" and dismissed the claimant's petition to review without prejudice.

13. The ICAO further noted that § 8-43-301(14) provides that an attorney's signature on a petition to review or brief constitutes certification that the petition is "well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law," and that the petition is "not interposed for any improper purpose." The ICAO observed that it lacks the statutory authority to find facts, and concluded it was necessary to "remand the matter to the ALJ with instructions to

conduct appropriate proceedings, including a hearing if necessary, to resolve the respondent's request for attorney fees."

14. The ALJ takes administrative notice of the OAC file in this matter. The file reflects that on August 10, 2009, the ALJ issued an Order Regarding ICAO Order of Remand. The ALJ ordered respondent's counsel to set a hearing within 60 days on the "issue of attorney fees and costs" in accordance with the ICAO's Order. The ALJ also directed respondent's counsel to consult with claimant's counsel concerning an appropriate date for the hearing.

15. On October 7, 2009, the ALJ issued an Order to File Status Reports. This order noted that no hearing had been set and directed the parties to file status reports on or before October 19, 2009, indicating whether the matter had been resolved or a hearing was necessary.

16. On October 19, 2009, respondent's counsel filed a status report indicating that he had contacted claimant's counsel regarding potential hearing dates, but the parties were unable to agree on a date. Counsel requested that an OAC clerk set a hearing date.

17. On October 22, 2009, the ALJ entered an Order to Set Hearing on Attorney Fees and Costs. The ALJ noted that no status report had been received from claimant's counsel, but the respondent's counsel had stated that the parties were unable to agree on a date for a hearing. The ALJ further noted that the ICAO had directed the ALJ to "take appropriate steps to resolve" the respondent's request for attorney fees. The ALJ directed that an OAC clerk "set the hearing to occur as soon as possible while affording the parties the required statutory notice."

18. On October 23, 2009, the ALJ received a status report from claimant's counsel stating that the parties had conferred but not reached an agreement concerning a hearing date to address the issue raised by the ICAO's remand.

19. On November 4, 2009, an OAC clerk issued a Notice of Hearing setting the matter for a hearing in Denver on December 7, 2009.

20. On November 23, 2009, claimant's counsel filed a Case Information Sheet in which he stated the issues for determination were, "issues raised by the ICAO's order."

21. At the hearing no testimony was offered. However, the ALJ received documentary evidence.

22. Respondent's counsel submitted an affidavit reflecting that he charges $150 per hour and that his paralegals charge $80 per hour. The affidavit reflects that respondent's counsel's firm charged $549 dollars for services connected to responding to the appeal.

23. The respondents proved it is more probably true than not that the petition to review the February 26, 2009, FFCL filed by the claimant's counsel, and the brief in support of that petition, were signed in violation of § 8-43-301(14). The ALJ finds that the FFCL did not award or deny any benefits or penalties within the meaning of § 8-43-301(2). Rather, as the ICAO noted in its Order, the FFCL merely determined that the issue of whether the respondent's potential defenses to an inchoate claim for PTD benefits were valid was not ripe for determination. The FFCL in no way prohibited the claimant from filing a claim for PTD benefits, denied a claim for PTD benefits, or assessed or denied any penalty authorized under the provisions of the Workers' Compensation Act. Moreover, the FFCL explicitly advised counsel for both parties that the order

did not award or deny any benefits or penalties, and advised them to consult § 8-43-301(2) if they were considering an appeal from the FFCL.

24. The claimant's counsel has not cited, nor did he testify to the existence of, any case law, statute or other legal authority that would warrant a belief that the February 26, 2009, FFCL were subject to immediate review by the ICAO under § 8-43-301(2). Indeed, claimant's counsel acknowledged in the brief in support of the petition to review that the FFCL did not award or deny any benefits, and that the FFCL "may not be final." Indeed, counsel cited cases supporting the conclusion that the FFCL were not final for purposes of § 8-43-301(2) because they did not award or deny any benefits or penalties. However, counsel did not cite any authority then, nor does he cite any now, that would suggest a reasonable basis for concluding that the FFCL were subject to review under existing law, or might have been determined to be subject to review based on a good faith argument for the extension, modification or reversal of existing law. Further, the ICAO ultimately determined that the FFCL were not final and subject to review because the only issue appealed did not award or deny any benefits or penalties.

25. The assertion of claimant's counsel that the FFCL erroneously found that the respondent did not raise the defense of "issue preclusion" in the response to the application for hearing, and that that this alleged error justified the appeal to the ICAO, is not persuasive. First, the FFCL contain an *explicit* finding that the respondent *did list* the defenses of issue preclusion, claim preclusion and claim closure in the response to the application for hearing. (Finding of Fact 5 of the FFCL). The ICAO expressly recognized this finding in its Order (Part I, paragraph 2, page 2 of ICAO's Order). Therefore there is no basis in fact for counsel's assertion that the appeal was initiated out of fear that that the FFCL contained an erroneous finding that the respondent *did not* raise the defense of issue preclusion in its response. Second, claimant's counsel has not presented any legal basis or authority for concluding that if the FFCL actually contained an erroneous finding of fact concerning the contents of the response to application, that such an error would have somehow converted the FFCL into an order subject to review under § 8-43-301(2).

26. The amount that respondent's counsel charged for services in connection with the appeal from the February 26, 2009, FFCL is reasonable.

CONCLUSIONS OF LAW

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

PROPRIETY OF HEARING WITHOUT FILING OF APPLICATION FOR HEARING ON ISSUE OF ATTORNEY FEES

Citing OACRP 7 and OACRP 12, the claimant first argues that the issue of attorney fees was not properly before the ALJ because the respondents never filed an application for hearing adding this issue, nor did they obtain permission of the ALJ to add the issue. The ALJ is not persuaded by this argument.

OACRP 7 provides that a party "may request a hearing on issues ripe for adjudication" by filing an Application for Hearing or Application for an Expedited Hearing or an

Application for Hearing Disfigurement – Only. OACRP 12 provides that issues "may be added" before the setting date by written notice to the OAC, and after the setting date issues "may only be added by written agreement of the parties or order of a judge or designee clerk for good cause shown."

The claimant's arguments notwithstanding, the ALJ does not read these rules as limiting or contradicting the jurisdiction of the ICAO to order the ALJ to consider the issue of attorney fees on remand. As a general matter, administrative rules are not the equivalent of a statute and should not be read in a manner that is inconsistent with express statutory authority. *See City of Englewood v. Industrial Claim Appeals Office,* 954 P.2d 640 (Colo. App. 1998).

Section 8-1-103(2), C.R.S. grants the ICAO the "duty and power to conduct administrative appellate review of any order entered pursuant to articles 43 to 74 of this title and to make a decision on said appeal." In appeals from ALJ orders in workers' compensation cases, § 8-43-301(8), C.R.S., provides that the ICAO "may correct, set aside, or remand any order" on various grounds, including the grounds that the "findings of fact are not sufficient to support appellate review."

Moreover, when the ICAO, acting under its statutory authority, enters an order instructing an ALJ to take a particular action, the ALJ has no choice but to comply with the instruction. *Musgrave v. Industrial Claim Appeals Office,* 762 P.2d 686, 688 (Colo. App. 1988). Indeed, the conclusions of an appellate tribunal concerning "issues presented to it, as well as rulings logically necessary to sustain such conclusions, become law of the case and generally must be followed in subsequent proceeding in that case." *In re Marriage of Burford,* 26 P.3d 550 (Colo. App. 2001).

Here, the respondent's request for attorney fees based on the filing of an appeal in violation of § 8-43-301(14) did not, and could not, arise until after the ALJ entered the February 26, 2009, FFCL. On consideration of the request for attorney fees the ICAO determined the requet presented potential factual issues beyond its jurisdiction to resolve, and it remanded the matter with directions to the ALJ to "conduct appropriate proceedings, including a hearing if necessary," to resolve the dispute.

Thus, the ALJ concludes that when he ordered the OAC clerk to set a hearing on the issue of attorney fees he was acting under the express direction of the ICAO, and that the ICAO was acting under its explicit statutory authority to remand matters to an ALJ with instructions to conduct additional proceedings, including a hearing, if necessary. In fact, the ALJ had no discretion or authority to ignore the direction of the ICAO and was obliged to conduct a hearing when he determined that the parties had not resolved the attorney fees issue and could not agree on a date to conduct a hearing. OACRP 7 and OACRP 12 cannot, and should not, be read as interfering with the express statutory authority of the ICAO to issue instructions on remand, or the responsibility of the ALJ to follow such instructions.

Insofar as the claimant's argument may be construed as asserting that there was a violation of due process because the respondent was not required to file an Applica-

tion for Hearing, the ALJ disagrees. Due process is a flexible standard and does not require any particular procedure. *See Bradshaw v. Cherry Creek School District No. 5,* 98 P.3d 886 (Colo. App. 2003). However, where administrative determinations turn on questions of fact, due process requires notice and an opportunity to be heard. A party should be apprised of the issues and evidence to be considered, afforded a reasonable opportunity to present evidence in support of its position, and to confront adverse witnesses and evidence. *Hendricks v. Industrial Claim Appeals Office,* 809 P.2d 1076 (Colo. App. 1990).

Here, claimant's counsel had known since early July 2009, when the ICAO issued its Order, that the ALJ had been directed to conduct additional proceedings to determine counsel's liability, if any, for attorney fees. Counsel was also aware that the legal and factual basis of the claim for attorney fees was that the ALJ's February 2009 FFCL did not award or deny benefits or penalties, and was not subject to immediate review under § 8-41-301(2). Moreover, counsel was notified of the nature of the issue for hearing by the ALJ's orders of August 10, 2009, October 7, 2009, and October 22, 2009. Finally, a notice of hearing was sent to claimant's counsel on November 4, 2009. The CIS filed by the claimant's counsel on November 23, 2009, demonstrates that counsel understood the issue to be adjudicated on December 7, 2009, was the issue of attorney fees raised by the ICAO's Order.

In these circumstances the ALJ concludes that claimant's counsel was given sufficient notice of the issue to be heard on December 7, 2009. Further, claimant's counsel was given a hearing to offer whatever evidence he desired to present, and was afforded an opportunity to challenge the respondent's evidence. The absence of a formal Application for Hearing did not deprive claimant's counsel of his due process rights to notice and an opportunity to be heard.

CLAIM FOR ATTORNEY FEES

The respondent contends that claimant's counsel violated § 8-43-301(14) by filing a petition to review the ALJ's February 2009 FFCL, and brief in support of the petition, when there was no reasonable belief that the FFCL were subject to immediate review under § 8-43-301(2). Claimant's counsel argues the evidence establishes there was no violation of § 8-43-301(14) because the FFCL found the claimant sought a ruling on the validity of a defense to a claim that had not been made, when in fact the respondent listed the defense of "issue preclusion" in its response to the application for hearing. Counsel states that out of "an abundance of caution" he did not want that erroneous "finding" to become final without seeking review because it might have subjected the claimant to attorney fees for endorsing an issue that was not ripe. Counsel further argues that the notice contained in the FFCL merely states that the FFCL "may not" be subject to review. Finally, claimant's counsel contends that § 8-43-301(14) requires a finding that the petition to review was imposed for an "improper purpose," and counsel argues there is no evidence he harbored such motivation when he filed the petition to review. The ALJ agrees with the respondent.

Section 8-43-301(14) provides as follows:

> The signature of an attorney on a petition to review or brief in support thereof constitutes a certificate by the attorney that such attorney has read the petition or brief; that, to the best of the attorney's knowledge, information, or belief formed after reasonable inquiry, it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass, cause delay, or unnecessarily increase the cost of litigation. If a petition or brief is signed in violation of this subsection (14), the director, the administrative law judge, or the panel shall award reasonable attorney fees and costs to the party incurring the fees and costs as a result of the improper actions.

As the party seeking an award of attorney fees, the respondent bears the burden to establish the right to an award under the provisions of the statute. *See Cowin & Co. v. Medina,* 860 P.2d 535, 538 (Colo. App. 1992) (burden of proof generally placed on party asserting the affirmative of a proposition, and on party relying on statutory exception).

Section 8-43-301(14) is nearly identical to that portion of CRCP 11 that permits the imposition of attorney fees and costs where an attorney signs a pleading that is in violation of the rule. Therefore, the ALJ concludes that cases interpreting the pertinent portion of CRCP 11 represent persuasive authority with respect to the interpretation of the § 8-43-301(14).

In *Stepanek v. Delta County*, 940 P.2d 364 (Colo. 1997), the court held that CRCP 11 provides that an attorney's signature on a pleading is a certification that (1) the attorney read the pleading; (2) that to the attorney's knowledge and belief formed after reasonable inquiry the pleading is well founded in fact and is warranted by existing law or a good faith argument for the extension of or change in existing law, and (3) that the pleading is not interposed for an improper purpose. However the *Stepanek* court noted that the rule, properly interpreted, does not require a showing of "bad faith" on the part of the attorney, and sanctions may be imposed where "an attorney's pleading fails to meet a test of objective reasonableness."

Similarly, in the case of *In re Trupp*, 92 P.3d 923 (Colo. 2004), the court considered whether disciplinary counsel was subject to rule 11 sanctions for filing a complaint and amended complaint charging an attorney with misconduct. In *Trupp* the parties agreed that the disciplinary counsel read the pleadings that she signed, and that "she did not harbor any improper purpose in filing them." Nevertheless, the court proceeded to analyze whether counsel was subject to sanctions because she allegedly failed to conduct a reasonable inquiry prior to filing the pleadings.

It follows from these cases that in order to impose sanctions on claimant's counsel the ALJ need not, as counsel argues, find that counsel harbored some improper intent or motive when he filed the petition to review and the brief ins support. Rather an award of attorney fees under § 8-43-301(14) can be based on a finding that the attorney signed a petition or brief that was in violation of any one of the three criteria set forth in the statute in the statute, including an improper certification that the attorney held a rea-

sonable belief, after sufficient inquiry, that the petition and brief were supported by existing law or by a good faith argument for the extension, modification or change in existing law.

Section 8-43-301(2) provides that any "party dissatisfied with an order that requires any party to pay a penalty or benefits or denies a claimant any benefit or penalty" may file a petition to review with the Division or the OAC, as appropriate. Section 8-43-301(4), C.R.S., permits a party to file a brief in support of the petition.

One of the most time honored and firmly established legal principles of workers' compensation law is that § 8-43-301(2) deprives the ICAO of jurisdiction to conduct immediate review of ALJ orders which do not award benefits or penalties, or deny the claimant any benefit or penalty. The courts have applied the same principles when considering whether or not review of an order of the ICAO is permissible. *See Ortiz v. Industrial Claim Appeals Office,* 81 P.3d 1110 (Colo. App. 2003). The underlying purpose for the statute is to avoid piecemeal litigation of workers' compensation by defining what types of orders are sufficiently "final" to warrant review by an appellate tribunal. *See BCW Enterprises, Ltd. v. Industrial Claim Appeals Office,* 964 P.3d 533 (Colo. App. 1997).

As determined in Finding of Fact 22, claimant's counsel has not advanced any reasonable argument that existing law, or a good faith argument for the extension, modification or change of existing law, would warrant the conclusion that the February 26, 2009, FFCL were final and subject to review under § 8-43-301(2). As found, the FFCL did not award or deny any benefits or penalties, nor did they in any way prohibit the claimant from presenting a claim for PTD benefits. The FFCL merely determined that issue concerning the legal validity of the respondent's defenses to a potential but unmade claim for PTD benefits was not ripe for determination.

As determined in Finding of Fact 23, the assertion by claimant's counsel that the appeal was justified because the FFCL contained an erroneous finding that the respondent did not "raise" the defense of issue preclusion does not establish any legal basis for concluding that the appeal was legally warranted. As found, the FFCL do not contain a factual finding that the respondent did not raise the defense of issue preclusion in the response to application. In fact, the FFCL contain the opposite finding.

In any event, claimant's counsel does not explain how, even if there had been an erroneous finding of fact, that such finding would have created a reasonable belief that the FFCL were subject to review under § 8-43-301(2). As the ICAO recognized, the ultimate determination of the FFCL was that the issue presented for hearing (the legal validity of the defenses in the event the claimant sought PTD benefits) was not ripe for hearing. Thus, regardless of whether the FFCL contained some erroneous finding of fact, such error was not subject to review because the FFCL did not award or deny any benefits or penalties. Indeed, review of the alleged factual error would constitute the type of piecemeal review that § 8-43-301(2) is designed to avoid.

Finally, the assertion of claimant's counsel that the allegedly erroneous finding of fact could have subjected the claimant to "attorney fees for endorsing an un-ripe issue" if not challenged by a petition to review is without merit. Apparently, claimant's counsel is asserting that the allegedly erroneous factual finding could bind the claimant in some future litigation under § 8-43-211(1)(d), C.R.S. However, no factual finding contained in the February 2009 FFCL could bind the claimant in any future litigation because the FFCL are interlocutory and do not constitute a final adjudication on the merits. *See M & M Management v. Industrial Claim Appeals Office,* 979 P.2d 574 (Colo. App. 1998).

The ALJ concludes that claimant's counsel shall pay attorney fees to the respondent in the amount of $549. The ALJ concludes that claimant's counsel violated § 8-43-301(14) by filing a petition to review the February 2009 FFCL when there was no reasonable basis to believe that existing law would warrant the conclusion that the FFCL were final and subject to review, and where there is no credible or persuasive evidence that counsel had any good faith argument that an extension, modification or change in existing law would result in a determination that the FFCL were final and subject to review.

ORDER

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

1. Claimant's counsel shall pay the respondent $549 in attorney fees.

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

DATED: December 23, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-749-037

ISSUES

1. Whether Claimant has established 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 her industrial injury.

2. Whether Respondents have proven by a preponderance of the evidence that Claimant is precluded from receiving Temporary Total Disability (TTD) benefits be-

cause 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").

3. Whether Respondents have demonstrated that Claimant's TTD benefits should be reduced because she engaged in an injurious practice pursuant to §8-43-404(3), C.R.S.

FINDINGS OF FACT

1. Claimant worked for Employer as a food server in a catering business. In August 2006 she suffered an admitted lower back injury. Employer directed Claimant to Authorized Treating Physician (ATP) Christopher Carpenter, M.D. for medical treatment.

2. Claimant visited Dr. Carpenter for an evaluation and he referred her for an MRI. The MRI revealed a right-sided disc protrusion at L5-S1 with an accompanying annular tear. After a course of conservative treatment, Dr. Carpenter referred Claimant to Chad Prusmack, M.D. for an evaluation. Dr. Prusmack then referred Claimant to Bradley Villims, M.D. for pain management.

3. On November 28, 2007 Dr. Villims examined Claimant. He noted that Claimant had been obtaining prescriptions from a non-authorized treating physician. Dr. Villims commented that Claimant had executed a medication agreement on April 11, 2007. However, by obtaining unauthorized prescriptions Claimant violated the medication agreement. Dr. Villims thus discharged Claimant from his practice.

4. On January 15, 2008 George Schakaraschwili, M.D. performed an independent medical examination of Claimant. He recommended a repeat MRI and additional conservative treatment. Dr. Schakaraschwili concluded that Claimant had not reached Maximum Medical Improvement (MMI). At Respondents' request he subsequently became Claimant's ATP.

5. On April 1, 2008 Claimant visited Dr. Schakaraschwili for an evaluation. He noted that Claimant had been receiving narcotic medications from anesthesiologist Kevin Smith, M.D. Dr. Schakaraschwili remarked that he would again examine Claimant after she underwent bilateral sacroiliac joint blocks. However, he explained that he would not prescribe additional narcotic medications and would discharge Claimant from care because she violated a narcotic medication contract.

6. On April 25, 2008 Claimant was terminated from her employment with Employer. Claimant's supervisor Jim DeLay credibly testified about the circumstances preceding Claimant's termination. He explained that the combination of Claimant's disruptive behavior with coworkers and undependability caused her termination. Mr. DeLay specifically commented that Claimant was late for work on multiple occasions in June 2007. He discussed Claimant's tardiness with her and noted that her behavior was disruptive to the work environment. In January 2008 Mr. Delay counseled Claimant that she needed to stop gossiping with other employees about her Workers' Compensation issues because her behavior created a poor work environment. He also remarked

that Claimant's tardiness issues had not improved through March 2008. Furthermore, Claimant's coworkers informed Mr. DeLay that Claimant occasionally walked off the job site without notifying them. Finally, Mr. Delay noted Claimant's problems with a time clock in April 2008 and advised her that her practice was unacceptable. Documentation of Claimant's repeated violations supports Mr. DeLay's testimony.

7. In June 2008 Dr. Carpenter determined that Claimant had reached MMI. Claimant objected to the MMI determination and sought a Division Independent Medical Examination (DIME).

8. On December 18, 2008 Claimant underwent a DIME with Christopher Ryan, M.D. He concluded that Claimant had not reached MMI for her lower back condition. Dr. Ryan commented that Claimant should pursue disc replacement surgery.

9. On May 18, 2009 Claimant underwent lower back surgery with Scott K. Stanley, M.D. Dr. Stanley did not seek prior authorization from Insurer for the surgery. The surgery addressed Claimant's lumbar degenerative disc disease and L5-S1 disc herniation. Dr. Stanley remarked that Claimant was referred to him by Chris Huser, M.D. Dr. Huser is a partner of Dr. Smith at Denver Pain Management. However, the record contains insufficient evidence to demonstrate that Respondents authorized doctors Huser and Stanley to provide medical treatment to Claimant.

10. Because Claimant did not have an ATP, Respondents requested an evaluation and possible treatment from Elizabeth Bisgard, M.D. Dr. Bisgard conducted an initial evaluation but did not wish to treat Claimant as a patient because of repeated medication contract violations. Dr. Bisgard commented that she was uncomfortable "dealing with addiction issues as a primary occupational provider."

11. Claimant subsequently obtained medical treatment from Richard Steig, M.D. through a referral from doctors Smith and Huser. Dr. Steig placed Claimant in Centennial Hospital for a four-day detoxification program. Dr. Steig did not seek authorization for the program and Centennial Hospital has not submitted any medical records or invoices for Claimant.

12. On October 20, 2009 Claimant visited Caroline Gellrick, M.D. for an independent medical examination. Dr. Gellrick remarked that Claimant suffered from opiod dependency and had engaged in narcotic contract violations. She commented that Claimant was not at MMI. Dr. Gellrick concluded that Claimant required a single doctor, one pharmacy and a narcotics contract.

13. Dr. Gellrick also testified at the hearing in this matter. She reviewed Claimant's history of narcotic contract violations. Dr. Gellrick explained that repeated narcotic violations can cause a patient to experience a delayed recovery. She remarked that Claimant properly underwent a detoxification program because of her drug dependency.

14. Claimant testified at the hearing in this matter. She explained that Dr. Carpenter referred her to a number of treating physicians. Claimant acknowledged that she underwent a detoxification program and is no longer taking prescription pain medication. She also addressed her termination from employment with Employer. Claimant commented that she generally had a positive relationship with Employer but became involved in a conflict with a coworker at Employer's café. She attributed her termination to her conflict with the other employee.

15. Claimant has failed to establish that it is more probably true than not that she received authorized medical treatment from doctors Huser, Smith, Stanley and Steig that was reasonable and necessary to cure or relieve the effects of her industrial injury. Respondents initially designated Dr. Carpenter as Claimant's ATP. Dr. Carpenter referred Claimant to Dr. Prusmack and then Dr. Prusmack referred Claimant to Dr. Villims for pain management. However, Dr. Villims discharged Claimant from his practice based on the violation of a medication agreement. Respondents subsequently designated Dr. Schakaraschwili as Claimant's ATP but he discharged her from treatment because she had been receiving additional narcotics from Dr. Smith. Claimant then obtained additional treatment for her condition from doctors Huser and Stanley. However, there is insufficient evidence in the record to reflect that Respondents authorized doctors Huser and Stanley to provide medical treatment to Claimant. Although Respondents subsequently attempted to retain Dr. Bisgard as an ATP, she declined because of Claimant's repeated narcotic contract violations. The record reveals that Claimant's repeated narcotic contract violations were caused by attempts to obtain treatment from physicians who were not authorized by Respondents. Claimant subsequently received medical treatment from Richard Steig, M.D. through a referral from doctors Smith and Huser. Dr. Steig placed Claimant in Centennial Hospital for a four-day detoxification program but did not seek Respondents' authorization for the program. Therefore based on a review of the medical records, Claimant changed physicians or employed additional physicians without obtaining permission from the insurer or an ALJ. Accordingly, Claimant's medical treatment from doctors Huser, Smith, Stanley and Steig was unauthorized.

16. Respondents have demonstrated that it is more probably true than not that Claimant committed a volitional act or exercised some control over her April 25, 2008 termination from employment with Employer. Mr. DeLay credibly testified about the circumstances preceding Claimant's termination. He noted that the combination of Claimant's disruptive behavior with coworkers and undependability caused her termination. Mr. DeLay specifically commented that Claimant was late for work on multiple occasions in June 2007. He discussed Claimant's tardiness with her and noted that her behavior was disruptive to the work environment. In January 2008 Mr. Delay counseled Claimant that she needed to stop gossiping with other employees about her Workers' Compensation issues because her behavior created a poor work environment. He also remarked that Claimant's tardiness issues had not improved through March 2008. Furthermore, Claimant's coworkers informed Mr. DeLay that Claimant occasionally walked off the job site without notifying them. Finally, Mr. Delay noted Claimant's problems with a time clock in April 2008 and advised her that her practice was unacceptable. Documentation

of Claimant's repeated violations supports Mr. DeLay's testimony. Finally, Claimant acknowledged that she had conflicts with coworkers. Accordingly, Claimant precipitated her termination by a volitional act that she would reasonably expect to cause the loss of employment.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

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. Authorization to provide medical treatment refers to a medical provider's legal authority to treat the claimant with the expectation that the insurer will compensate the provider. *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). Once the respondents have designated an ATP the claimant may not ordinarily change physicians or employ additional physicians without obtaining permission from the in-

surer or an ALJ. *Yeck v. Industrial Claim Appeals Office,* 996 P.2d 228 (Colo. App. 1999). If the claimant obtains unauthorized medical treatment, the respondents are not liable for the treatment. *Id.* Authorized providers include those to whom the employer directly refers the claimant and those 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).

6. As found, Claimant has failed to establish by a preponderance of the evidence that she received authorized medical treatment from doctors Huser, Smith, Stanley and Steig that was reasonable and necessary to cure or relieve the effects of her industrial injury. Respondents initially designated Dr. Carpenter as Claimant's ATP. Dr. Carpenter referred Claimant to Dr. Prusmack and then Dr. Prusmack referred Claimant to Dr. Villims for pain management. However, Dr. Villims discharged Claimant from his practice based on the violation of a medication agreement. Respondents subsequently designated Dr. Schakaraschwili as Claimant's ATP but he discharged her from treatment because she had been receiving additional narcotics from Dr. Smith. Claimant then obtained additional treatment for her condition from doctors Huser and Stanley. However, there is insufficient evidence in the record to reflect that Respondents authorized doctors Huser and Stanley to provide medical treatment to Claimant. Although Respondents subsequently attempted to retain Dr. Bisgard as an ATP, she declined because of Claimant's repeated narcotic contract violations. The record reveals that Claimant's repeated narcotic contract violations were caused by attempts to obtain treatment from physicians who were not authorized by Respondents. Claimant subsequently received medical treatment from Richard Steig, M.D. through a referral from doctors Smith and Huser. Dr. Steig placed Claimant in Centennial Hospital for a four-day detoxification program but did not seek Respondents' authorization for the program. Therefore based on a review of the medical records, Claimant changed physicians or employed additional physicians without obtaining permission from the insurer or an ALJ. Accordingly, Claimant's medical treatment from doctors Huser, Smith, Stanley and Steig was unauthorized.

Temporary Total Disability Benefits

7. Section 8-42-103(1), C.R.S. requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subsequent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997). 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).

8. As found, Respondents have demonstrated by a preponderance of the evidence that Claimant committed a volitional act or exercised some control over her April 25, 2008 termination from employment with Employer. Mr. DeLay credibly testified about the circumstances preceding Claimant's termination. He noted that the combination of Claimant's disruptive behavior with coworkers and undependability caused her termination. Mr. DeLay specifically commented that Claimant was late for work on multiple occasions in June 2007. He discussed Claimant's tardiness with her and noted that her behavior was disruptive to the work environment. In January 2008 Mr. Delay counseled Claimant that she needed to stop gossiping with other employees about her Workers' Compensation issues because her behavior created a poor work environment. He also remarked that Claimant's tardiness issues had not improved through March 2008. Furthermore, Claimant's coworkers informed Mr. DeLay that Claimant occasionally walked off the job site without notifying them. Finally, Mr. Delay noted Claimant's problems with a time clock in April 2008 and advised her that her practice was unacceptable. Documentation of Claimant's repeated violations supports Mr. DeLay's testimony. Finally, Claimant acknowledged that she had conflicts with coworkers. 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. Respondents are not responsible for Claimant's medical treatment from doctors Huser, Smith, Stanley and Steig because it was unauthorized.

2. Claimant is not entitled to receive TTD benefits subsequent to April 25, 2008 because she was responsible for her termination from employment. It is therefore unnecessary to address whether Claimant's TTD benefits should be reduced because she engaged in an injurious practice pursuant to §8-43-404(3), C.R.S.

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

DATED: December 23, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-711-268

ISSUES

Whether Claimant is entitled to an award of permanent impairment benefits in addition to the 14% impairment of the lower extremity as assessed by Dr. Messenbaugh, M.D. and admitted by Insurer.

FINDINGS OF FACT

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

1. Claimant worked as a climbing course manager for Employer. Claimant's job including providing instruction on climbing and conducting climbing courses for Employer.

2. Claimant sustained an admitted injury to her right foot and ankle on September 25, 2006. On that date, Claimant sustained a twisting injury to her right foot and ankle while climbing.

3. Dr. Robert Leland, M.D., an orthopedist, evaluated Claimant on October 11, 2006. Dr. Leland diagnosed Claimant with symptomatic cavovarus right foot and mild ankle instability.

4. Dr. Lelend performed surgeries on Claimant's right foot/ankle on January 30, 2007, December 14, 2007 and May 6, 2008.

5. At an office visit on November 17, 2008 Dr. Leland noted that Claimant had had significant improvement in her right foot pain. Dr. Lelend stated that Claimant would continue with her activities as tolerated. At an office visit on February 11, 2009 Dr. Leland noted that Claimant's right foot pain continued to gradually improve. On physical examination on February 11, 2009 Dr. Leland noted minimal tenderness about the right talonavicular joint.

6. Claimant was evaluated by Dr. Robert Messenbaugh, M.D., an orthopedist, on March 9, 2009 and Dr. Messenbaugh issued a report from this evaluation dated March 21, 2009. Mr. Messenbaugh opined, and it is found, that Claimant reached maximum medical improvement as of March 9, 2009 for her right foot and ankle injury.

7. On March 9, 2009 Dr. Messenbaugh conducted a physical examination of Claimant's right foot and ankle including observation of Claimant's range of motion. Dr. Messenbaugh recorded the range of motion measurements in his report. Dr. Messenbaugh opined, and it is found, that Claimant's range of motion measurements resulted in 14% impairment of the lower extremity. Dr. Messenbaugh evaluated Claimant's permanent impairment under the provisions of the American Medical Association's Guides to the Evaluation of Permanent Impairment, 3d Edition, Revised, ("AMA Guides").

8. At the time of his evaluation of Claimant on March 9, 2009 Dr. Messenbaugh noted that Claimant had returned to work for Employer as an Associate Program Director working 40 hours per week with 30 of those hours spent at a desk. Dr. Messenbaugh further noted that Claimant complained that with walking and weightbearing and when cross-country skiing her right foot would supinate. Dr. Messenbaugh did not place any specific restrictions on the Claimant's ability to return to work.

9. Claimant feels that she is limited in the amount of climbing she can do and experiences pain in the foot and ankle with off-trail activities involving walking on un-even ground. Claimant testified she also notices differences in her balance. Claimant feels she is more limited in her leisure time activities such as climbing and access to the outdoors.

10. Claimant did not present persuasive evidence of a rating of permanent impairment done under the provisions of the AMA Guides that differs from that of Dr. Messenbaugh.

11. Insurer filed a Final Admission of Liability dated April 24, 2009 admitting for 14% impairment of the lower extremity equaling $6,904.64 in permanent impairment benefits. Claimant had not challenged the calculation of permanent impairment benefits in Insurer's Final Admission.

12. Claimant has failed to prove an entitlement to permanent impairment benefits above the level of permanent impairment assessed by Dr. Messenbaugh and admitted by Insurer in the Final Admission of April 24, 2009.

CONCLUSIONS OF LAW

13. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the

rights of respondents. Section 8-43-201, *supra*.). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

14. 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).

15. For injuries occurring on and after July 1, 1991, all physical impairment ratings used under the Workers' Compensation Act of Colorado shall be based on the revised third edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment", in effect as of July 1, 1991, Section 8-42-101(3.7), C.R.S. Under Section 8-42-107, C.R.S., when an injury results in permanent medical impairment, and the employee has an injury or injuries enumerated in the schedule set forth in subsection (2) of Section 8-42-107, C.R.S., the employee shall be limited to medical impairment benefits as specified in subsection (2) of Section 8-42-107, C.R.S. This system of medical impairment is designed to compensate for lost earning capacity. *Salazar v. Hi-Land Potato Company,* 917 P.2d 326 (Colo. App. 1996).

16. Claimant questions the thoroughness of Dr. Messenbaugh's evaluation at the time he placed her at maximum medical improvement and assigned an impairment rating. Claimant testified that she was not confident of the results obtained by Dr. Messenbaugh. Claimant contends that Dr. Messenbaugh did not consider her "functionality" with respect to her type of work, specifically her outdoor activities of climbing and hiking. Although Claimant questions the thoroughness of Dr. Messenbaugh's evaluation Claimant has not persuaded the ALJ that Dr. Messenbaugh mis-applied the AMA Guides or otherwise failed to follow the AMA Guides in assessing her permanent impairment. Claimant has not offered persuasive evidence that the condition of her right foot and ankle merit an impairment rating under the AMA Guides different than that provided by Dr. Messenbaugh and admitted to by Insurer.

17. Claimant's argument that her "functionality" should be considered as part of the determination of permanent impairment has emotional appeal. However, consideration of "functionality" is not the basis for an award of permanent impairment benefits under the Workers' Compensation Act of Colorado. As set forth above, awards of permanent impairment are determined under the provisions of the AMA Guides. Claimant has not persuasively shown that her loss of "functionality" with respect to any inability to continue to participate in outdoor activities as she was able to do before the injury merits an impairment rating under the AMA Guides different from that given by Dr. Messenbaugh. As found, Claimant has failed to prove by a preponderance of the evidence that she is entitled to an award of permanent impairment benefits greater than that assessed by Dr. Messenbaugh and admitted to by Insurer.

ORDER

It is therefore ordered that:

Claimant's claim for permanent impairment benefits greater than that admitted by Insurer in the Final Admission of April 24, 2009 is denied and dismissed. The Final Admission of April 24, 2009 as to permanent impairment benefits is hereby made the award of the ALJ.

DATED: December 24, 2009

Ted A. Krumreich

Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-659-247

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that Claimant has suffered a functional impairment that is not listed in the schedule of disabilities thereby entitling Claimant to medical impairment benefits for whole person impairment.

2. Whether Claimant has established by a preponderance of the evidence that the low back x-ray recommended by Dr. Giarratano is reasonable and necessary medical care for the compensable injury.

FINDINGS OF FACT

1. In August of 2005, the Respondent-Employer employed Claimant in their warehouse. The Claimant was required to work the majority of the day on cement floors.
2. The Claimant suffered a work-related injury to her feet. Dr. Angelo S. Giarratano, a podiatrist, treated the Claimant for these injuries over a period of several years.
3. The Claimant ultimately underwent a plantar fasciectomy and removal of a small spur on her left heel on February 23, 2007.
4. On March 12, 2009 Dr. Shea examined the Claimant as part of an 18-month Division IME. Dr. Shea placed Claimant at maximum medical improvement as of February 1, 2008. Dr. Shea determined that Claimant had suffered a 12% lower left extremity impairment and an 8% lower right extremity impairment. Dr. Shea converted the extremity ratings to an 8% whole person impairment for the left extremity and a 6% whole person impairment for the right extremity. These two whole person ratings combine to equal 14% whole person impairment for this compensable injury.

5. On February 24, 2009 Respondents filed a Final Admission of Liability based upon Dr. Shea's opinions. The Respondents admitted for permanent partial disability benefits based upon the extremity ratings and compensated Claimant according to the schedule of disabilities. Respondents admitted for post-MMI medical benefits.

6. Since being placed at MMI, Claimant has continued to receive maintenance medical treatment from Dr. Giarratano.

7. Claimant continued to experience low back, hip and thigh pain on a regular basis. On June 25, 2009, Dr. Giarratano saw the Claimant. On June 29, 2009, as a result of Claimant's persistent and increasing complaints of hip and low back and leg pain, Dr. Giarratano requested preauthorization for a low back x-ray. Dr. Giarratano indicated that he would requests a back x-ray first and, depending on the result, probably a lumbar MRI in the future.

8. The Claimant testified that she continues to experience pain in her feet, which is worse on the right. She also experiences discomfort in her knees, legs, hips and back. Her back problems started in approximately August of 2004 and have worsened since that time. The Claimant's knee problems developed after she had undergone surgery with Dr. Giarratano. The Claimant's physical problems limit her range of motion and she has trouble sleeping. She also is limited in her ability to perform housecleaning and go shopping.

9. The Claimant stated that she babies her feet or limps when she walks. Dr. Roth testified that on observation and testing at the time of his April 5, 2006 and his December 18, 2008 examinations the Claimant had a normal gait and was not limping. She had a symmetrical push-off and a normal arm swing. It was his observation at the time of the hearing that the Claimant continued to walk without a limp. Dr. Roth also had the opportunity to review a surveillance tape taken of the Claimant in July of 2009. On the tape, the Claimant was observed walking to a medical building and also walking through an ARC store. Throughout the tape, the Claimant did not demonstrate any altered gait or limp.

10. The Claimant was seen by Dr. Henry Roth for an independent medical examination requested by the Respondent on December 18, 2008. It was his opinion that the Claimant's bilateral plantar fasciitis was at maximum medical improvement and that further treatment was not likely to result in additional benefit to the Claimant. The Claimant was then seen by Dr. Brian Shea for a Division Independent Medical Examination on March 14, 2009.

11. It was Dr. Roth's opinion that the Claimant's low back problems are in no way related to her bilateral plantar fasciitis. Initially, the Claimant does not demonstrate any altered gait which would potentially cause residual low back problems. Dr. Roth cited literature involving amputees and individuals with significant discrepancies in the length of their lower limbs. In none of these studies was it demonstrated that people with significantly altered gait have a higher onset of low back problems than the general population. The doctor further noted that, even if an altered gait would temporarily cause some back discomfort, that that discomfort should go away when the individual was no longer experiencing the altered gait. Although the Claimant has been seen walking in a normal fashion, she contends that her low back problems have been constantly present since 2004 and this would rule against any problems in the back being related to her bilateral plantar fasciitis.

12. In addition to treating the Claimant's bilateral plantar fasciitis, Dr. Giarratano has also noted in his report that the Claimant has back discomfort. In his report of May 14, 2009, he indicates that he had reviewed EMG studies performed on November 10, 2008 by Dr. Sandell which stated the Claimant had bilateral tibial neuropathy. In a follow up report of June 25, 2009, the doctor stated that he would like to obtain a low back x-ray and possibly an MRI of the low back to see if any of the Claimant's problems were coming from her L3-4, S1 area. His follow up note of July 9, 2009 indicated that the Claimant had some low back pain on palpation, mainly the sciatic nerve going down to the left heel. At no point does Dr. Giarratano state that the Claimant's low back problems are related directly or indirectly to her bilateral foot injuries. He does recommend x-rays and possibly an MRI to see if the Claimant's problems are actually the result of a problem with her lumbar spine and/or tibial neuropathy.

13. Dr. Roth set forth that tibial neuropathy is not a condition that would be related directly or indirectly to the Claimant's bilateral foot injuries. Tibial neuropathy would be as a result of a problem at the L3-4 level of the spine and would be a possible cause of the Claimant's lower extremity problems, which would be unrelated to her industrial injuries. Based on his review of the overall medical records in the case, Dr. Roth further stated that there is no medical report that supports a finding that the Claimant's low back problems are related directly or indirectly to her altered gait or any other problems resulting from her industrial.

14. Dr. Roth testified that it would not be unreasonable to perform diagnostic testing to further delineate the source of the Claimant's low back discomfort. However, he did not believe that an x-ray would be the appropriate test. If diagnostic testing was to be performed, it would include an MRI. However, the diagnostic testing would not be to identify any problem causally related to the industrial injuries but would be to establish if the Claimant was suffering from a non-work-related low back problem which required care and treatment.

15. The ALJ finds Dr. Roth's opinions to be credible and persuasive under the facts of this case.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act) Section 8-40-101, et seq. C.R.S. (2004), 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 in this case that there is a basis for a conversion of her extremity rating to a whole person impairment rating and that her need for further diagnostic testing is casually related to her industrial injuries. See *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of Claimant nor in favor of the rights of Respondents.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice or interests. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936). A workers' compensation case is decided on its merits. The ALJs factual findings concern only evidence that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

3. The Claimant alleges that her work-related plantar fasciitis has caused an altered gait, which has led to functional impairment in her low back. The Claimant stated that since the onset of her bilateral foot injuries that she had babied her feet. She did not testify as to any significantly altered gait or limp. Dr. Roth who had the opportunity to view the Claimant in July of 2006, December of 2008, on the date of the hearing and to view a July 14, 2009 surveillance film, set forth that on none of these occasions did the Claimant demonstrate any altered gait or limp and that her movements were symmetrical. It was Dr. Roth's opinion that the Claimant's low back problems were not related directly or indirectly to her work-related injuries. Further, Dr. Giarratano does not state that the Claimant's back problems are causally related to her industrial injuries. Rather, Dr. Giarratano has suggested testing to see if the Claimant's low back problems may be related to tibial neuropathy or other problems at the L3-4, S1 level of the spine. While it is found that the Claimant is experiencing discomfort in her low back which limits her activities, the Claimant has failed to carry her burden of proof in establishing by a preponderance of the evidence that the low back problems are causally related to her work-related bilateral plantar fasciitis or any other work-related problems with her feet.

4. Dr. Giarratano has recommended that the Claimant undergo an x-ray of the low back. However, his reports establish that he is trying to determine if the Claimant's problems are related to bilateral tibial neuritis or any other problems generated in the low back. Dr. Roth has testified that it would be reasonable to perform diagnostic testing of the low back. He went on to indicate that an x-ray would not be helpful to the doctors in trying to determine appropriate treatment for any problems the Claimant has in her back. He would recommend testing including an MRI. Dr. Roth noted that the need for such diagnostic testing would be totally unrelated to the Claimant's industrial injuries and would be to try to identify a non-work-related anatomical change or other problem in the Claimant's low, back which could be treated outside the workers' compensation system. Dr. Giarratano, in his reports, does not set forth that the need for the x-ray would be related to the Claimant's work injuries. It is therefore found that the Claimant has failed to establish by a preponderance of the evidence that the recommendations for diagnostic testing in the low back are causally related to her industrial injuries.

ORDER

It is therefore ordered that:

1. The Claimant's request to convert her extremity rating to a whole person impairment rating is denied and dismissed.
2. The Claimant's request for an x-ray or other diagnostic testing of the low back is denied and dismissed.
3. All matters not determined herein are reserved for future determination.

DATE: December 28, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-741-268

ISSUES

¬ Did claimant prove by a preponderance of the evidence that she sustained an occupational disease type injury arising out of the course and scope of her employment?
¬ Did claimant prove by a preponderance of the evidence that her condition has worsened such that she is entitled to additional medical and temporary disability benefits?
¬ Did claimant make a proper showing for change of physician?

FINDINGS OF FACT

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

Employer operated the parking concession at Denver International Airport until October 15, 2008. Claimant's date of birth is October 1, 1977; her age at the time of hearing was 32 years. Claimant emigrated from Ethiopia in 2002, when she began working for employer as a parking lot attendant/cashier in one of the booths at DIA. After October 15, 2008, claimant continued performing at the same job at DIA for the subsequent operator of the parking concession.

Claimant sustained an admitted occupational disease type injury involving her right upper extremity, allegedly from overusing her right hand to operate a joystick unit to position a camera to photograph license plates. The admitted date of onset of claimant's injury is April 9, 2007, when claimant sought emergent treatment for complaints of right shoulder and upper back pain.

Employer referred claimant to Concentra Medical Centers for treatment of her right upper extremity complaints. At Concentra, Christian Updike, M.D., initially evaluated claimant on April 18, 2007, and diagnosed her with shoulder and cervical strain. Dr. Updike referred claimant for physical therapy treatment. Sharon Walker, M.D., evaluated claimant on May 1 and May 15, 2007. Because claimant failed to improve, Dr. Walker recommended a consultation with a physiatrist, specializing in the area of physical medicine and rehabilitation.

Physiatrist Kathy McCranie, M.D., began treating claimant on May 30, 2007. Dr. McCranie noted claimant complained of tenderness in the right scapula and neck region and believed claimant's pain more myofascial (muscular). Dr. McCranie performed trigger point injections, which failed to help claimant. Dr. McCranie recommended a job site evaluation and referred claimant for a magnetic resonance imaging (MRI) scan of her cervical spine on September 21, 2007.

Darrel Quick, M.D., initially evaluated claimant on September 26, 2007, and noted diffuse mild breakaway weakness of the right arm. Dr. Quick recommended a neurodiagnostic evaluation as well as further evaluation to assess possible non-occupational causes of claimant's complaints.

On September 27, 2007, Physical Therapist Kathleen McCarthy, M.S., and Occupational Therapist Carol Torssell, OTR, performed a job site analysis of claimant's job.

Dr. McCranie noted that the MRI revealed only early arthritic changes in claimant's cervical spine that failed to explain or correspond to claimant's complaints and symptoms. Dr. McCranie recommended electrodiagnostic nerve conduction studies (NCS) of claimant's upper extremities and biofeedback treatment. Dr. McCranie performed the NCS on October 12, 2007, which was within normal limits, ruling out cervical radiculopathy. Biofeedback treatment failed to change claimant's complaints and symptoms.

Dr. McCranie placed claimant at maximum medical improvement (MMI) on November 30, 2007. Dr. McCranie rated claimant's permanent medical impairment at 7% of the right upper extremity, based upon range of motion deficits.

On December 12, 2007, Dr. Quick recommended permanent restrictions limiting claimant's lifting with the right arm to 10 pounds, with no overhead use, and allowing a 10-minute break from every hour of repetitive right upper extremity use.

Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation. The division appointed John S. Hughes, M.D., the DIME physician. Dr. Hughes examined claimant on April 24, 2008. Dr. Hughes described claimant's demeanor as extremely withdrawn and shy, making it difficult for him to obtain a medical history from her. Claimant reported to Dr. Hughes that her symptoms had grown worse, with pain in the right side of her neck, as well as headache and right shoulder pain traveling down her arm. Claimant reported to Dr. Hughes that her pain at times made it difficult to breathe. Claimant reported to Dr.

Hughes that she had progressively been calling in sick, such that she was working only one to two days per week. Although claimant was reporting worsening symptoms, Dr. Hughes agreed with Dr. McCranie's determination of MMI.

Dr. Hughes reviewed the job site analysis and performed a physical examination of claimant. Dr. Hughes wrote:'

> [Claimant] has undergone diagnostic testing that has not revealed any more than soft tissue pain and tenderness. **Indeed, I question if this is truly an occupational disorder.** I will, however, accept the diagnosis offered by her attending physicians of reactive myofascial pain with associated mobility restrictions of the right shoulder.

(Emphasis added). Dr. Hughes also diagnosed an adjustment reaction with features of depression. Dr. Hughes assessed claimant's impairment at 15% of the right upper extremity, based upon loss of mobility in the right shoulder, which he converted to 9% of the whole person.

Some five months after her evaluation by Dr. Hughes, claimant returned to Dr. McCranie on September 8, 2008, complaining of increased symptomotology migrating to her left upper extremity. Claimant told Dr. McCranie that she sought emergent medical treatment for her increased symptoms during the prior week. Upon physical examination, Dr. McCranie noted that claimant displayed moderate pain behavior and tearfulness. Dr. McCranie found claimant's complaints unexplained by physical examination findings because the findings were non-focal and non-physiologic. Dr. McCranie wrote:

> I reviewed with her that having under gone a **significant amount of treatment** for similar symptoms previously, **none of which have helped her whatsoever**, such that I think there is little that I can offer for her continued symptoms.
>
> ****
>
> I plan on seeing her only on a as-needed basis, as I feel that there is … very little other medical treatment that would give any significant benefit.

(Emphasis added).

Claimant returned to Dr. McCranie on January 16, 2009, when Dr. McCranie again found non-physiologic signs of breakaway weakness in the right upper extremity, diffuse complaints, and reports of decreased sensation to light touch throughout her right arm. Dr. McCranie gave claimant samples of Lidoderm patches. Dr. McCranie re-examined claimant on February 6, 2009, when claimant reported the Lidoderm patches were unhelpful. Upon physical examination, Dr. McCranie once again found breakaway motor strength. Claimant reported decreased sensation in the entire right arm.

Claimant returned to Dr. McCranie on February 27, 2009. Claimant reported that she had undergone a magnetic resonance imaging (MRI) scan of her right shoulder through her personal physician. According to Dr. McCranie, the MRI showed:

> [T]endinosis at the supraspinatous and infraspinatous tendon without evidence of frank rotator cuff tearing, os acromiale with mild to moderate hypertrophic acromioclavicular joint degeneration, and a 6mm, synovial ganglion cyst in the posterior aspect of the biceps tendon sheath along the proximal humerus.

Upon physical examination, claimant once again demonstrated breakaway weakness and reported decreased sensation to pinprick testing diffusely throughout the right upper extremity. Dr. McCranie reported:

> It appears that [claimant's] symptoms are out of proportion to the findings on the MRI. Also, her examination is non-physiologic. At this point, I am not sure if there is additional treatment to offer her. I also have questions … how her job duties correlate with the findings of the MRI.

Dr. McCranie recommended an evaluation by an orthopedic specialist in order to address issues of causal relationship of her work duties to the MRI findings.

Orthopedic Surgeon Mark Failinger, M.D., evaluated claimant on April 2, 2009. According to Dr. Failinger surgery was not medically reasonable; Dr. Failinger wrote:

> [G]iven the overall picture, **I am not going to recommend [surgery]**, at least from my hands.
>
> ****
>
> I would be reluctant to perform the surgery only because of her diffuse picture ….

(Emphasis added).

Dr. McCranie reevaluated claimant on April 6th and May 29, 2009. On physical examination, Dr. McCranie continued to find claimant's symptoms diffuse and unexplained physiologically. Dr. McCranie referred claimant to Alireza T. Alijani, M.D., for a second surgical opinion on June 5, 2009. Dr. Alijani examined claimant and reviewed her shoulder MRI scan. Dr. Alijani agreed with Dr. Failinger's opinion, advising against surgical intervention; Dr. Alijani explained:

> [Claimant] has had perfectly appropriate treatment … yet she has persistent pain and discomfort.
>
> ****

I do not believe she would do well with the surgical procedures …. My concern is that … she could potentially be made worse by the surgery and **her symptoms do not correspond with the MRI findings** ….

(Emphasis added). Dr. Alijani agreed with Dr. McCranie's management of claimant's chronic complaints of pain.

Dr. McCranie reevaluated claimant on June 22, 2009, when examination findings were again non-physiologic, which she described as follows:

[Claimant] demonstrates breakaway weakness in her right upper extremity. With pinprick, she reports absent sensation in the right upper extremity and decreased sensation to her entire left upper extremity as well.

Dr. McCranie continued to find claimant's report of her symptoms unexplainable based upon physiology. Dr. McCranie had no additional diagnostic or treatment recommendations. Dr. McCranie discharged claimant from her care.

Claimant returned to Dr. McCranie for a follow-up appointment on July 27, 2009. Although she reported that her symptoms were 90% worse, claimant continued to demonstrate non-physiologic findings upon Dr. McCranie's physical examination.

Claimant's husband testified that claimant's emotional attitude has changed since January of 2008, such that she appears more upset after a day at work because of her pain. Claimant's husband explained that, when claimant comes home from work, she just cries and does not want to interact with the family.

Claimant was so emotional on the witness stand that she immediately broke into sobbing before her attorney could ask any questions. Claimant services some 400 customers per day from her booth at DIA. Claimant continues to attribute her right upper extremity pain to using the joystick to position the camera on the license plate of each car. Claimant stated that she often is too busy to take a 10-minute break every hour from using the joystick, which she feels involves repetitive use of her right upper extremity. Claimant agreed that she has continued to perform these same activities on a full-time basis since her new employer took over the parking concession on October 15, 2008.

Dr. McCranie testified as an expert in the area of Physiatry and as a Level II accredited physician, which involves special training in analyzing medical causation. Dr. McCranie's testimony was credible and persuasive.

Crediting Dr. McCranie's testimony, the Judge finds: In May of 2007, Dr. McCranie diagnosed claimant's complaints as myofascial or muscle pain of the right scapular musculature. Dr. McCranie referred claimant for conservative treatment: massage therapy, physical therapy, trigger point injections, biofeedback treatment, and medication. Claimant failed to report any benefit whatsoever from conservative treatment. In addition, Dr. McCranie referred claimant for diagnostic testing in an attempt

to find the etiology of her symptoms. Claimant underwent a cervical MRI, two shoulder MRIs, and electrodiagnostic testing, none of which identified a pathophysiologic cause of claimant's pain complaints. For instance, the cervical MRI and normal nerve conduction studies ruled out the possibility of nerve impingement or radiculopathy as an explanation for claimant's complaints.

Crediting Dr. McCranie's testimony, the Judge finds: Throughout Dr. McCranie's many physical examinations of her, claimant consistently displayed non-physiologic findings. For instance, when testing claimant's motor strength, claimant gave inconsistent effort, demonstrating a ratcheting-type resistance, where her resistance should have been smooth. Claimant's demonstration of breakaway motor strength indicates a non-physiologic cause, suggesting a psychological component or outright symptom magnification. In addition, claimant's diffuse, non-focal complaints, breakaway weakness, and pinprick evaluation were non-physiologic. For instance, claimant's report of no sensation to pinprick in her entire right upper extremity fails to follow physiologic patterns of upper extremity nerve distribution. This finding demonstrated to Dr. McCranie the absence of any physiologic explanation for claimant's response to pinprick testing.

Crediting Dr. McCranie's testimony, the Judge finds: Claimant began reporting diffuse complaints of left upper extremity pain on September 9, 2008. As with her right shoulder complaints, claimant's left-sided complaints were physiologically unexplainable and of unknown etiology. Dr. McCranie treated claimant's right and left-sided complaints as muscular pain, which should have responded to conservative treatment. Claimant's report of worsening symptoms is unsupported by medical evidence. There is no persuasive medical explanation for claimant's report that her symptoms have worsened.

Crediting Dr. McCranie's testimony, the Judge finds: There is no persuasive evidence of any repetitive activity, mechanism of injury, or other association between claimant's work activities and her complaints of pain. Claimant's belief that operating the camera joystick involves repetitive activity is unpersuasive. Dr. McCranie based her opinion here upon the September 27, 2007, job analysis. In addition, the absence of clear objective findings on physical examination fails to support claimant's complaint that her job activities caused job-related symptoms or pathology. Indeed, Dr. McCranie was unable to find any physiologic correlation between claimant's complaints and her job duties. Dr. McCranie's medical opinion here was amply supported by the medical opinion of the DIME physician, Dr. Hughes.

Claimant failed to show it more probably true than not that her condition from her admitted injury at employer has worsened since Dr. McCranie and Dr. Hughes placed her at MMI. As found, Dr. McCranie's medial opinion was persuasive. Crediting Dr. McCranie's medical opinion, the Judge finds it more probably true that claimant's complaints of pain and symptoms are the result of symptom magnification and psychological problems unrelated to any job activity at employer. In light of this finding, the Judge is unable to credit claimant's testimony either about her condition

or that her condition has worsened. The Judge is further unable to correlate claimant's husband's testimony about her condition to claimant's work activities at employer.

Claimant failed to show it more probably true than not that her right and left upper extremity complaints, or other physical complaints, arose out of a hazard of her employment or were caused, intensified, or aggravated by her job-related work activities. As found, claimant's physical complaints are more probably the result of symptom magnification. In addition, the Judge finds it medically improbable that claimant's complaints are related to any repetitive activity, mechanism of injury, or otherwise associated with her job-related activities at employer.

CONCLUSIONS OF LAW

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

Insurer contends it improvidently admitted liability for claimant's claim and that claimant thus shoulders the burden of proving that her physical complaints are work-related. Claimant argues she has proven by a preponderance of the evidence that she sustained an occupational disease type injury arising out of the course and scope of her employment. The Judge disagrees that claimant carried her burden of proof.

The purpose of the Workers' Compensation Act of Colorado (Workers' Compensation Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

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

to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

An insurer may not obtain retroactive relief from an admission of liability in the absence of "fraud." *See Lewis v. Scientific Supply Co*., 897 P.2d 905 (Colo. App. 1995); *Vargo v. Industrial Commission*, 626 P.2d 1164 (Colo. App. 1981). However, an insurer may obtain prospective relief from an improvidently filed general admission of liability. *See HLJ Management Group v. Kim*, 804 P.2d 250 (Colo. App. 1990).

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

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

(Emphasis added).

A claimant seeking benefits for an occupational disease must establish the existence of the disease and that it was directly and proximately caused by the claimant's employment duties or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251, 252 (Colo. App. 1999). This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.*

Here, the Judge found claimant failed to show it more probably true than not that her right and left upper extremity complaints, or other physical complaints, arose out of a hazard of her employment or were caused, intensified, or aggravated by her job-related work activities. Claimant thus failed to prove by a preponderance of the evidence that she sustained a compensable occupational disease type injury.

Based upon the totality of the evidence, the Judge found claimant's physical complaints more probably the result of symptom magnification. The Judge further found

it medically improbable that claimant's complaints are related to any repetitive activity, mechanism of injury, or otherwise associated with her job-related activities at employer.

The Judge concludes that insurer's request to prospectively withdraw its admission of liability should be granted and that claimant's claim for benefits under the Workers' Compensation Act should be denied and dismissed.

ORDER

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

1. Insurer's request to prospectively withdraw its admission of liability is granted.

2. Claimant's claim for benefits under the Workers' Compensation Act is denied and dismissed.

DATED: _December 28, 2009__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-796-843

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered compensable injuries during the course and scope of his employment with Employer on October 29, 2008.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to receive Temporary Total Disability (TTD) benefits for the period October 29, 2008 until terminated by statute.

STIPULATIONS

The parties agreed to the following:

1. Claimant earned an Average Weekly Wage (AWW) of $562.00;

2. Claimant's monthly COBRA benefits totaled $931.17 effective February 1, 2009;

3. Claimant's normal daily work hours lasted from 7:00 a.m. until 3:30 p.m.;

4. Claimant was traveling on a direct route from his home to Employer's job site when he was injured in a motor vehicle accident on October 29, 2008;

5. The medical treatment that Claimant received after his October 29, 2008 motor vehicle accident was reasonable and necessary to cure or relieve the effects of his injuries.

FINDINGS OF FACT

1. Claimant typically worked for Employer as a pipe layer. On October 29, 2008 at approximately 6:38 a.m. Claimant was involved in a motor vehicle accident while driving to Employer's temporary job site. On the date of the incident Claimant was not working as a pipe layer. Instead, his job duties involved patching areas of a street that had settled because of soil compaction.

2. Claimant lived at 14660 East Bolling Drive in Denver, Colorado. The temporary job site was located at 6231 Dunkirt Court in Aurora, Colorado. The motor vehicle accident occurred at East 56th Avenue and the Pena Boulevard on ramp.

3. Claimant was transported to Denver Health Medical Center for emergency treatment. He was diagnosed with a C2 odontoid fracture and received a halo to stabilize the fracture. Claimant eventually underwent a tracheotomy and required the assistance of a ventilator to breathe.

4. Claimant testified through an evidentiary deposition in this matter on November 4-5, 2009. He explained that he had several items of safety equipment in his car at the time of his motor vehicle accident. These items included a hard hat, safety vest and safety glasses. Claimant remarked that he had received the safety vests from Employer. He had received the green and white vest about three years prior to his motor vehicle accident and a green and orange vest approximately one year prior to the accident. Claimant also commented that he had a foldable ruler and a darker red eye level that had been issued by Employer. However, Claimant acknowledged that he was not going to use the surveying equipment on the day of his motor vehicle accident but only required the equipment while he was working as a pipe layer.

5. Ramon Chavez testified through an evidentiary deposition in this matter on October 13, 2009. He explained that he worked for Employer as a foreman who supervised Claimant until 2005. As a foreman, Mr. Chavez had all the equipment that was needed for each job. Mr. Chavez received a company truck that included assorted tools. The foreman also had the responsibility for transporting all the equipment to the job site. Furthermore, there was a trailer at the job site that stored additional equipment required for a job. Mr. Chavez also remarked that employees parked wherever the job site trailer was located. The foreman parked the company truck wherever the actual work was occurring.

6. Mr. Chavez testified that he gave one eye level and a ruler to Claimant. He stated this was "only so that [Claimant] would learn responsibility that those were the

things he was going to use." Normally the items were to be carried in the foreman's company truck. Mr. Chavez acknowledged that it was a mistake for him not to recover the items from Clamant once he returned the company truck to Employer.

7. Gabriel Hernandez testified at the hearing in this matter. He stated that he has worked as a foreman for Employer for 18 years. Mr. Hernandez had been Claimant's foreman for approximately two years prior to the October 29, 2008 motor vehicle accident. However, on the date of the accident Claimant was not working for Mr. Hernandez.

8. Mr. Hernandez explained that workers were not required to leave the job site during the day and travel was not part of the services they provided to Employer. He noted that jobs would last at one location from approximately one week to three months. Employees reported directly to the job site. They were not instructed on how to get to work and were permitted to use any method of transportation they chose to arrive at the job site. Mr. Hernandez specified that company policy prohibits the use of personal vehicles for any company business and employees are never asked to use their personal vehicles for company business.

9. Mr. Hernandez testified that company trucks contain side boxes for carrying tools and equipment. Each day the foremen drive the trucks to their job sites with all the equipment needed for the scheduled work. The equipment included shovels, eye levels, rulers, and lasers. Additional tools such as wrenches, cables, bars, ladders and fittings remained at the job site in Employer's trailers.

10. Mr. Hernandez commented that the foremen supervise only one crew at any given time and remain at the job site with the crew any time they are working. Each morning, the foremen meet the crewmembers at the trailer where they had parked their vehicles. Foremen then conduct daily morning meetings to discuss work activities, safety issues and retrieve whatever equipment the crew may need from the trailer for the day's work. The tools are then transported to the actual work site. The foremen also park the company truck at the actual work site so that the tools are easily accessible. Mr. Hernandez specifically testified that the crewmembers were not required to bring any tools or equipment to the job site except for personal safety equipment that included a hard hat, eyeglasses and ear protection. Beginning in January 2009 crewmembers were also required to bring a safety vest to the job site.

11. Mr. Hernandez specifically noted that he always carries a ruler and an eye level in the glove box of his truck. In addition, he carries a spare set at all times. Thus, at any job site there are two levels and rulers available to the workers. The crew thus did not rely on Claimant to bring an eye level to work Moreover, Mr. Hernandez never instructed Claimant to bring an eye level or ruler to work. He also never observed Clamant carrying the eye level after his promotion to pipe layer. Finally, Mr. Hernandez instructed Claimant to return all tools and equipment to the company truck at the end of the workday.

12. Donald Pfief testified at the hearing in this matter. He was the foreman on the jobsite where Claimant was scheduled to work on October 29, 2008. Mr. Pfief had worked as a foreman for Employer for 20 years. He explained that, because the work for Mr. Hernandez's crew had been somewhat slow, he "borrowed" Claimant to work as a laborer. Mr. Pfief noted that the crew consisted of himself, Claimant and a backhoe operator. The jobsite was located at 62nd and Dunkirk. The location of Claimant's traffic accident at East 56th Avenue and the Pena Boulevard on ramp was not part of the jobsite. Mr. Pfief estimated that the motor vehicle accident occurred approximately two to three miles away from the jobsite entrance.

13. Claimant's only job duties for Mr. Pfief were to assemble and disassemble trench boxes and sweep dirt from the street. Claimant was not required to travel during the day. Mr. Pfeif also did not exercise any control over the method Claimant used to commute to and from the job site. Moreover, Mr. Pfeif had not instructed Claimant to run any type of work-related errand on the morning of the accident. Mr. Pfief commented that Claimant was only required to bring his hardhat and safety glasses to work each day. Mr. Pfief never observed Clamant carrying an eye level or ruler at the job. More importantly the eye level and ruler were not used at all on the job site because the crew was not laying any pipe.

14. Employer's safety coordinator Paul Andrews also testified at the hearing in this matter. Mr. Andrews remarked that new employees receive copies of Employer's Employee Manual. The Manual contains information concerning company policies and includes a comment that employees may not use personal vehicles for company business. The Manual also provides that travel to and from work is not compensated for the crewmembers and that company tools and equipment are to be kept by the foremen and not in personal vehicles. Furthermore, crewmembers are not reimbursed or compensated in any way for travel to and from work and there is no contemplated travel during the workday. Finally, the Manual states that personal vehicles may not be used for company errands or business. Mr. Andrews noted that Claimant's personnel file reflects that he received a copy of the Employee Manual.

15. Mr. Andrews explained that when Claimant began working for Employer he received a hardhat, safety glasses and ear protection. He noted that crewmembers are expected to have their personal protection equipment with them each day and take these items home at night. In contrast, crewmembers are supposed to return tools, equipment and supplies to the foremen at the end of the workday. The equipment either goes back into the trailers or into the foremen's trucks. Mr. Andrews specifically testified that a violation of company policy would occur if a foreman gave equipment to a crewmember to keep in his personal car.

16. Claimant has failed to demonstrate that it is more probably true than not that he suffered compensable industrial injuries during the course and scope of his employment on October 29, 2008. Applying the *Madden* factors, he has failed to establish an exception to the "traveling to or from work rule" because his travel was not considered the performance of services arising out of and in the course of employment. Ini-

tially, Claimant's motor vehicle accident on October 29, 2008 did not occur during working hours but instead occurred while he was traveling to his designated job site. Second, the motor vehicle accident occurred off of Employer's jobsite. As explained by Mr. Pfief, Claimant's accident occurred approximately two to three miles away from the jobsite at East 56th Avenue and the Pena Boulevard on ramp. Third, the conditions of Claimant's employment did not create a zone of special danger. Claimant has failed to produce evidence to establish that the location of his October 29, 2008 motor vehicle accident was so closely associated with his employment that it constituted a part of the employment premises.

17. The critical inquiry is whether travel was contemplated by Claimant's employment contract and constituted a substantial part of his service to Employer. The credible testimony of foremen Mr. Chavez and Mr. Hernandez reflects that travel was not contemplated by Claimant's employment contract and was not a substantial part of his service to Employer. The testimony of the foremen reveals that the foremen were responsible for all the equipment that was needed for each job. Crewmembers were not required to bring any tools or equipment to the job site except for personal safety equipment that included a hard hat, eyeglasses and ear protection. Employer thus did not rely on Claimant to bring equipment such as a foldable ruler or an eye level to work. Mr. Hernandez also remarked that he never instructed Claimant to bring an eye level or ruler to work. Furthermore, Mr. Pfief explained that Claimant's only job duties on the date of the motor vehicle accident were to assemble and disassemble trench boxes and sweep dirt from the street. Claimant was not required to travel during the day. Mr. Pfief reiterated that Claimant was only required to bring his hardhat and safety glasses to work each day. An eye level and ruler were not used at all on the job site because the crew was not laying any pipe. Finally, safety coordinator Mr. Andrews noted that crewmembers are expected to have their personal protection equipment with them each day and take these items home at night. In contrast, crewmembers are expected to return tools, equipment and supplies to the foremen at the end of the workday.

18. Based on the preceding testimony, Claimant has failed to establish that "special circumstances" exist justifying an exception to the "traveling to or from work" rule. Claimant did not engage in travel or transport special equipment with the express or implied consent of Employer. Employer thus did not receive any special benefit from Claimant's travel in addition to his mere arrival at work A review of the *Madden* factors thus reveals that Claimant has failed to demonstrate a nexus between his injuries and his employment for Employer. Because Claimant was on his way to work when he was involved in a motor vehicle accident on October 29, 2008, his claim for Workers' Compensation benefits is denied and dismissed.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving

entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. To establish a compensable injury an employee must prove by a preponderance of the evidence that his injury arose out of the course and scope of employment with his employer. §8-41-301(1)(b), C.R.S. (2006); *see City of Boulder v. Streeb*, 706 P.2d 786, 791 (Colo. 1985). An injury occurs "in the course of" employment when a claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. *Triad Painting Co. v. Blair*, 812 P.2d 638, 641 (Colo. 1991). The "arise out of" requirement is narrower and requires a claimant to show a causal connection between the employment and injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *Id.* at 641-62.

5. Generally, injuries sustained by employees while they are traveling to or from work are not compensable because such travel is not considered the performance of services arising out of and in the course of employment. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999). However, injuries incurred while traveling are compensable if "special circumstances" exist that demonstrate a nexus between the injuries and the employment. *Id.* at 864. In ascertaining whether "special circumstances" exist the following factors should be considered:

- Whether travel occurred during working hours;
- Whether travel occurred on or off the employer's premises;
- Whether travel was contemplated by the employment contract; and

- Whether obligations or conditions of employment created a "zone of special danger" out of which the injury arose.

Id. In considering whether travel is contemplated by the employment contract the critical inquiry is whether travel is a substantial part of service to the employer. *See id.* at 865.

6. "Special circumstances" may be found where the employment contract contemplates the employee's travel or the employer delineates the employee's travel for special treatment as an inducement. *See Staff Administrators Inc. v. Reynolds,* 977 P.2d 866, 868 (Colo. 1999). "Special circumstances" may also exist when the employee engages in travel with the express or implied consent of the employer and the employer receives a special benefit from the travel in addition to the employee's mere arrival at work. *See National Health Laboratories v. Industrial Claim Appeals Office,* 844 P.2d 1259, 1260 (Colo. App. 1992).

7. As found, Claimant has failed to demonstrate by a preponderance of the evidence that he suffered compensable industrial injuries during the course and scope of his employment on October 29, 2008. Applying the *Madden* factors, he has failed to establish an exception to the "traveling to or from work rule" because his travel was not considered the performance of services arising out of and in the course of employment. Initially, Claimant's motor vehicle accident on October 29, 2008 did not occur during working hours but instead occurred while he was traveling to his designated job site. Second, the motor vehicle accident occurred off of Employer's jobsite. As explained by Mr. Pfief, Claimant's accident occurred approximately two to three miles away from the jobsite at East 56th Avenue and the Pena Boulevard on ramp. Third, the conditions of Claimant's employment did not create a zone of special danger. Claimant has failed to produce evidence to establish that the location of his October 29, 2008 motor vehicle accident was so closely associated with his employment that it constituted a part of the employment premises.

8. As found, the critical inquiry is whether travel was contemplated by Claimant's employment contract and constituted a substantial part of his service to Employer. The credible testimony of foremen Mr. Chavez and Mr. Hernandez reflects that travel was not contemplated by Claimant's employment contract and was not a substantial part of his service to Employer. The testimony of the foremen reveals that the foremen were responsible for all the equipment that was needed for each job. Crewmembers were not required to bring any tools or equipment to the job site except for personal safety equipment that included a hard hat, eyeglasses and ear protection. Employer thus did not rely on Claimant to bring equipment such as a foldable ruler or an eye level to work. Mr. Hernandez also remarked that he never instructed Claimant to bring an eye level or ruler to work. Furthermore, Mr. Pfief explained that Claimant's only job duties on the date of the motor vehicle accident were to assemble and disassemble trench boxes and sweep dirt from the street. Claimant was not required to travel during the day. Mr. Pfief reiterated that Claimant was only required to bring his hardhat and safety glasses to work each day. An eye level and ruler were not used at all on the job

site because the crew was not laying any pipe. Finally, safety coordinator Mr. Andrews noted that crewmembers are expected to have their personal protection equipment with them each day and take these items home at night. In contrast, crewmembers are expected to return tools, equipment and supplies to the foremen at the end of the workday.

9. As found, based on the preceding testimony, Claimant has failed to establish that "special circumstances" exist justifying an exception to the "traveling to or from work" rule. Claimant did not engage in travel or transport special equipment with the express or implied consent of Employer. Employer thus did not receive any special benefit from Claimant's travel in addition to his mere arrival at work A review of the *Madden* factors thus reveals that Claimant has failed to demonstrate a nexus between his injuries and his employment for Employer. Because Claimant was on his way to work when he was involved in a motor vehicle accident on October 29, 2008, his claim for Workers' Compensation benefits is denied and dismissed.

ORDER

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

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

DATED: December 28, 2009.

Peter J. Cannici

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-781-535

ISSUES

Whether Claimant has proven that she sustained a compensable injury to her low back on December 13, 2008. Respondents seek to withdraw a previously filed General Admission of Liability for this December 13, 2008 injury.

Whether the right of selection of the treating physician passed to Claimant and whether Dr. Perry Haney, M.D. should be considered to be the authorized treating physician.

Whether Claimant is entitled to temporary total disability benefits beginning December 14, 2008 and continuing.

Whether Claimant was responsible for her separation from employment and should therefore be barred from receiving temporary total disability benefits under Section 8-42-105(4), C.R.S.

If Claimant is entitled to temporary total benefits whether those benefits are to be offset for Claimant's receipt of Social Security Disability benefits.

At hearing, the parties stipulated that if found compensable Claimant's Average Weekly Wage would be $250.00.

FINDINGS OF FACT

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

1. Claimant was employed with OfficeMax as an IM press associate. Prior to December 13, 2008 Claimant had been working for the employer for 6 months. Claimant last worked for Employer on December 13, 2008.

2. On December 13, 2008 Claimant was given a work assignment by her store manager, Darrell Howard, to finish a project involving the printing and binding of recipe cards for a customer. Claimant was assigned to cut the individual recipe cards measuring 3 inches by 5 inches from a laminated roll of printed cards. Claimant used a paper cutter to perform this task in a standing position. Claimant also was required to punch holes in the recipe cards. On December 13, 2008 Claimant worked cutting and punching holes in the recipe cards in a standing position for approximately 4 hours of her 8 hours shift. While standing,Claimant's work activities on December 13, 2008 required her to repetitively lean and bend in order to cut and punch holes in the recipe cards. Later in the day, Claimant began receiving some help from co-workers in completing this task. Claimant also had to work the cash register and do printing jobs.

3. Claimant began experiencing back pain after leaving work the evening of December 13, 2008. When Claimant woke up the next morning she was unable to move because of the back pain.

4. Claimant has had polymyositis or muscular dystrophy since age 7 causing weakness in her arms and legs. Claimant also suffers from systemic lupus erythematosus. Prior to December 13, 2008 Claimant had reported occasional back pain to University Hospital in March 2006. Claimant also had low back pain associated with seizures but had not had a seizure for two years prior to December 13, 2008. As of December 13, 2008 Claimant had not been disabled from performed her job with Employer because of low back pain nor did Claimant have a chronic condition of low back pain.

5. Employer was notified of Claimant's claim that she was injured on December 14, 2008 when Claimant's husband went to the Employer and reported the injury to Phil Anderson, the assistant manager and Claimant's supervisor. Mr. Anderson then

contacted Mr. Howard to advise him that Claimant's husband had reported that she had been injured on December 13, 2008. Claimant completed and signed an Associate Injury Report on December 17, 2008 describing the injury of December 13, 2008 from "standing, bending and cutting 300 project order." Claimant identified the part of the body injured as "back".

6. Claimant went to Rocky Mountain Urgent Care for treatment of her low back complaints on December 17, 2008. Claimant complained of low back pain radiating to both legs with an onset 4 days ago on the preceding Sunday, December 14, 2008 and worsening 2 days ago. Claimant was evaluated by an unidentified nurse practitioner whose assessment was acute lumbar pain. The nurse practitioner noted that this pain was work related. Claimant was instructed to follow up "with employer for work comp issue". Claimant was given a restriction to remain off work until December 22, 2008.

7. When Darrel Howard was advised by the assistant manager, Mr. Anderson, on December 14, 2008 of Claimant's report of injury Mr. Howard instructed Mr. Anderson to access the proper paperwork and then contact Human Resources. The injury paperwork generally contains a list of medical providers for employees to see in the event of a work injury. However, Mr. Howard did not know if, in fact, Claimant or Claimant's husband were actually given a list of providers by the assistant manager, Phil Anderson, because he was not present at the time.

8. Cynthia Robles is a sales associate for Employer. Ms. Robles testified that on a Saturday after the injury she gave a list of providers to Claimant's husband but does not recall the date when she did this. Ms. Robles' testimony is not persuasive to prove that she gave Claimant or Claimant's husband a list of medical providers within seven (7) business days following the date that Employer had notice of Claimant's injury.

9. Kim Mitcham is the Human Resources manager for Employer. On January 16, 2009 she sent a list of medical providers to Claimant at Claimant's home e-mail address. Ms. Mitcham had spoken with Claimant over the phone on December 17, 2008 and told her at that time she need go to one of the Employer's doctors. On December 17 Ms. Mitcham was under the assumption that Claimant had been given a list of providers. Ms. Mitcham did not personally provide Claimant with a written list of medical providers until the e-mail of January 16, 2009.

10. Because Claimant was not given a written list of at least two medical providers to pick from by Employer within seven (7) business days following the date of Employer's notice of the injury the right of selection of the treating physician passed to Claimant. Employer had notice of Claimant's injury as of December 14, 2008 and the right of selection passed to Claimant as of December 24, 2008.

11. Claimant sought treatment from Spine One, Dr. Perry Haney, M.D., on January 23, 2009. On that date Claimant was evaluated by Physicians Assistant Kristin Reck. Claimant reported low back pain with pain and numbness in the legs bilaterally.

P.A. Reck obtained a history that Claimant had a long order to fill at work and had done quite a bit of standing and leaning, following this Claimant had had constant back pain and numbness. P. A. Reck diagnosed lumbar three-joint complex disorder with bilateral radiculopathy. P. A. Reck noted Claimant's past medical history of muscular dystrophy, lupus, epilepsy and aplastic anemia. P.A. Reck referred Claimant for physical therapy and for a lumbar MRI scan. Dr. Perry Haney, M.D., Spine One, became Claimant's authorized treating physician as of January 23, 2009. As of January 23, 2009, Dr. Haney or his physicians assistant considered the Claimant to be unable to return to her regular job.

12. In a Progress Note of February 5, 2009 Dr. Haney noted that the lumbar MRI revealed multi-level degenerative disc disease at L4-5 and L5-S1. Dr. Haney recommended epidural steroid injection.

13. Claimant wishes to continue to receive treatment from Dr. Haney for her low back complaints.

14. Claimant was terminated by Employer approximately six months after the date of injury because she did not return from leave of absence, personal medical reasons. The ALJ finds that Claimant was unable to return to work because of her physical condition related to her low back injury and was not responsible for her separation from employment.

15. Dr. William Striplin, M.S. evaluated Claimant at the request of Insurer and issued a report dated August 12, 2009. Dr. Striplin opined that Claimant the MRI findings were compatible with Claimant's age and that the work activities of December 13, 2008 did not provide a plausible mechanism of injury to conclude that Claimant's lumbar spine disease was caused or aggravated by that activity.

16. At hearing, Dr. Striplin testified that he concluded that no injury had occurred because there was no history of abrupt pain at any point in time. Dr. Striplin further testified that Claimant had what appeared to be a disc protrusion at L5-S1 and that with no history of abrupt pain or of doing anything that he would construe as overtly strenuous that he would not conclude that the disc herniation was likely given the Claimant's activities as described to him. The ALJ finds the opinions of Dr. Striplin unpersuasive to prove that Claimant did not sustain an injury to her low back on December 13, 2008.

17. Insurer filed a Notice of Contest dated January 13, 2009. Thereafter, Insurer filed a General Admission of Liability on February 24, 2009, for medical benefits only.

18. Claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her low back on December 13, 2008 arising out of and in the course of her employment with Employer. The ALJ finds Claimant's testimony to be credible and persuasive to establish as a matter of fact that Claimant's work activities of December 13, 2008 aggravated a pre-existing degenerative disc disease condition in

her lumbar spine sufficient to cause the need for Claimant to seek medical treatment and to be unable to continue to perform her regular work for Employer.

19. Claimant began receiving Social Security Disability benefits in 1977. Claimant's initial entitlement amount was $149.20 per month. This amount equals a weekly offset to temporary total disability benefits of $17.22.

20. Claimant has been unable to perform her regular job for Employer since December 14, 2008 and has not returned to work since that date.

CONCLUSIONS OF LAW

21. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

22. 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).

23. 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).

24. 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).

25. 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 func-

tions. 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).

26. If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. 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).

27. An occupational disease is an injury that results directly from the employment or conditions under which work was performed and can be seen to have followed as a natural incident of the work. Section 8-40-201(14), C.R.S.; *Climax Molybdenum Co. v. Walter*, 812 P.2d 1168 (Colo. 1991); *Campbell v. IBM Corporation*, 867 P.2d 77 (Colo. App. 1993). A claimant is entitled to recovery if he or she demonstrates that the hazards of employment cause, intensify, or aggravate, to some reasonable degree, the disability. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). Once the claimant makes such a showing, the burden of establishing the existence of a nonindustrial cause and the extent of its contribution to the occupational disease shifts to the employer. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

28. Where an insurer seeks to withdraw an admission of liability, it does not have the burden of showing why the admission was improvident. The burden remains on the claimant to show a compensable injury. *Pacesetter Corp. v. Collett,* 33 P.3d 1230 (Colo. App. 2001).

29. As found, Claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her low back as a result of her work activities for Employer on December 13, 2008. While it is true that Claimant suffers from several significant, pre-existing medical conditions that may have made her susceptible to injury, this does not preclude Claimant from establishing a compensable injury if the conditions of the employment aggravate or accelerate the pre-existing condition. Although Claimant in 2006 reported to medical providers that she had occasional low back pain this evidence is considered unpersuasive to show that Claimant's low back pain after December 13, 2008 was simply the continuation or progression of a pre-existing condition unrelated to the hazards of Claimant's work. Claimant began experiencing low back symptoms the evening of December 13, 2008 after performing work that required leaning and bending. Claimant did not have this type of pain prior to December 13, 2008 and did not have a chronic low back pain condition nor was she unable to perform her usual work because of low back pain prior to this date.

30. The ALJ finds Dr. Striplin's causation analysis to be unpersuasive. Dr. Striplin's analysis equates causation with the occurrence of a specific event or incident.

However, the absence of a specific event or incident does not preclude Claimant from proving a compensable injury if the conditions of employment cause an injury or aggravate a pre-existing condition. In his report, Dr. Striplin did express an opinion that Claimant's work did not aggravate her lumbar spine condition but provided no explanation as to why he reached this conclusion. In his testimony at hearing, Dr. Striplin testified that Claimant's work activities did not aggravate her muscular dystrophy or lupus but did not further address the issue of aggravation of an underlying degenerative spine condition.

31. Respondents argued that Claimant's low back pain was a new condition arising as of December 15, 2008, and because Claimant did not work on that day, it is not related to her work for Employer. The ALJ is not persuaded. Respondents' argument reads inferences into the medical records to reach this conclusion. The ALJ declines to reach similar inferences. The December 17, 2008 record from Rocky Mountain Urgent Care noted a complaint of low back and bilateral leg pain with an onset 4 days ago. Although this record also contains the statement, "back pain is new", the ALJ construes this to be in reference to Claimant's pre-existing leg weakness from muscular dystrophy and noting that she had not had back pain prior to 4 days ago. Respondents attempted to argue that Claimant's low back pain arose on December 15 when her pain worsened. The medical record does state the pain worsened 2 days before the visit of December 17 but does not stand for the proposition inherent in Respondents' argument that Claimant did not have back pain prior to December 15, 2008. Claimant credibly testified that she was having back pain beginning the evening of December 13, 2008 after completing her work. In addition, Respondents have failed to prove any intervening event or cause for Claimant's worsened low back pain as of December 15, 2008 that is not causally related to Claimant's employment. The ALJ concludes that while Claimant's condition worsened as of December 15, 2008, that worsening occurred as a result of and was a progression of Claimant's injury of December 13, 2008.

32. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Respondents have the right to select the initial authorized treating physician. The employer or insurer shall provide a list of at least two physicians or two corporate medical providers or at least one physician and one corporate medical provider, where available, in the first instance form which list an injured employee may select the physician who attends the employee Section 8-43-404(5)(a)(I)(A), C.R.S. Respondents are liable only for treatment from authorized providers. A physician may become authorized to treat the claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). If the services of a physician are not tendered at the time of injury, the employee shall have the right to select a physician or chiropractor. Section 8-43-404(5)(a)(I)(A), C.R.S., *Greager,* supra.

33. When an employer has notice of an on the job injury, the employer or insurer shall provide the injured worker with a written list in compliance with Section 8-43-

404(5)(a)(I)(A). If the list is provided verbally or through a pre-injury designation, a written designated provider list shall be mailed, hand-delivered or furnished in some other verifiable manner to the injured worker within seven (7) business days following the date the employer had notice of the injury. WCRP 8-2(A)(2). Failure to comply with WCRP 8-2 allows the injured worker to select an authorized treating physician of the worker's choosing. WCRP 8-2(D).

34. As found, Employer had notice of Claimant's injury as of December 14, 2008. Thereafter, the persuasive evidence establishes that Claimant was not provided a written list of designated providers until January 16, 2009, more than seven business days after Employer's notice of Claimant's injury. The testimony of Darrell Howard, Cynthia Robles and Kim Mitcham is not persuasive to establish that Claimant was provided with a written list of physicians prior to this date. Since Employer did not comply with the provisions of Section 8-43-404(5)(a)(I)(A), C.R.S. or WCRP 8-2, the right of selection passed to Claimant. Claimant selected Dr. Haney and began treatment with him. Dr. Haney therefore became Claimant's authorized treating physician for her low back injury of December 13, 2008. Respondents have not contended that Dr. Haney's treatment is not reasonable or necessary. Claimant is entitled to have her medical expenses for treatment by Dr. Haney paid by Insurer.

35. 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 term "disability," as used in workers' compensation cases, connotes two elements. The first is "medical incapacity" evidenced by loss or reduction of bodily function. There is no statutory requirement that the Claimant present medical opinion evidence from of an attending physician establish his physical disability. See *Lymburn v. Symbois Logic*, 952 P.2d 831 (Colo. App. 1997). Rather, the Claimant's testimony alone is sufficient to establish a temporary "disability." The second element is loss of wage earning capacity. *Culver v. Ace Electric,* 971 P.2d 641 (Colo. 1999). The impairment of earning capacity element of "disability" may be evidenced by a complete or partial inability to work, or physical restrictions which preclude the claimant from securing employment.

36. Claimant's credible testimony as well as the medical records of Rocky Mountain Urgent Care and Dr. Haney establish that Claimant has been disabled due to her compensable low back pain since December 14, 2008. Claimant last worked December 13, 2008 and has not been released to return to work since that date and has not returned to work. Claimant is entitled to temporary total disability benefits beginning December 14, 2008 and continuing.

37. Under the provisions of Sections 8-42-105(4) and 8-42-103(1)(g), C.R.S. where it is determined that a temporarily disabled worker is responsible for termination of employment the resulting wage loss shall not be attributable to the on-the-job injury. A Claimant is responsible for a termination if the Claimant performs a volitional act or

exercises some degree of control over the circumstances leading to the termination considering the totality of the circumstances. This concept is broad and turns on the specific facts of each case. *Padilla v. Digital Equipment Corp.,* 902 P.2d 414 (Colo. App. 1994). The burden to show that Claimant was responsible for the separation from employment rests with Respondents. *Colorado Compensation Insurance Authority v. Indus. Claim Appeals Office,* 18 P.3d 790 (Colo. App. 2000).

38. As found, Respondents have failed to sustain their burden of proof to show that Claimant was responsible for her separation from employment. Although there was some testimony regarding Claimant's not submitting paperwork concerning her leave of absence, this testimony is not persuasive to establish that Claimant would not have been terminated had she submitted the necessary paperwork. The persuasive evidence shows that Claimant was terminated due to her physical inability to return from the leave of absence. This was not a volitional act by Claimant or something over which Claimant exercised a degree of control. Regardless, Claimant's wage loss here was not occasioned by her termination as the termination did not occur until six months after Claimant had left work and was no longer able to perform her work for Employer. Termination statutes apply to the loss regular or modified employment. *Colorado Springs Disposal v. Indus. Claim Appeals Office,* 58 P.3d 1061 (Colo. App. 2002). The termination statutes are not applicable under the facts of this case. The ALJ concludes that Claimant is not barred from receipt of temporary total disability benefits by the provisions of Section 8-42-105(4), C.R.S.

39. The parties stipulated that Claimant's Average Weekly Wage is $250.00. This equals a weekly temporary total disability rate of $166.67. From that is offset $17.22 per week due to Claimant's receipt of Social Security Disability benefits. Section 8-42-103(1)(c)(I), C.R.S., *Engelbrecht v. Hartford Indemnity Insurance Co.,* 680 P. 2d. 231 (Colo. 1984). Claimant's weekly temporary total disability benefit rate, after offset, is $149.45.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation and benefits for an injury to her low back on December 13, 2008 is granted. Respondents' request to withdraw the General Admission of Liability of February 24, 2009 is denied.

2. Insurer shall pay the medical expenses for Claimant's treatment from Spine One, Dr. Perry Haney, M.D., that are reasonable, necessary and causally related to the injury of December 13, 2008 in accordance with the Official Medical Fee Schedule of the Division of Workers' Compensation.

3. Insurer shall pay Claimant temporary total disability benefits in the amount of $149.45 per week beginning December 14, 2008 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: December 28, 2009

Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-800-546

ISSUES

¬ Did claimant prove by a preponderance of the evidence that she sustained an injury arising out of the course and scope of her employment?
¬ Did claimant prove by a preponderance of the evidence that she is entitled to medical and temporary disability benefits?

FINDINGS OF FACT

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

1. Markham owns and operates a hamburger stand business (employer). Claimant worked for employer. On July 29, 2009, claimant was cleaning the hamburger stand in preparation for closing. At around 11:30 p.m. on July 29th, claimant accidentally burned her right hand when cleaning the fryer. Claimant's right hand slipped into hot, fryer grease. Claimant thus sustained a burn injury that arose out of and within the course and scope of her employment at employer.
2. On September 14, 2009, the Office of Administrative Courts (OAC) mailed Markham a Notice of Hearing, indicating the date, time, and place of hearing. The OAC mailed the Notice of Hearing to Markham at the following address:
3. Steven Markham, Owner DBA Hamurger (sic) Stand 427, 3030 N. 72nd Avenue, Westminster, CO 80030
4. Despite the above legal notice, Markham failed to appear for hearing.
5. Claimant reported her injury on July 29th to Markham, who suggested she seek medical attention. Claimant applied an aloe salve and thought her hand would be all right. When claimant awoke on July 30th, her right hand had blistered and was painful.
6. On July 30, 2009, claimant sought emergent treatment for her burn at the Emergency Department of Denver Health Medical Center (ER). The ER medical provider bandaged claimant's hand, gave her pain medications, and referred her to the burn unit of University Hospital at the University of Colorado Hospital Authority (UCH Burn Unit).

7. Claimant sought treatment at the UCH Burn Unit on August 1, 2009, where medical providers debrided and redressed her wound. The medical providers at the UCH Burn Unit provided claimant medicated creams and pain medications.

8. Claimant's treatment at the ER and UCH Burn Unit was authorized medical treatment because it was emergent medical treatment. The treatment claimant received from providers at the ER and the UCH Burn Unit was reasonable and necessary to cure and relieve the effects of claimant's injury at employer. The University of Colorado Hospital has billed claimant $1,550.56 for treatment at the UCH Burn Unit. University Physicians, Inc., has billed claimant $280.00 for providing her professional services at the UCH Burn Unit.

9. Because of her burn injury, claimant was unable to perform her regular job at employer. Claimant was unable to work during a period of 33 days from July 30 through August 31, 2009, after which she returned to full-duty work at another employer. Claimant has shown it more probably true than not that her injury at employer proximately caused her wage loss from July 30 through August 31, 2009.

10. Claimant showed it more probably true than not that an average weekly wage (AWW) of $300.00 adequately represents her wage loss and loss of earning capacity as a result of her injury at employer. Crediting claimant's testimony, employer paid claimant $7.50 per hour and she averaged 40 hours per week ($7.50 x 40 = $300).

11. Crediting claimant's testimony, Markham failed to carry insurance to cover workers' compensation injuries as required under the Workers' Compensation Act. Markham and employer thus were non-insured for benefits under the Workers' Compensation Act on July 29, 2009. Markham thus is subject to a 50% penalty pursuant to §8-43-408(1), C.R.S. Applying the 50% penalty, Markham should pay claimant her compensation benefits at the weekly rate of $300.00, or a daily rate of $42.86.

CONCLUSIONS OF LAW

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

A. Compensability:

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

The purpose of the Workers' Compensation Act of Colorado (Workers' Compensation Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The

facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Here, the Judge found claimant sustained a burn injury to her right hand on July 29, 2009, that arose out of and within the course and scope of her employment at employer. Claimant thus proved by a preponderance of the evidence that she sustained a compensable injury.

B. Medical and Temporary Benefits:

Claimant argues she has proven by a preponderance of the evidence that she is entitled to medical and temporary disability benefits. The Judge agrees.

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.

Respondent thus is 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).

Respondent is liable for authorized or emergency medical treatment. *See* §8-42-101(1), *supra*; *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). While claimant may obtain emergency treatment without prior authorization, claimant's need for emergency treatment does not affect respondent's right to designate the authorized treating physician for all non-emergency treatment. *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Thus, at the conclusion of the emergency, claimant must request that the employer refer her to a provider for non-emergent treatment of the work injury. *Sims v. Industrial Claim Appeals Office, supra*.

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 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). 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 her 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 her regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998).

Here, the Judge found that claimant's treatment at the ER at Denver Health Medical Center and at the UCH Burn Unit at University of Colorado Hospital was authorized and reasonably necessary medical treatment. The Judge further found claimant showed it more probably true than not that her injury at employer proximately caused her wage loss over the 33-day period from July 30 through August 31, 2009. Claimant thus proved by a preponderance of the evidence that she is entitled to medical and temporary disability benefits.

The Judge concludes that Markham should pay the bill from Denver Health Medical Center, the bill from University of Colorado Hospital in the amount of $1,550.56, and the bill from University Physicians, Inc., in the amount of $280.00. Markham further should pay claimant compensation in the amount of $1,414.38 (33 x $42.86 = $1,414.38). In lieu of such payment, Markham should post a bond in the amount of $4,000.00 pursuant to §8-43-408(2), *supra*.

ORDER

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

1. Markham shall pay the bill from Denver Health Medical Center, the bill from University of Colorado Hospital in the amount of $1,550.56, and the bill from University Physicians, Inc., in the amount of $280.00.

2. Markham shall pay claimant compensation benefits in the amount of $1,414.38.

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

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

5. In lieu of payment of the above compensation and benefits to the claimant, the Markham shall:

   a. Deposit the sum of $4,000.00 with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to: 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 $4,000.00 with the Division of Workers' Compensation within ten (10) days of the date of this order:
   (1) Signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation; or
   (2) Issued by a surety company authorized to do business in Colorado.
   The bond shall guarantee payment of the compensation and benefits awarded.

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

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

DATED: _December 29, 2009__

Michael E. Harr
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-634-828

ISSUES

1. Whether a spinal stimulator implant trial surgical procedure is reasonable, necessary and related medical treatment to maintain Claimant's condition such that Insurer is liable for the implant trial pursuant to Section 8-42-101, C.R.S., and *Grover v. Industrial Commission*, 759 P. 2d 705, 710 (Colo. 1988).

2. Whether a surgical consultation conducted by Dr. Jeffrey Donner on May 7, 2009, was reasonable, necessary and related medical treatment to maintain Claimant's condition such that Insurer is liable for said treatment pursuant to Section 8-42-101, C.R.S. and *Grover v. Industrial Commission*, 759 P. 2d 705, 710 (Colo. 1988).

3. Whether Claimant established that Respondents failed to comply with W.C.R.P. 16-10 in responding to a request by Dr. Sisson for authorization for the stimulator trial on June 3, 2008 such that the trial should have been "deemed authorized" under Rule 16-10(E), W.C.R.P.

FINDINGS OF FACT

1. Claimant sustained an admitted injury to his low back on November 15, 2004, and since that time has received authorized treatment primarily from Dr. Jeffrey Donner and Dr. Bradley Sisson. On March 9, 2007, Respondents filed a Final Admission of Liability (FAL), admitting liability for ongoing medical treatment.

2. On July 25, 2007, the parties entered into a Full and Final Settlement Agreement that was approved by the Director of the Division of Workers' Compensation on July 30, 2007. As part of this settlement agreement, the parties resolved the indemnity portion of Claimant's claim and Insurer agreed to pay for Claimant's maintenance care until such time as the parties and Medicare (CMS) agreed upon the amount of money necessary to cover Claimant's future medical treatment.

3. Claimant attended at least two independent medical examinations with Dr. Barton Goldman. Dr. Goldman testified at hearing regarding the appropriateness of the trial spinal cord stimulator; the permanent spinal cord stimulator; that there is a risk of a false-positive result from the trial cord stimulator; and Claimant's alleged secondary gain issues. Dr. Goldman's reports and testimony opposed the trial spinal cord stimulator.

4. Claimant's authorized treating physician and spinal surgeon, Dr. Jeffrey Donner of Rocky Mountain Associates in Orthopedic Medicine, P.C., referred Claimant to pain management specialist Dr. C. Bradley Sisson. Dr. Sisson is licensed to practice medicine in Colorado and is board certified in anesthesiology and pain management. Dr. Sisson is an authorized treating physician. Dr. Sisson provided medical treatment to Claimant beginning in April 2006 and continuing.

5. On June 3, 2009, an individual in Dr. Sisson's office sent a fax to "AIG Ronica Rexroat" with the following request:

> We are looking for approval for Spinal Cord Stimulator Trial CPT 63650 x 2 to be done as outpatient at Loveland Surgery Center as soon as possible. Let me know if you require a psych evaluation to be done first. Attached clinical information you requested. Let me know when you have made your decision.

6. On June 9, 2008, Respondents sent a letter to Dr. Sisson, with a copy to all parties, indicating that Respondents would not authorize the procedure based on the rationale contained in Dr. Goldman's IME reports of April 2, 2007 and April 25, 2007.

7. On July 29, 2008, Claimant was examined by Dr. Richard Stieg. Dr. Stieg opined that all of the medications and all of the interventional strategies employed by Dr. Sisson were reasonable, necessary and appropriate.

8. In his report, Dr. Stieg outlined the applicable portions of the Division of Workers' Compensation Medical Treatment Guidelines relevant to spinal cord stimulators. He opined that the Treatment Guidelines required 1) that all conservative treatment had been exhausted; 2) that the patient had no significant complicating psychiatric issues; and 3) that the spinal cord stimulator would be expected to cover the bodily region of pain. Dr. Stieg opined that as of July 29, 2008, the Medical Treatment Guidelines had not been met. One of Dr. Stieg's primary objections to the trial spinal cord stimulator pertained to Claimant's failure to obtain a psychological or psychiatric evaluation.

9. On August 29, 2008, Claimant's counsel faxed Dr. Stieg's July 29, 2008 IME report to Dr. Sisson for his review and to consider implementing Dr. Stieg's recommendations with respect to the trial spinal cord stimulator.

10. On September 17, 2008, Respondents' counsel took Dr. Sisson's deposition. Dr. Sisson provided credible testimony supporting the trial spinal cord stimulator as reasonable and necessary medical treatment that was related to the Claimant's industrial injury. He testified that a trial spinal cord stimulator trial was necessary to determine whether it was appropriate to proceed to implant a stimulator. He testified that he had previously referred Claimant to Patrick DeMarco, PhD, for a psychological evaluation, but Respondents had denied authorization.

11. On August 12, 2008, Dr. Sisson renewed his referral to Dr. DeMarco. Respondents again denied liability for this referral.

12. On November 6, 2008, Claimant was examined by Howard Entin, M.D. He opined that Claimant did not have significant psychosocial issues and that he did not see any contraindications to a spinal cord stimulator. However, Dr. Entin opined that it was not in Claimant's best interest to proceed with a spinal cord stimulator and that Claimant should manage his symptoms with medications and by managing his activities.

13. On December 2, 2008, Dr. Sisson supported in writing his referral to Dr. DeMarco as being reasonable, necessary and work-related treatment and to satisfy the medical treatment guidelines pertaining to a trial spinal cord stimulator. Dr. Demarco became an authorized treating provider.

14. Dr. DeMarco developed a Psychological Treatment Plan and provided reasonable, necessary and work related psychological treatment to Claimant between January 13, 2009 and February 12, 2009.

15. On February 12, 2009, Dr. DeMarco cleared Claimant to proceed with a spinal cord stimulator, thereby satisfying one of the requirements of the Medical Treatment Guidelines.

16. During a March 17, 2009 examination with Dr. Sisson, Claimant reported the onset of new, severe, left-sided lower back symptoms following a work-related Botox injection administered by Dr. Sisson.

17. On March 18, 2009, Dr. Sisson referred Claimant back to Dr. Donner to evaluate the new onset of radicular symptoms down Claimant's left leg in the L4-5 dermatomal distribution. After some dispute over whether Dr. Sisson withdrew his referral to Dr. Donner, Dr. Sisson renewed his referral to Dr. Donner on April 22, 2009.

18. Respondents denied Dr. Sisson's referral back to Dr. Donner.

19. Dr. Jeffrey Donner examined Claimant on May 7, 2009. Dr. Donner provided and recommended reasonable and necessary medical treatment and diagnostic procedures intended to cure and relieve the effects of Claimant's industrial injuries and injuries caused by Dr. Sisson's work-related medical treatment.

20. On March 30, 2009, Respondents filed an Application for Hearing requesting the Office of Administrative Courts determine whether the trial spinal cord stimulator was reasonable and necessary medical treatment. On April 7, 2009, Claimant filed a timely Response to Application for Hearing endorsing issues including, but not limited to, reasonable and necessary medical treatment and authorized provider.

21. Respondents took a second deposition of Dr. Sisson on July 27, 2009 wherein he provided further, credible support for the trial spinal cord stimulator and his referral back to Dr. Donner that resulted in Dr. Donner's May 7, 2009 examination, treatment and recommendations.

22. Dr. Sisson testified credibly that the trial spinal cord stimulator was necessary to cure and relieve the effects of Claimant's November 15, 2004 industrial injuries. Dr. Sisson testified credibly that he satisfied the Division of Workers' Compensation Medical Treatment Guidelines. During both depositions, Dr. Sisson testified credibly that Claimant's medical providers exhausted conservative treatment. Dr. Sisson testified that he believed based upon a reasonable degree of medical probability that the lumbar fusion hardware installed as part of Dr. Donner's prior work-related surgery was the source of some of Claimant's symptoms which he believed the trial spinal cord stimulator could relieve. During both depositions, Dr. Sisson testified credibly that the trial spinal cord stimulator was intended to relieve some but not all symptoms of Claimant's industrial injuries. He testified that Claimant had more than one pain generator. Dr. Sisson disclosed the risks of the trial spinal cord stimulator to Claimant. He testified that the trial spinal cord stimulator was one-hundred percent reversible if it did not work which would leave Claimant with a band-aid on his back.

23. The trial spinal cord stimulator poses only nominal risks to Claimant when compared to the potential benefits, and Claimant is fully aware of the potential risks and benefits.

CONCLUSIONS OF LAW

The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient deliver 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 worker's 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 o 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, 592 P.2d 792 (Colo. 1979); People v. M.A., 104 P.3d 273, 275 (Colo.App. 2004). The facts in a worker's compensation case are not interpreted liberally in favor of either the rights of the injured work 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 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, 389 (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. *Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); CJI, Civil 3:16 (2005).

The Judge is free to credit one medical opinion to the exclusion of a contrary medical opinion. *Dow Chemical Co. v. ICAO*, 843 P.2d 122, 125 (Colo.App. 1992).

1. Whether a spinal stimulator implant trial surgical procedure is reasonable, necessary and related medical treatment to maintain Claimant's condition such that Respondents are liable for the implant trial pursuant to Section 8-42-101, C.R.S. and *Grover v. Industrial Commission***, 759 P. 2d 705, 710 (Colo. 1988).**

Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. Section 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. *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).

A spinal stimulator implant is designed to relieve pain by the use of neurostimulation. The Workers' Compensation Medical Treatment Guidelines, Rule 17 G(1), W.C.R.P., provides the following regarding neurostimulation:

> c. Surgical Indications — Failure of conservative therapy including active and/or passive therapy, medication management, or therapeutic injections. Pre-authorization is required. Habituation to narcotic analgesics in the absence of a history of addictive behavior does not preclude the use of neurostimulation. Only patients who meet the following criteria should be considered candidates for neurostimulation:
>
> i. A diagnosis of a specific physical condition known to be chronically painful has been made on the basis of objective findings; and
>
> ii. All reasonable surgical and non-surgical treatment has been exhausted; and
>
> iii. Pre-surgical psychiatric or psychological evaluation has been performed and has demonstrated motivation and long-term commitment without issues of secondary gain; and
>
> iv. There is no evidence of addictive behavior. (Tolerance and dependence to narcotic analgesics are not addictive behaviors and do not preclude implantation.); and
>
> v. The topography of pain and its underlying pathophysiology are amenable to stimulation coverage (the entire painful area has been covered); and
>
> vi. A successful neurostimulation screening test of 2-3 days. A screening test is considered successful if the patient (a) experiences a 50% decrease in pain, which may be confirmed by visual analogue scale (VAS), and (b) demonstrates objective functional gains or decreased utilization of pain medications. Functional gains may be evaluated by an occupational therapist and/or physical therapist prior to and before discontinuation of the trial.

vii. For spinal cord stimulation, a temporary lead is implanted at the level of pain and attached to an external source to validate therapy effectiveness. (For peripheral nerve screening, a nerve block is performed to define the specific nerve branch but if multiple branches are involved, a screening test for spinal cord stimulation may be indicated.) Long-term functional improvement is anticipated when objective functional improvement has been observed during time of neurostimulation screen exam.

d. Contraindications — Unsuccessful neurostimulation test – either inability to obtain functional improvement or reduction of pain, those with cardiac pacemakers, patient unable to properly operate the system. It should not be used if future MRI is planned.

Claimant has established by preponderance of the evidence that his alleged secondary gain issues, as asserted by Respondents, Dr. Entin and Dr. Goldman, do not disqualify him psychologically or psychiatrically from having the trial or permanent spinal cord stimulator. Claimant has established by a preponderance of the evidence that the authorized medical providers in this claim have met the Division of Workers' Compensation Medical Treatment Guidelines as they pertain to trial spinal cord stimulators.

*As found, the persuasive and credible testimony of Dr. C. Bradley Sisson demonstrates that the trial spinal cord stimulator is a reasonable medical modality nec*essary to determine if Claimant should receive a permanent spinal cord stimulator implant. As opined by Dr. Barton Goldman, there is a risk of a false positive result of such a trial. However, it is not probable that the test will be positive, or if positive, it will be a false positive. If such a trial is conducted and an authorized treating physician recommends proceeding with the permanent implant, Respondents will have an opportunity to challenge the reasonableness and necessity of the implant.

Claimant has established by a preponderance of the evidence that a trial spinal cord stimulator is reasonably needed post-MMI care related to Claimant's November 15, 2004, industrial injury. Insurer is liable for the costs of such a trial should the trial be performed by a physician authorized in this claim.

2. Whether a surgical consultation conducted by Dr. Jeffrey Donner on May 7, 2009, was reasonable, necessary and related medical treatment to maintain Claimant's condition such that Insurer is liable for said treatment pursuant to Section 8-42-101, C.R.S., and *Grover v. Industrial Commission***, 759 P. 2d 705, 710 (Colo. 1988).**

Under the 'quasi-course of employment' doctrine, injuries sustained during authorized medical treatment of an industrial injury are compensable. *Kneebone v. Ferrellgas*, W. C. Nos. 4-521-119 & 4-521-168 (Mar. 6, 2003) *citing Price Mine Service Inc. v. ICAO,* Case No. 02CA0375 (Colo.App. Jan 2, 2003).

Dr. C. Bradley Sisson, his clinic the Colorado Pain Clinic – Integrated Medical Consultants, L.L.C.; Dr. Jeffrey Donner, and his clinic Rocky Mountain Associates in Orthopedic Medicine, P.C., and Patrick DeMarco PhD are authorized treating providers in this claim.

Dr. Donner's May 7, 2009, examination was a reasonably, necessary work related post-MMI examination. Dr. Donner's treatments and recommendations made during the May 7, 2009 examination were necessary to cure and relieve the effects of Claimant's November 15, 2004 industrial injury and authorized medical treatment provided as part of this claim. Insurer is liable for the costs of that examination, medical treatment and recommendations made at the May 7, 2009 examination in amounts not to exceed the Division of Workers' Compensation fee schedule. Sections 8-42-101(1) & (3), C.R.S.

3. Whether Claimant established that Respondents failed to comply with W.C.R.P. 16-10 in responding to a request by Dr. Sisson for authorization for SCS trial on June 3, 2008 such that the SCS trial should have been "deemed authorized" under Rule 16-10(E), W.C.R.P.

Claimant bears the burden of proving that Respondents violated the workers' compensation statute, procedural rules, or an order. *See Pioneers Hospital of Rio Blanco County v. Industrial Claim Appeals Office,* 114 P.3d 97 (Colo.App. 2005).

Rule 16-10(A) and (B), WCRP, contain the requirements which govern Respondents' contest of requests for prior authorization for medical services. Rule 16-10(B) contains the requirements for denying such a request for "medical reasons," having to do with whether medical services are medically reasonable and necessary. The Rule provides, if "the payer" (usually Insurer) wishes to contest a medical provider's request for prior authorization for medical reasons, the payer must, within seven (7) business days, have the request reviewed by a qualified physician or other health care professional and provide a written contest to the requesting medical provider. The requirements of Rule 16-10(A) and (B), W.C.R.P., are triggered by the payer's receipt of the requesting medical provider's "completed request as defined in Rule 16-9(E)."

A completed request for prior authorization is defined under Rule 16-9(E), W.C.R.P., as follows:

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

If a "payer" fails to timely and appropriately respond to a completed request for prior authorization, Rule 16-10(E), W.C.R.P., provides the requested medical services

shall be "deemed authorized," unless the payer requests a hearing and notifies the requesting provider that the matter is proceeding to a hearing.

In this case, Claimant requested that implant trial be "deemed authorized" pursuant to W.C.R.P. 16-10(E). However, Claimant failed to introduce sufficient evidence to establish by a preponderance that Dr. Sisson made a valid request for prior authorization meeting the requirements of W.C.R.P. 16-9(E) such that Insurer was required to respond. Other than the one-page facsimile cover letter from Dr. Sisson's office dated June 3, 2008 and Respondents' letter of June 9, 2008, Claimant did not introduce any other evidence showing that Dr. Sisson made a "completed request" for prior authorization of an implant trial. The request did not explain the medical necessity of the services requested and did not provide relevant supporting medical documentation. Claimant did not establish Insurer was required to respond under Rule 16-10, W.C.R.P.

Respondents argued Claimant's request that implant trial be "deemed authorized" under Rule 16(E), W.C.R.P. constituted a claim for a penalty which Claimant failed to plead with "specificity," pursuant to OACRP 8(A). Respondents argued Claimant first raised the issue at the beginning of the hearing on August 13, 2009, and they further asserted Claimant's claim [that the stimulator implant should be "deemed authorized"] was barred under the statute of limitations contained at Section 8-43-304(5), C.R.S. [one-year limitation on actions for penalties]. Because Claimant did not establish Respondents were required to respond to Dr. Sisson's June 3, 2008 facsimile, these arguments need not be addressed by the ALJ.

ORDER

1. Insurer is liable for the costs of a trial Spinal Cord Stimulator should the trial be performed by a physician authorized in the claim.
2. Insurer is liable for the costs of Dr. Donner's examination on May 7, 2009, in amounts not to exceed the Division of Workers' Compensation fee schedule.
3. Issues not determined herein are reserved for future decision.

DATED: *December 29, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-800-818

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered compensable injuries on July 8, 2009 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 July 9, 2009 until October 1, 2009.

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

5. Whether Employer is subject to penalties pursuant to §8-43-408(1), C.R.S. for failing to carry worker's compensation insurance on July 8, 2009.

6. Whether Claimant is entitled to a disfigurement award.

FINDINGS OF FACT

1. On September 9, 2009 the Office of Administrative Courts (OAC) mailed a Notice of Hearing to the parties in this matter. The Notice specified that a hearing was scheduled for 1:30 p.m. on December 9, 2009 and was mailed to Employer at its address on file with the OAC. However, Employer failed to attend or otherwise participate in the December 9, 2009 hearing.

2. Claimant testified at the hearing that he began working for Employer in approximately 2003 as an HVAC repairman. His duties involved repairing air conditioning units and furnaces. On July 8, 2009 Claimant was repairing an air conditioning unit at a customer's home. He accidentally touched an electrically charged condenser with his right index finger. Claimant was shocked and burned as a result of the incident. Although Claimant reported the incident to Employer, he was not directed to obtain medical treatment.

3. Claimant earned $16.00 per hour while working for Employer and worked five hours each week. He thus earned an Average Weekly Wage (AWW) of $80.00.

4. Employer did not possess Colorado Worker's Compensation insurance on July 8, 2009.

5. Claimant initially visited the Medical Center of Aurora for emergency treatment. However, he immediately transferred care to Denver Health Medical Center to obtain discounted medical services. Claimant received treatment for an electrical burn of the right thumb and right index finger. A radiology report of Claimant's right hand revealed a "laceration in the region of the distal phalanx of the common along the palmar aspect." He also had a "second smaller laceration with some radiopacity at its margins . . . in the region of the distal phalanx of the index finger."

6. On July 14, 2009 Claimant underwent an evaluation with Raffi Gurunluoglu, M.D. at the Denver Health Medical Center. Dr. Gurunluoglu noted that Claimant

had suffered a "deep tissue injury to the right finger, right thumb palmar surface." He remarked that Claimant was scheduled for "irrigation debridement and stage interdigital flap from the right finger donor site." On July 15, 2009 Dr. Gurunluoglu performed several procedures on Claimant's index finger including "debridement of the burn wound," "excision of necrotic tissue" and skin grafting. Claimant subsequently underwent an additional procedure with Dr. Gurunluoglu to repair his right index finger.

7. During the course of his medical treatment for his July 8, 2009 injuries, Claimant incurred medical bills from Denver Health Medical Center, Colorado Surgical Care, Medical Center of Aurora, Carepoint P.C. and Regional EKG Interpretation Group. Claimant's medical treatment was reasonable and necessary to cure or relieve the effects of his July 8, 2009 injuries.

8. Claimant ceased working for Employer after the July 8, 2009 incident because of the finger injuries on his right hand. He was unable to return to work until October 1, 2009.

9. Claimant underwent a disfigurement evaluation at the hearing in this matter. Because of Claimant's July 8, 2009 industrial injuries he incurred disfigurement consisting of the following: (1) a dime-sized scar on the right middle finger; (2) a dime-sized scar on the tip of the right index finger; (3) minor right thumb scarring; and (4) a scar on the lower abdomen that measures approximately two and one-half inches long by one-half inch wide. The disfigurement is serious, permanent, and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $500.00.

10. Claimant has demonstrated that it is more probably true than not that he suffered compensable injuries on July 8, 2009 during the course and scope of his employment with Employer. Claimant testified that he worked for Employer as an HVAC repairman. He credibly explained that he accidentally touched an electrically charged condenser with his right index finger. Claimant was shocked and burned as a result of the incident.

11. 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 industrial injuries. Although Claimant reported his injuries, Employer did not direct Claimant to obtain medical treatment. He subsequently underwent diagnostic treatment and a number of procedures to repair his finger injuries. Claimant also incurred medical bills from several different providers. All of Claimant's medical treatment was reasonable and necessary to cure or relieve the effects of his July 8, 2009 industrial injuries.

12. Claimant has proven that it is more probably true than not that he is entitled to TTD benefits for the period July 9, 2009 until October 1, 2009. Because of his industrial injuries, Claimant was unable to perform his job duties. Claimant has thus demonstrated that his July 8, 2009 industrial injuries caused a disability that contributed to a subsequent wage loss.

13. Claimant has established that Employer was not insured on July 8, 2009. His disability benefits shall be increased by 50% because of Employer's failure to comply with the insurance provisions of the Act.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

Compensability

4. For an injury to be compensable under the Act, it must "arise out of" and "occur within the course and scope" of employment. *Price v. Industrial Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. § 8-41-301(1)(c) C.R.S.; *Faulkner v. Industrial Claim Appeals Office,*12 P.3d 844, 846 (Colo. App. 2000). The question of causation is generally one of fact for determination by the ALJ. *Faulkner,* 12 P.3d at 846.

5. As found, Claimant has demonstrated by a preponderance of the evidence that he suffered compensable injuries on July 8, 2009 during the course and scope of his employment with Employer. Claimant testified that he worked for Employer as an HVAC repairman. He credibly explained that he accidentally touched an electrically charged condenser with his right index finger. Claimant was shocked and burned as a result of the incident.

Medical Benefits

6. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

7. If an employer is notified of an industrial injury and fails to designate an Authorized Treating Physician (ATP) the right of selection passes to the employee. *Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565, 567 (Colo. App. 1987). An employer is deemed notified of an injury when it has "some knowledge of the accompanying facts connecting the injury or illness with the employment, and indicating to a reasonably conscientious manager that the case might involve a potential compensation claim." *Bunch v. industrial Claim Appeals Office,* 148 P.3d 381, 383 (Colo. App. 2006).

8. As found, Claimant has established by a preponderance of the evidence that he received authorized medical treatment that was reasonable and necessary to cure or relieve the effects of his industrial injuries. Although Claimant reported his injuries, Employer did not direct Claimant to obtain medical treatment. He subsequently underwent diagnostic treatment and a number of procedures to repair his finger injuries. Claimant also incurred medical bills from several different providers. All of Claimant's medical treatment was reasonable and necessary to cure or relieve the effects of his July 8, 2009 industrial injuries.

TTD Benefits

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

10. As found, Claimant has proven by a preponderance of the evidence that he is entitled to TTD benefits for the period July 9, 2009 until October 1, 2009. Because of his industrial injuries, Claimant was unable to perform his job duties. Claimant has thus demonstrated that his July 8, 2009 industrial injuries caused a disability that contributed to a subsequent wage loss.

AWW

11. Section 8-42-102(2), C.R.S. requires the Judge to determine a claimant's AWW based on her earnings at the time of injury. The Judge must calculate the money rate at which services are paid to the claimant under the contract of hire in force at the time of injury. *Pizza Hut v. ICAO,* 18 P.3d 867, 869 (Colo. App. 2001). However, §8-42-102(3), C.R.S. authorizes a Judge to exercise discretionary authority to calculate an AWW in another manner if the prescribed methods will not fairly calculate the AWW based on the particular circumstances. *Campbell v. IBM Corp.,* 867 P.2d 77, 82 (Colo. App. 1993). The overall objective in calculating an AWW is to arrive at a fair approximation of a claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997). Therefore, §8-42-102(3), C.R.S. grants an ALJ substantial discretion to modify the AWW if the statutorily prescribed method will not fairly compute a claimant's wages based on the particular circumstances of the case. *In Re Broomfield,* W.C. No. 4-651-471 (ICAP, Mar. 5, 2007). As found, Claimant earned an AWW of $80.00.

Penalties for Employer's Failure to Carry Worker's Compensation Insurance

12. Claimant seeks penalties against Employer for failing to carry worker's compensation insurance pursuant to §8-43-408, C.R.S. Section 8-43-408(1), C.R.S. provides that an injured employee's benefits shall be increased by 50% for an employer's failure to comply with the insurance provisions of the Act. If compensation is awarded the Judge shall compute and require the employer to pay a trustee an amount equal to the present value of all unpaid compensation or require the employer to file a bond within 10 days of the order. §8-43-408(2), C.R.S. The term "compensation" refers to disability benefits. *In Re of Shier,* W.C. No. 4-573-910 (ICAP, Dec. 15, 2005).

13. As found, Claimant has established that Employer was not insured on July 8, 2009. His disability benefits shall be increased by 50% because of Employer's failure to comply with the insurance provisions of the Act.

Disfigurement

14. 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, because of Claimant's July 8, 2009 industrial injuries he incurred disfigurement consisting of the following: (1) a dime-sized scar on the right middle finger; (2) a dime-sized scar on the tip of the right index finger; (3) minor right thumb scarring; and (4) a scar on the lower abdomen that measures approximately two and one-half inches long by one-half inch wide. The disfigurement is serious, permanent, and normally exposed to public view. Claimant is thus entitled to a total disfigurement award of $500.00.

ORDER

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

1. Claimant suffered compensable injuries during the course and scope of his employment with Employer on July 8, 2009.

2. Claimant is entitled to reasonable and necessary medical treatment that is designed to cure or relieve the effects of his July 8, 2009 industrial injuries.

3. Claimant is entitled to TTD benefits for the period July 9, 2009 until October 1, 2009.

4. Claimant earned an AWW of $80.00.

5. Claimant's benefits shall be increased by 50% because of Employer's failure to comply with the insurance provisions of the Act. In lieu of payment of the above compensation and benefits to Claimant, Respondents shall:

a. Deposit an amount equal to the present value of all unpaid compensation with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to and sent to the Division of Workers' Compensation, Attn: Sue Sobolik, Special Funds Unit, 633 17th St, Suite 900, Denver, CO, 80202, or

b. File a bond in an amount equal to the present value of all unpaid compensation 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 <u>or</u>

(2) Issued by a surety company authorized to do business in Colorado.

The bond shall guarantee payment of the compensation and benefits awarded.

c. Respondent shall notify the Division of Workers' Compensation and Claimant of payments made pursuant to this Order.

d. The filing of any appeal, including a petition for review, shall not relieve Respondent of the obligation to pay the designated sum to the trustee or to file the bond. §8-43-408(2), C.R.S.

Any interest that may accrue on a cash deposit shall be paid to the parties receiving distribution of the principal of the deposit in the same proportion as the principal, unless the agreement or order authorizing distribution of the principal provides otherwise.

6. Claimant shall receive a disfigurement award in the amount of $500.00.

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

DATED: December 29, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-766-273

ISSUES

Whether Dr. David Yamamoto and his referrals should be found to be authorized treating physicians or chiropractic providers.

Whether the treatment by Dr. Yamamoto and referral of Claimant back to Dr. Larimore, D.C. is reasonable and necessary to maintain Claimant's condition after MMI and is causally related to the admitted injury.

FINDINGS OF FACT

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

1. Claimant sustained an admitted injury on June 25, 2008. At that time, Claimant was employed as a meat processor in the "bag rib" section of Employer's plant in Longmont, CO. Claimant sustained injuries to her neck, upper back and left shoulder.

2. Hearing in this matter was previously held before ALJ David P. Cain on October 1, 2009. One of the issues presented for determination by ALJ Cain at hearing was "Did the claimant prove by a preponderance of the evidence that Dr. Darin Busse, D.C. is an authorized chiropractic medical provider?"

3. ALJ Cain issued Findings of Fact, Conclusions of Law, and Order dated November 12, 2009 that were admitted into evidence as Respondents' Exhibit L. ALJ Cain concluded as a matter of law that the "right of selection" of the treating physician had passed to Claimant and that Claimant had selected Dr. Busse, D.C. as the authorized treating chiropractor. ALJ Cain ordered that Dr. Busse, D.C. was an authorized chiropractic provider for purposes of Claimant's June 25, 2008 injury.

4. Claimant began treatment with Dr. Busse, D.C. on July 2, 2008 and continued treating with this provider through October 14, 2008.

5. On August 1, 2008 Claimant's counsel sent a letter addressed to the clam adjuster for Insurer. Counsel asserted that a designated provider list had not been pro-

vided to Claimant in compliance with Section 8-43-404(5)(a)(I)(A) and that Claimant therefore had the right to select the treating physician. The letter informed the Insurer that Claimant had selected Dr. David Yamamoto, M.D. as the treating physician.

6. Claimant was not referred to Dr. Yamamoto by Dr. Busse, D.C. Claimant began treatment with Dr. Yamamoto at the direction of her counsel.

7. Dr. Yamamoto began treatment of Claimant on August 27, 2008. Dr. Yamamoto continued to follow up and direct Claimant's medical treatment at visits occurring on September 9, September 30, October 28, November 11, December 1 and December 22, 2008. On September 30, 2008 Dr. Yamamoto referred Claimant to Dr. Michael Larimore, D.C. for further chiropractic care. Dr. Yamamoto made this referral because Dr. Larimore was a Level I chiropractic provider through the Division of Workers' Compensation and Dr. Busse was not.

8. Claimant treated with Dr. Larimore, D.C. from October 28, 2008 through January 14, 2009.

9. Claimant has not been required to pay for the treatment that she has received from Dr. Yamamoto and Dr. Larimore, D.C. The ALJ therefore finds, as a reasonable inference from the totality of the record evidence that the expenses for Claimant's treatment with Dr. Yamamoto and Dr. Larimore, D.C. from August 27, 2008 through January 14, 2009 have been paid by Insurer.

10. Dr. Yamamoto placed Claimant at MMI for the injury of June 25, 2008 on January 12, 2009 and assigned Claimant 4% whole person permanent impairment. Dr. Yamamoto did not place any work restrictions on Claimant. Dr. Yamamoto noted that Claimant's treatment with Dr. Larimore, D.C. had been helpful. Dr. Yamamoto did not recommend or schedule Claimant for any maintenance treatment. Dr. Yamamoto did state that Claimant should return for re-evaluation if she had any worsening of her condition.

11. Insurer filed a Final Admission of Liability on March 17, 2009 to place Claimant at MMI and admit for permanent impairment benefits. Insurer relied upon the January 12, 2009 report from Dr. Yamamoto as the basis for Claimant being at MMI and for their admission to permanent impairment benefits. Insurer admitted liability for post-MMI medical treatment provided by the authorized treating physician that is reasonable, necessary and related to the compensable injury.

12. After being placed at MMI, Claimant returned to her usual job at Employer of "bagging ribs". Claimant credibly testified, and it is found, that prior to the injury she was able to perform this job without pain or limitation. Since returning to this position, Claimant's pain has worsened and she requires more physical effort to perform the duties of the job.

13. Claimant returned to Dr. Yamamoto for re-evaluation on August 5, 2009. Claimant complained of upper back and left-sided neck pain that had been bothering

her lately, with some increase in the pain with working. Dr. Yamamoto again noted that chiropractic treatment had been effective and referred Claimant back to Dr. Larimore, D.C. for up to twelve (12) treatments.

14. Claimant was again evaluated by Dr. Yamamoto on August 26, 2009. Dr. Yamamoto noted that the chiropractic treatments had not been authorized by insurance. Dr. Yamamoto again recommended chiropractic treatment.

15. Claimant is currently receiving treatment for her low back from a fall at work on November 16, 2009. Claimant is receiving treatment including massages and medication under the direction of Dr. Laura Caton, M.D. Claimant's treatment by Dr. Caton may include chiropractic treatment in the future and Claimant remains interested in receiving this type of treatment.

16. Dr. Brian Lambden, M. D. performed a medical record review at the request of Insurer. Dr. Lambden has not examined Claimant. Dr. Lambden opined that he could not recommend further chiropractic treatment as it appeared to him that Claimant's symptoms were for the most part completely resolved at MMI. Dr. Lambden felt further chiropractic treatment was not within the Medical Treatment Guidelines of the Division of Workers' Compensation. However, Dr. Lambden stated that occasionally a few extra visits of chiropractic care can be utilized for exacerbation of symptoms. Dr. Lambden believed that there were other activities, either occupational or non-occupational, or perhaps emotional issues that were feeding into Claimant's complaints of increased pain. Dr. Lambden did not believe further chiropractic care would be considered maintenance care as he believed something else was going on to explain Claimant's increasing symptomatology. The ALJ finds Dr. Lambden's opinions to be unpersuasive.

17. Claimant has proven, by a preponderance of the evidence, that Dr. David Yamamoto, M.D. should be considered to be an ATP for her injury of June 25, 2008. Dr. Yamamoto referred Claimant to Dr. Larimore, D.C. in the normal course of treatment for Claimant's injury. Dr. Larimore, D.C. is also found to be an ATP based upon the referral from Dr. Yamamoto.

18. Claimant has proven by a preponderance of the evidence that the further treatment by Dr. Yamamoto and Dr. Larimore, D.C. beginning August 5, 2009 is reasonable and necessary to maintain Claimant's condition and is causally related to the injury of June 25, 2008.

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 prov-

ing entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

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

21. 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).

22. However, respondents may by their conduct or acquiescence waive the right to object to a change of physician. A claimant "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, 170 (Colo. App. 1985); *see also, Brickell v. Business Machines, Inc.,* 817 P.2d 536 (Colo. App. 1990).

23. 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).

24. 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).

25. The need for medical treatment may extend beyond the point of maximum medical improvement where claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury or to prevent further deterioration of his condition. *Grover v. Industrial Commission*, 759 P.2d 705

(Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995). An award for *Grover* medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that claimant is actually receiving medical treatment. *Holly Nursing Care Center v. Industrial Claim Appeals Office,* 992 P.2d 701 (Colo. App. 1999). The claimant must prove entitlement to *Grover* medical benefits by a preponderance of the evidence. *Lerner v. Wal-Mart Stores, Inc.,* 865 P.2d 915 (Colo. App. 1993). An award of *Grover* medical benefits should be general in nature, subject to Respondents' right to contest compensability, reasonableness and necessity. *Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003). Post-MMI medical benefits are available to relieve the effects of the injury or prevent deterioration of the claimant's otherwise stable condition. *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995).

26. The "law of the case" doctrine is a discretionary rule, which provides that issues that have been litigated and decided ordinarily should not be relitigated in the same proceeding. *Verzun v. Rouse,* 660 P.2d 1301 (Colo. App. 1982). The doctrine applies to decisions of law rather than to the resolution of factual questions. *Mining Equipment v. Leadville Corp.,* 856 P.2d 81, 85 (Colo. App. 1993).

27. Applying the "law of the case" doctrine, the ALJ concludes from the prior order of ALJ Cain that Claimant initially selected Dr. Busse, D.C. as her authorized provider for the June 25, 2008 injury, as ordered by ALJ Cain. Claimant was not referred to Dr. Yamamoto by Dr. Busse, D.C. and cannot change physicians without permission of the Insurer or an ALJ.

28. Respondents position with respect to Dr. Yamamoto's status as an ATP is curious. At the prior hearing before ALJ Cain, Respondents attempted to argue that Dr. Yamamoto should be considered the ATP instead of Dr. Busse, D.C. Although ALJ Cain did not address this issue in his order, Respondents now attempt to take a wholly different position, i.e., that Dr. Yamamoto should not be considered an ATP because he does not stand in the chain of referral from Dr. Busse, D.C. and Claimant has not properly requested a change of physician to Dr. Yamamoto. The ALJ finds Respondents position unpersuasive.

29. The ALJ concludes that Insurer, by its conduct, has acquiesced to Dr. Yamamoto as an ATP. As found, Dr. Yamamoto provided treatment to Claimant over a considerable period of time and that treatment was paid for by Insurer. Dr. Yamamoto referred Claimant to Dr. Larimore, D. C. and that treatment was paid for by Insurer. Further, Insurer has utilized and relied upon Dr. Yamamoto's opinion in filing a Final Admission in Claimant's case. Respondents' argument that this was simply a "mistake" is not persuasive. Respondents' argument that this "mistake" is uncontested by Claimant is consistent with Claimant's position that Dr. Yamamoto should be considered an ATP.

30. As found, Claimant has proven by a preponderance of the evidence that the treatment by Dr. Yamamoto and his referral of Claimant back to Dr. Larimore, D.C. for up to twelve (12) chiropractic treatments is reasonable and necessary to maintain Claimant's condition after MMI and is related to the injury of June 25, 2008. Dr. Lamb-

den's opinion is not persuasive for several reasons. First, Dr. Lambden believes that "something else" is at work in producing Claimant's increased symptoms in August 2009 but fails to specify what that "something else" is or where it is supported in the medical records. There is no persuasive evidence that Claimant had sustained any type of intervening event or injury prior to August 2009 that might be responsible for her increased symptoms. Dr. Lambden's supposition that Claimant's increased symptoms are emotional in origin is nothing more than a supposition, and, as such is unpersuasive.

31. Respondents and Dr. Lambden refer to the Division of Workers' Compensation's Medical Treatment Guidelines in support of their position that further chiropractic care is not reasonable and necessary. The ALJ is not persuaded. An excerpt of the Treatment Guidelines was admitted into evidence as Exhibit 9. That excerpt contains the language from the Guidelines that "The recommendations in this guideline are for pre-MMI care and are not intended to limit post-MMI treatment." Thus, by their own provisions the Guidelines are not intended to be utilized in determining post-MMI treatment issues. Further, as recognized by Dr. Lambden, additional visits for chiropractic care can be utilized for exacerbations of an injury. The ALJ finds and concludes that Claimant's return to work at her usual job has exacerbated her condition to the extent that further treatment is necessary to maintain Claimant's condition. Regardless of whether Claimant has not sustained a subsequent injury for which she may receive chiropractic care in the future, Claimant has established by a preponderance of the evidence that such care was reasonable and necessary to maintain the condition related to her June 25, 2008 injury prior to the occurrence of any new injury in November 2009.

32. In light of the above findings and conclusions, the ALJ does not address the issue of whether Claimant's counsel's letter of August 1, 2009 should be considered a proper request for a change of physician. See, *Lutz v. Indus. Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000).

ORDER

It is therefore ordered that:

1. Dr. David Yamamoto, M.D. is an ATP and Dr. Michael Larimore, D.C. is an authorized chiropractic provider for purposes of Claimant's June 25, 2008 injury.

2. Insurer shall pay the expenses for Claimant's treatment by Dr. Yamamoto beginning August 5, 2009 and for up to twelve (12) chiropractic visits with Dr. Larimore, D.C.

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

All matters not determined herein are reserved for future determination.

DATED: December 29, 2009

Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-669-749

ISSUES

The issues determined herein are medical benefits for right shoulder surgery and maximum medical improvement ("MMI").

FINDINGS OF FACT

1. On November 26, 2005 claimant, who was then 72 years old, sustained admitted industrial injuries when she slipped and fell forward onto her outstretched hands and knees in the break room of the employer.

2. On December 6, 2005 claimant signed and dated a Workers' Claim for Compensation that describes that claimant was injured when she "tripped over chair leg. Went flat on front side of me. Hitting-breast. Lt. shoulder and rt. knee." Claimant did not indicate in her Claim for Compensation that she injured her right shoulder as a result of the fall.

3. Claimant submitted a handwritten statement documenting her accident to the employer. The handwritten statement indicates that claimant "tripped, fell flat on right knee and rt. bust, hit left shoulder and hurt left pinky." Claimant did not indicate that she injured her right shoulder.

4. On November 26, 2005, claimant's primary care provider, Dr. Mark Fraley, D.O., examined claimant, who reported that she "hit her right breast, twisted her right knee and right foot, and hit her left shoulder and left pinky on the floor when she fell." There is no mention in the report of claimant reporting right shoulder pain.

5. On November 28, 2005 claimant was evaluated by authorized treating provider, Dr. Rosemary Greenslade, M.D. Dr. Greenslade's report indicates that claimant only reported pain in her right knee and left shoulder.

6. On December 1, 2005 claimant was evaluated by authorized treating provider, Dr. Suzanne Malis. Claimant continued to describe only right knee discomfort and left shoulder pain with limited movement.

7. On December 5, 2005 claimant followed up with Dr. Greenslade and reported left shoulder and right knee pain. At a follow up evaluation with Dr. Malis on December 5, 2005, claimant again only reported pain complaints to her right knee and left shoulder.

8. On December 9, 2005 claimant was evaluated by orthopedic surgeon, Dr. Timothy O'Brien. Claimant described to Dr. O'Brien that as a result of the work-related trip and fall incident, she injured her right knee and left shoulder. Dr. O'Brien had previously treated the claimant for degenerative arthritis in her right knee, for which she had undergone two total knee replacements. Dr. O'Brien x-rayed claimant's right knee and opined that claimant had sustained a contusion with a hematoma to the right knee, but otherwise had not sustained any appreciable damage to the pre-existing right total knee replacement. Dr. O'Brien's report does not indicate that the claimant described pain complaints in her right shoulder.

9. On December 9 and 20, 2005 claimant returned to Dr. Malis for follow up of her right knee and left shoulder complaints. There is no indication in the reports stemming from these evaluations that the claimant reported right shoulder pain.

10. Dr. Malis referred claimant for a magnetic resonance image ("MRI") of the left shoulder and referred her to Dr. Wiley Jinkins, an orthopedic surgeon.

11. On January 4, 2006 claimant returned to Dr. O'Brien and described significant improvement in her right knee symptoms. Dr. O'Brien's report does not indicate that the claimant described pain complaints in her right shoulder.

12. On January 30, 2006 claimant underwent her initial evaluation with Dr. Jinkins. Dr. Jinkins' report indicates that claimant described injuries to her "left knee, right knee, and left shoulder." Dr. Jinkins reviewed the MRI of the claimant's left shoulder and recommended that she proceed with left shoulder surgery for repair of a large rotator cuff tear documented by MRI. There is no indication in Dr. Jinkins' report that the claimant reported right shoulder pain.

13. On February 6, 2006 claimant consulted with Dr. Malis for ongoing complaints of right knee and left shoulder pain. Dr. Malis' report does not indicate that the claimant reported right shoulder pain.

14. Claimant underwent surgery for the left shoulder by Dr. Jinkins on February 22, 2006. On February 28, 2006 claimant followed up with Dr. Jinkins for a post-surgical consult. Dr. Jinkins' report does not indicate that claimant reported right shoulder pain complaints.

15. Claimant's left shoulder was immobilized for approximately six weeks post-surgery. Claimant had made limited use of the left arm before the surgery. She gradually increased use of the left arm beginning in approximately April 2006. Claimant had been on narcotic pain medications since the work injury and remained on them until the summer of 2006.

16. Claimant followed up again with Dr. Malis on March 13, 2006, April 10, 2006, and May 1, 2006. Claimant did not report any pain complaints in her right shoulder at any of these evaluations.

17. On March 27, 2006 and May 26, 2006 claimant returned to Dr. Jinkins for follow up evaluations. Again, claimant did not report right shoulder pain at either of these evaluations. In his May 26, 2006 report, Dr. Jinkins noted that claimant was complaining of left elbow and wrist pain. Dr. Jinkins noted in his report that he performed an injection in the claimant's wrist and gave her a splint for her thumb.

18. Claimant returned to Dr. Malis on June 1, 2006 and July 10, 2006. Again, claimant did not report at either of these evaluations that she was experiencing right shoulder pain.

19. On June 23, 2006 claimant returned to Dr. Jinkins and again did not describe pain complaints in her right shoulder. Dr. Jinkins noted in his June 23, 2006 report that the claimant was having more problems with her left elbow than with her left shoulder and that she was wearing a brace for her left wrist. Dr. Jinkins recommended that claimant proceed with an MRI of her elbow and requested that she return for a follow up after the MRI of her elbow was completed.

20. On July 10, 2006 claimant was evaluated by Dr. Jinkins. At this evaluation, claimant described that she was having problems with her right shoulder, which she attributed to overuse due to her inability to fully utilize her left shoulder. Dr. Jinkins noted a positive impingement test. Dr. Jinkins' report notes that the claimant described having surgery to her right shoulder 25 years previously. Dr. Jinkins noted in this report that the claimant also complained of left wrist pain, that she was wearing an immobilizer on her thumb, and that claimant had undergone an MRI of her left elbow, which revealed findings consistent with bursitis.

21. Later on July 10, 2008, Dr. Malis reexamined claimant, but recorded no complaints of right shoulder pain.

22. On July 28, 2006 claimant underwent her initial evaluation with authorized treating provider, Dr. Darrel Quick. Dr. Quick's report notes that the claimant described experiencing the onset of right shoulder pain at the time of the initial fall. Dr. Quick noted in his report that he was evaluating claimant without access to her medical file and that his report documented the claimant's subjective reports regarding her medical history. Dr. Quick diagnosed right shoulder pain, which he thought was possibly compensatory.

23. On August 21, 2006 claimant returned to Dr. Jinkins and described that her left shoulder was doing fine and that her primary complaints were related to her left wrist. Dr. Jinkins further opined that he agreed with the recommendation from Dr. Quick to refer claimant for an MRI of her thumb. Dr. Jinkins' report does not reference that claimant reported right shoulder pain complaints.

24. On September 1, 2006, Dr. Quick reexamined claimant and diagnosed bilateral shoulder myofascial pain right worse than left.

25. Claimant returned to Dr. Jinkins on September 18 and October 16, 2006. At these evaluations, Dr. Jinkins evaluated the claimant for pain complaints and injury to her left wrist, left shoulder, and left thumb. Neither of the reports from these evaluations references that the claimant reported right shoulder pain.

26. On November 10, 2006, Dr. Quick reexamined claimant and diagnosed shoulder girdle and cervical spine pain.

27. On November 13, 2006 Dr. Jinkins discharged claimant from care to follow up as needed. Dr. Jinkins noted in his report that the claimant was continuing to experience left wrist pain and that her left shoulder pain had improved significantly. The report does not indicate that claimant complained of right shoulder pain.

28. On December 8, 2006 claimant presented to Dr. Quick complaining of thumb pain. Dr. Quick's report does not indicate that claimant reported right shoulder pain.

29. On January 12, 2007 claimant presented to Dr. Quick complaining of left shoulder, right wrist, and right thumb pain. Dr. Quick's report does not indicate that claimant reported right shoulder pain. Dr. Quick referred only to "shoulder girdle and cervical spine pain possibly related to left shoulder injury and subsequent surgery."

30. On February 9, 2007, claimant complained to Dr. Quick about bilateral arm pain. Dr. Quick suspected basilar joint arthrosis in the right thumb. He continued to note, "shoulder girdle and cervical spine pain possibly related to left shoulder injury and subsequent surgery."

31. On March 2, 2007 claimant presented to Dr. Quick complaining of left wrist and thumb pain. Dr. Quick's report does not indicate that claimant reported right shoulder pain, but he specified "left shoulder girdle and cervical spine pain possibly related to the left shoulder injury and subsequent surgery."

32. On April 6, 2007 claimant was evaluated by Dr. Quick and described continued complaints of pain in her left hand and wrist. Dr. Quick diagnosed claimant with left shoulder girdle and cervical spine pain, possibly related to left shoulder surgery. The report does not indicate that the claimant described right shoulder pain.

33. On June 22, 2007, Dr. Quick reexamined claimant, who complained primarily of left thumb pain. She reported that she was compensating more with her left arm and was still experiencing pain in her left elbow, left shoulder, and left shoulder girdle. She also reported that she was compensating more with her right arm and suffering pain, especially right thumb pain. Dr. Quick noted that the right arm pain was possibly related to compensation for the left arm problems.

34. On September 6, 2007 claimant underwent surgery on her left thumb performed by authorized provider, Dr. Conyers.

35. On January 21, 2008 claimant returned to Dr. Quick who diagnosed her with "left shoulder girdle and cervical spine pain, stable." The report does not indicate that the claimant described right shoulder pain.

36. On February 19, 2008 Dr. Conyers performed surgery on claimant's right thumb.

37. On March 31, 2008 claimant returned to Dr. Quick and reported a chief complaint of left knee pain. Claimant also described soreness and "muscular knots" in her bilateral shoulders. Dr. Quick diagnosed claimant with "gradual recurrence of bilateral myofascial shoulder girdle pain, which previously responded well to massage therapy."

38. On May 12, 2008 claimant returned to Dr. Quick and described pain and stiffness in her bilateral shoulders and neck, which was "responsive to massage therapy." Dr. Quick diagnosed claimant with "bilateral myofascial shoulder girdle and cervical spine pain."

39. On June 16, 2008, Dr. Quick noted that the insurer had approved referral to Chiropractor Polvi for treatment of the neck and bilateral shoulder girdles.

40. On July 1, 2008, Chiropractor Polvi treated claimant. By July 22, 2008, claimant reported 85% improvement and Dr. Polvi discharged her.

41. On August 4, 2008, Dr. Quick reexamined claimant, who reported improvement with chiropractic care, but increased pain after the chiropractic treatment stopped. Dr. Quick referred claimant for additional chiropractic and massage therapy treatment.

42. On August 14, 2008 Carlos Cebrian, M.D. performed a medical records review at the request of the respondents. Dr. Cebrian opined that claimant had reached MMI for all work-related conditions. Dr. Cebrian opined that as a result of the November 26, 2005 accident, claimant had sustained the following injuries: a left rotator cuff tear, a right knee contusion, a right breast contusion, a left foot sprain, and a left 5th finger sprain. Dr. Cebrian opined that any injuries to claimant's left knee, left elbow, right arm, left ankle, 4th metatarsal fracture and thoracic spine were not causally related to claimant's November 26, 2005 industrial accident.

43. On September 22, 2008 Dr. Quick determined that claimant was at MMI for her industrial injuries. Dr. Quick opined in his report that he had previously noted complaints of shoulder girdle and cervical myofascial pain, which he suspected may be referred from her left shoulder rotator cuff tear. Dr. Quick noted in his report that he had reviewed a copy of Dr. Cebrian's August 14, 2008 report, which provided a thorough records review of claimant's medical history predating her date of injury in this claim. Dr. Quick noted in his report that there were some "additional issues beyond those expressed by Dr. Cebrian" which he felt were work-related. Dr. Quick concluded that after having information regarding the claimant's medical history that it was his opinion that

claimant did not suffer from primary disorders to the cervical spine or right shoulder girdle that were causally related to her industrial accident. Dr. Quick assigned the claimant an impairment rating for injuries to her right thumb, right wrist, and left wrist. This assessment was in contrast to Dr. Cebrian's opinion that these injuries were not causally related to the industrial accident. Dr. Quick opined that claimant did not sustain any impairment or injuries to her left knee. Dr. Quick opined that the injuries related to claimant's November 26, 2005 industrial accident were the following: left rotator cuff tear, left wrist injury, right wrist, right thumb pain, left elbow contusion, right knee contusion, and a minor exacerbation of pre-existing chronic depression.

44. On October 21, 2008, respondents filed a Final Admission of Liability ("FAL") consistent with the findings of Dr. Quick. Claimant objected to the FAL and requested a Division Independent Medical Examination ("DIME"). Dr. Velma Campbell was selected to perform the DIME.

45. On November 17, 2008, claimant reported to Dr. Quick that she had neck and bilateral shoulder pain that she attributed to stopping chiropractic treatment.

46. On December 29, 2008 claimant presented to Dr. Quick complaining of increased right shoulder pain. Dr. Quick noted that claimant had mild to moderately limited right shoulder range of motion. Dr. Quick did not alter his previous assessment regarding causation of the claimant's injuries.

47. On February 9, 2009, Dr. Quick again noted bilateral shoulder girdle pain.

48. On March 5, 2009, Dr. Campbell performed the DIME. Claimant reported a history of injury to her bilateral shoulders and bilateral knees. She reported a history of right thoracic outlet ("TOS") surgery 25 years earlier with some residual right arm symptoms. Claimant reported recent increase in right shoulder symptoms, which Dr. Campbell thought might be due to bursitis. Dr. Campbell agreed with Dr. Quick's determination that claimant reached MMI on September 22, 2008. Dr. Campbell determined that the injuries related to claimant's November 26, 2005 industrial accident were contusions and sprains to the right knee, left shoulder, bilateral hands, right breast, and left 5th digit, as well as situational depression, aggravation of degenerative joint disease and injuries to bilateral thumbs, left shoulder rotator cuff tear and right knee contusion. Dr. Campbell determined that claimant's osteoarthritis to her left knee and need for a left knee arthroplasty were not causally related to the November 26, 2005 industrial accident. Dr. Campbell further determined that injuries to claimant's bilateral feet, bilateral elbows, cervical and lumbar spine, and persisting chronic depression and probable personality disorder were not causally related to claimant's November 26, 2005 industrial accident. Dr. Campbell opined that claimant's right arm and shoulder girdle pain were not causally related to her industrial accident. She concluded that claimant suffered only a temporary exacerbation of myofascial pain syndrome.

49. On March 12, 2009 Dr. Cebrian performed an IME for respondents. Dr. Cebrian noted in his report that the claimant's chief complaints were left knee pain, right shoul-

der pain, and cervical spine pain. Dr. Cebrian's report indicates that the claimant described that in December 2005 she had an MRI of her left shoulder and around that time period began to notice that her right arm was hurting, which she believed was a result of overcompensation following her left shoulder injury. Dr. Cebrian again opined in this report that the injuries claimant sustained as a result of the November 26, 2005 industrial accident were a left rotator cuff tear, right knee contusion, right breast contusion, left foot sprain, and left 5th finger sprain. Dr. Cebrian disagreed that claimant's injuries to her bilateral thumbs were causally related to her work accident. Dr. Cebrian again opined that claimant's left knee pain and need for a total knee replacement were not causally related to claimant's industrial accident. Dr. Cebrian indicated in his report that the claimant had a longstanding history of polyarthritis in her bilateral shoulders, bilateral knees, bilateral feet and hands and fingers. Dr. Cebrian noted that the claimant had been recently diagnosed as a diabetic and that she was therefore at higher risk of developing adhesive capsulitis in her shoulders without any injury and that claimant had a history of fibromyalgia prior to her work injury. Dr. Cebrian noted at the time of his evaluation the claimant had significantly worsened range of motion in her right shoulder, which he suspected could be related to adhesive capsulitis. Dr. Cebrian opined that although claimant had described occasional right shoulder girdle complaints, her symptomatology of right shoulder symptoms was not consistent with being causally related to the acute injury that occurred on November 26, 2005 or as a result of overcompensation from claimant's left shoulder surgery.

50. On March 30, 2009, Dr. Quick concluded that claimant's right shoulder problems were preexisting.

51. On April 29, 2009, Dr. Daniel Peterson examined claimant, who reported worsening right shoulder symptoms. Dr. Peterson's report indicates that the claimant's medical chart was not available for his review. Dr. Peterson documented that the claimant felt her right shoulder symptoms were symptomatic secondary to overuse related to her left shoulder surgery, although claimant described that now all of a sudden she was unable to raise her right arm, which she acknowledged was an "acute change" and the claimant was extremely upset. Dr. Peterson noted signs for positive impingement on the right side and referred claimant to Dr. Jinkins.

52. On May 11, 2009 claimant returned to Dr. Quick and described bilateral shoulder girdle musculature pain and right shoulder tenderness with moderately limited active range of motion. Dr. Quick reiterated his opinion in his report that he did not believe claimant's right shoulder symptoms were causally related to her work accident.

53. On May 19, 2009 claimant underwent an evaluation with Dr. Jinkins. Claimant described severe pain in her right shoulder. Claimant reported that she injured her right shoulder at the same time that she injured her left arm in the November 26, 2005 industrial accident. Dr. Jinkins referred claimant for an MRI of her right shoulder and administered an injection.

54. On May 22, 2009 claimant underwent an MRI of her right shoulder, which revealed a "tiny interstitial tear" of the supraspinatus tendon.

55. On June 16, 2009 claimant returned to Dr. Jinkins, who recommended that claimant proceed with right shoulder surgery.

56. On June 22, 2009 claimant returned to Dr. Quick, who again opined that he did not believe claimant's right shoulder injuries were causally related to her work accident.

57. On June 24, 2009 Dr. Cebrian reviewed updated medical records from Dr. Jinkins as well as claimant's MRI report regarding her right shoulder. Dr. Cebrian opined that the findings on the MRI were not caused by the claimant's November 26, 2005 fall and were additionally not caused as a result of overcompensation from the immobilization of claimant's left shoulder post surgery.

58. On June 25, 2009, the insurer denied the request by Dr. Jinkins for authorization of the right shoulder rotator cuff surgery.

59. On July 15, 2009, Dr. Jinkins wrote that claimant had reported right shoulder pain in his initial examination on January 30, 2006. Dr. Jinkins noted that claimant had been on narcotic medications due to her left shoulder and right knee injuries and that the narcotics could mask the right shoulder pain. He explained that trauma to the right rotator cuff could cause hemorrhage, which could then inflame and weaken the cuff, leading to the tear found three and one-half years later on the MRI.

60. On August 10, 2009, Dr. Cebrian wrote to disagree with Dr. Jinkins due to the temporal problems.

61. On October 13, 2009, Dr. Hugh McPherson, orthopedic surgeon, reviewed a complete set of the claimant's medical records and opined that claimant's right shoulder injuries were not causally related to her work accident. In support of his opinion, Dr. McPherson noted that claimant's report of right shoulder pain and symptomatology was significantly delayed following her November 26, 2005 industrial accident. Further, Dr. McPherson articulated that the claimant had been receiving a course of chiropractic treatment and noted an 85% improvement in her cervical, thoracic, and superior trapezius region by the end of July 2008 from manipulation therapy. Dr. McPherson noted that if the claimant's symptoms at that time had been causally related to a rotator cuff tear that it is unlikely that she would have experienced any improvement in her symptoms. Dr. McPherson opined that it would be improbable to experience a hemorrhage in the rotator cuff as a result of the November 26, 2005 fall and not have any documented symptoms in the right shoulder until five months post date of accident. Based on this delay of reported symptomatology, Dr. McPherson opined that claimant's right shoulder injuries could not be attributable to trauma.

62. Dr. McPherson further opined that he did not believe claimant's right shoulder injuries resulted from overcompensation from her left shoulder. In support of his opinion, Dr. McPherson noted that there were large gaps of time as indicated in claimant's treatment records when there were no defined symptoms that could be identified as true

rotator cuff pathology for claimant's right shoulder. Claimant did have short periods of time when she was complaining of pain in the region of her right shoulder, but Dr. McPherson opined that these complaints appeared to be myofascial. In support of this opinion, Dr. McPherson noted that claimant's pain complaints were improved as a result of physical manipulation from her chiropractor.

63. Dr. McPherson opined that claimant has a longstanding history of right shoulder pathology, which predated her date of injury in this claim. In 1995 claimant underwent an MRI of her right shoulder, which revealed tendon pathology in her right shoulder, and documented a pre-existing history of intermittent symptoms of right shoulder pain. Dr. McPherson acknowledged that the claimant may have experienced pain complaints in her right shoulder as a result of overcompensation from the immobilization of her left shoulder, but Dr. McPherson opined that there was no underlying change to the pathology in claimant's right shoulder resulting from this overcompensation. As for claimant's left knee, Dr. McPherson opined that claimant's left knee pain complaints were not causally related to the November 26, 2005 industrial accident.

64. Claimant's medical history prior to November 26, 2005 documents pre-existing injuries, degeneration, and waxing and waning pain complaints to the right shoulder. On December 23, 1980 claimant was evaluated by Lester Cramer, M.D. for pain complaints in the neck, right upper extremity and right shoulder. On November 17, 1981 claimant consulted with Gerald Pise, M.D. for neck, right shoulder, and right arm pain. On February 9, 1984 claimant was evaluated by David Roos, M.D. for pain complaints in the back of her neck and right shoulder. Dr. Roos diagnosed claimant with "severe right shoulder tendonitis." Claimant returned to Dr. Roos on February 27, 1985 and described pain in the right trapezius and right neck. Dr. Roos' report indicates that claimant had an insidious onset of right shoulder pain in 1978.

65. On July 24, 1995 Dr. Charles Ripp evaluated the claimant for right shoulder pain and arthritis. Pursuant to a referral from Dr. Ripp, on July 25, 1995 claimant underwent an MRI of her right shoulder, which revealed tendinopathy. On September 12, 1995 Dr. Ripp injected the claimant's right shoulder to relieve pain complaints. On December 6, 1995 claimant presented to the ER after she fell four to five feet from a stepstool landing on her right shoulder.

66. On March 13, 2003 claimant underwent an x-ray of her right shoulder, which revealed degenerative changes. On April 15, 2004 claimant was evaluated at Penrose Hospital and she was diagnosed with polyarthritis in her bilateral shoulders. On September 17, 2004 claimant presented to Dr. Fraley complaining of shoulder pain. Dr. Fraley noted that the claimant's abduction was limited to 90 degrees with mild to moderate pain.

67. Dr. Cebrian and Dr. Campbell testified by deposition consistent with their reports. Dr. Campbell, Dr. Cebrian, and Dr. Jinkins testified at the hearing consistent with their reports.

68. Until her deposition testimony, Dr. Campbell had not been aware that the May 2009 MRI showed a partial tear of the right rotator cuff. She admitted that claimant's age, Type III acromion, and preexisting degenerative changes could result in a right rotator cuff tear from the November 2005 fall onto her outstretched arm. Dr. Campbell, however, explained that the temporal delay in reporting symptoms in the right shoulder make it unlikely that the tear occurred at that time. She also agreed with Dr. Jinkins that trauma to the right shoulder might accelerate the degenerative process in the rotator cuff. She concluded, however, that the medical records do not provide a sufficient indication of accelerating a cuff tear in this case. She noted that the time frame of claimant's symptoms did not make it probable that overuse after the work injury led to the cuff tear. Claimant's 2006 and 2008 right shoulder pain was more likely due to myofascial pain, as demonstrated by her improvement with treatment. Consequently, Dr. Campbell determined that the right shoulder rotator cuff surgery recommended by Dr. Jinkins is not reasonably necessary to cure or relieve the effects of the work injury and claimant is at MMI for the work injury.

69. Claimant has failed to prove by clear and convincing evidence that Dr. Campbell erred in determining that claimant was at MMI for the work injury. Dr. Campbell's demeanor revealed her to be a very careful, attentive, conscientious physician witness. The contrary causation opinion by Dr. Jinkins does not demonstrate that it is highly probable or free from serious or substantial doubt that Dr. Campbell's determination is wrong. Dr. Jinkins is certainly an experienced and knowledgeable orthopedic surgeon. He could not, however, determine when claimant suffered the right cuff tear. His skill as a surgeon does not provide him with a better basis for making causation decisions in the claim. He provided a medically plausible explanation that trauma could lead to hemorrhage, which could lead to inflammation and additional degeneration of the tendon until it developed a partial tear. Dr. Jinkins admitted that claimant did not report right shoulder pain in his initial January 30, 2006 examination. Claimant reported numerous other developing symptoms, which were recorded and treated. She did not, however, report any right shoulder pain until July 2006 and that pain resolved. By November 2006 the claimant had use of her left shoulder and there was no need to overcompensate with the right shoulder for left shoulder immobilization. Claimant subsequently had left thumb surgery in September 2007 and then right thumb surgery in February 2008, which probably altered her use of her arms. She clearly had recurrent neck and bilateral shoulder girdle pain, but the chiropractic treatment in 2008 improved the symptoms. The first mention of limited range of motion in the right shoulder was not until December 29, 2008. Nobody knows how or when the right cuff tear occurred. The record evidence does not demonstrate by clear and convincing evidence that Dr. Campbell's determinations are incorrect. Claimant is at MMI for the work injury and the right rotator cuff surgery is not reasonably necessary to cure or relieve the effects of the work injury.

CONCLUSIONS OF LAW

1. Section 8-42-107(8)(b)(III), C.R.S., provides that the determination of the DIME with regard to MMI shall only be overcome by clear and convincing evidence.

Montoya v. Industrial Claim Appeals Office, 203 P.3d 620 (Colo. App. 2008); *Brownson-Rausin v. Industrial Claim Appeals Office*, 131 P.3d 1172 (Colo. App. 2005). Because the issue of MMI inherently requires a determination of whether there is a causal relationship between the claimant's condition and the industrial injury, the DIME physician's findings concerning causation must also be 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 proven 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. Campbell, determined that claimant was at MMI. Consequently, claimant must prove by clear and convincing evidence that this determination is incorrect.

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

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

Reasonable and necessary treatment and diagnostic procedures are a prerequisite to MMI. MMI is largely a medical determination heavily dependent on the opinions of medical experts. *Villela v. Excel Corporation*, W.C. Nos. 4-400-281, 4-410-547, 4-410-548, & 4-410-551 (Industrial Claim Appeals Office, February 1, 2001). As found, claimant has failed to prove by clear and convincing evidence that the MMI determination by the DIME is incorrect.

ORDER

It is therefore ordered that:

1. Claimant's claim for medical benefits in the form of authorization for the right shoulder surgery by Dr. Jinkins is denied and dismissed.

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

DATED: December 30, 2009 Martin D. Stuber

Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-657-188

ISSUES

Whether Claimant's Petition to Re-Open on the basis of change of condition should be granted.

FINDINGS OF FACT

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

1. Claimant sustained an admitted injury to her back on June 16, 2005. At the time of her injury Claimant was President of Employer, a homeowner's association.

2. Following the injury, Dr. Jill Castro, M.D. became Claimant's ATP for the June 16, 2005 injury.

3. Dr. Castro placed Claimant at MMI as of September 20, 2006. At MMI, Dr. Castro assigned Claimant 20% whole person impairment. Dr. Castro recommended maintenance medical treatment including follow up visits with the physician to address any pain flare-ups or medication issues.

4. Insurer filed a Final Admission of Liability on September 10, 2007 admitting to the 20% whole person impairment in accordance with Dr. Castro's opinion and admitting for medical treatment after MMI.

5. Claimant returned to Dr. Castro on October 27, 2006 noting a pain flare in the right flank region. Dr. Castro opined that Claimant remained at MMI.

6. Dr. Castro authored a report dated December 7, 2006 clarifying Claimant's permanent work restrictions. In this report, Dr. Castro stated that Claimant may have flare-up days.

7. Claimant returned to Dr. Castro on January 31. 2007 because of increased back pain. Dr. Castro continued Claimant on her previous restrictions.

8. Dr. Castro re-evaluated Claimant on April 17, 2007. Dr. Castro noted that Claimant had been evaluated by Dr. Douglas Wong, M.D. who did not feel Claimant had a surgical spine. Dr. Castro suggested Claimant participate in a daily exercise program.

9. Dr. Castro evaluated Claimant on August 30, 2007 and noted that she continued with chronic back pain. Dr. Castro recommended continued follow-up visits

and medications. Dr. Castro evaluated Claimant on October 21, 2008 and noted that Claimant continued to experience chronic lower back pain and that Claimant remained on medications for pain management. Dr. Castro stated, and it is found, that Claimant had no other new injuries or abnormalities that would contribute to her current symptoms.

10. Claimant testified that her condition worsened in March 2009 as she felt she was experiencing more pain than at the time she was placed at MMI. Claimant testified that she was now on different medications than at the time of MMI and that her daily usage of medications had increased since MMI.

11. Claimant filed a Petition to Re-Open based upon change in medical condition dated July 10, 2009. In support of her Petition to Re-Open Claimant attached a March 18, 2009 report from Dr. Castro.

12. Dr. Castro saw Claimant for follow-up on March 18, 2009. Dr. Castro noted that Claimant continued to struggle with chronic low and mid back pain. Dr. Castro noted that Claimant's pain increased with increase in activities. Dr. Castro's assessment was: "Continued chronic back pain with underlying degenerative disc changes."

13. Dr. Castro again evaluated Claimant on August 19, 2009 and noted that she has continued to struggle with chronic low back pain. Dr. Castro reviewed recent X-rays and diagnostic studies and stated that they did not show any significant change with regard to degenerative changes in the lumbosacral spine. Dr. Castro's assessment included: "History of chronic lumbar hypertonicity with previous history of trauma." Dr. Castro opined, and it is found, that Claimant did not require any surgical intervention for her back at that point. Dr. Castro opined that Claimant remained on medical maintenance treatment and that her MMI status had not changed.

14. Claimant was evaluated by orthopedist Dr. Hugh McPherson, M.D. on October 21, 2009. Dr. McPherson reviewed a significant amount of medical records concerning Claimant's past medical treatment and surgery for the injury of June 16, 2005. Dr. McPherson did not have a clear indication as to the manner in which Claimant's symptoms were worsening it appeared that Claimant had had ongoing low back pain since her injury. Dr. McPherson opined, and it is found, that the records indicated that Claimant's lumbar spine did not show significant degenerative change and that Claimant did not present as an appropriate candidate for surgical intervention on her lumbar spine. Dr. McPherson opined that Claimant remained at MMI and that the maintenance therapy measures that had been followed remained reasonable and necessary.

15. At the request of Respondents Claimant was evaluated by Dr. Henry Roth, M.D. on October 30, 2009. Dr. Roth performed an extensive review of the medical records from Claimant's treatment for the work injury and also physically examined Claimant. Claimant stated to Dr. Roth that basically she was the same but was not getting better and was using more pain medication. Dr. Roth opined that Claimant remained at MMI and that there was no clinically appreciable worsening of condition.

16. Dr. Roth testified at hearing that although Claimant is currently taking more medication it is the same type of medication that she was prescribed at the time of MMI. Dr. Roth further testified that adjustment of medications if part of maintenance treatment and that it is expected that chronic pain will "wax and wane". Dr. Roth opined that there was nothing else medically to provide to Claimant for her condition. Dr. Roth admitted that his range of motion measurements may result in an increased impairment rating but that range of motion is variable from one examination to the next.

17. The ALJ finds the opinions of Dr. Castro, Dr. McPherson and Dr. Roth as to Claimant's MMI status to be credible and persuasive. Claimant remains at MMI for the injury of June 16, 2005.

18. Claimant has failed to prove by a preponderance of the evidence that she has sustained a change in her physical condition related to the compensable injury of June 16, 2005. The opinions of Dr. Castro, Dr. McPherson and Dr. Roth are credible and persuasive to establish that Claimant has not suffered a change or worsening of her physical condition sufficient to support a re-opening.

19. Claimant continues to receive reasonable and necessary maintenance medical treatment under the direction of her ATP, Dr. Castro, which is being paid for by Insurer.

20. Claimant has failed to carry her burden of proof to show the necessary elements for re-opening.

CONCLUSIONS OF LAW

21. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

22. 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).

23. 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 ac-

tions; 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).

24. Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. The claimant shoulders the burden of proving her condition has changed and her entitlement to benefits by a preponderance of the evidence. Section 8-43-201; *Berg v. Industrial Claim Appeals Office,* 128 P.3d 270 (Colo. App. 2005); *Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to a change in the claimant's physical or mental condition that can be causally related to the original injury. *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082 (Colo. App. 2002); *Chavez v. Industrial Commission,* 714 P.2d 1328 (Colo. App. 1985). Reopening is warranted if the claimant proves that additional medical treatment or disability benefits are warranted. Reopening is not warranted if once reopened, no additional benefits may be awarded. *Richards v. Industrial Claim Appeals Office,* 996 P.2d 756 (Colo. App. 2000); *Dorman v. B & W Construction Co.,* 765 P.2d 1033 (Colo. App. 1988).

25. Reopening is not required based upon a worsened condition whenever evidence shows an increased impairment rating following MMI. *Heinicke v. Indus. Claim Appeals Office,* 197 P.3d 220 (Colo. App. 2008). No statutory limitation exists on the number of times a claimant may petition to re-open a claim. *Graden Coal Co. v. Ytuarralde,* 137 Colo. 527, 328 P.2d 105 (1958).

26. As found, Claimant has failed to sustain her burden of proof for reopening based upon a change in condition. The credible and persuasive opinion of her ATP, Dr. Castro, supported by the further credible and persuasive opinions of Dr. McPherson and Dr. Roth, is that Claimant remains at MMI. As opined by Dr. Roth, and supported by the reports of Dr. Castro and Dr. McPherson, Claimant has a chronic back pain condition that can at times be expected to increase in severity. This increase in pain does not, by itself, show that Claimant has had a change in condition sufficient to support reopening. Similarly, that Claimant requires more or different medications at this time for her chronic pain condition does not mean that Claimant's underlying condition has changed. The reports and opinions of Dr. Castro, Dr. McPherson and Dr. Roth all indicate that no change in Claimant's underlying condition has occurred. And, although Dr. Roth conceded in his testimony that his range of motion measurements would support a higher impairment rating (by 2%) than what was assigned by Dr. Castro at MMI, this does not require the ALJ to reopen the claim.

27. Further, the ALJ concludes that reopening is not warranted here as no additional benefits can be awarded. Insurer admitted to medical benefits after MMI and those benefits continue to be provided to Claimant under the care of her ATP, Dr. Castro. Claimant has not persuasively identified any additional medical treatment that could be provided to her or any medical treatment that has been denied by Respondents. Thus, even if reopened, there would be no additional medical treatment to be awarded

other than the treatment Claimant is already receiving at the direction of her ATP and which has been admitted to and is being paid for by Respondents.

ORDER

It is therefore ordered that:

1. Claimant Petition to Re-Open dated July 10, 2009 is denied and dismissed.

DATED: December 30, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-777-652

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that the insurer is subject to penalties under § 8-43-304(1), C.R.S., because it dictated medical treatment in violation of § 8-43-503(3), C.R.S.?

¬ Was the claimant's Application for Hearing deficient under § 8-43-304(4), C.R.S., because it did not specifically plead the grounds on which the penalty was sought?

FINDINGS OF FACT

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

At hearing, the parties stipulated to the resolution of certain issues that were then pending. The parties stipulated that effective November 1, 2009, the claimant's average weekly wage shall be increased to $316.79 per week based on COBRA health insurance benefits. The parties stipulated that the claimant is entitled to a general award of ongoing medical benefits after maximum medical improvement, subject to the respondents' right to contest the reasonableness and necessity of specific treatments. The parties stipulated that the claimant is not responsible for the payment of medical bills presented to Colorado Rehabilitation and Occupational Medicine.

On September 19, 2008, the claimant sustained a low back injury in the State of Kansas while working for the employer. The claimant returned to Colorado where Dr. Eric Tentori, D.O., became an authorized treating physician (ATP).

The claimant credibly testified that during the course of treatment Dr. Tentori referred the claimant to Dr. Barry Ogin, M.D. The ALJ finds that this referral occurred in the normal progression of authorized treatment, and infers from the medical records of both physicians that the referral was for the purpose of diagnosing, evaluating, and treating the claimant's industrial injury. In connection with the referral from Dr. Tentori, Dr. Ogin examined the claimant on December 5, 2008. Dr. Ogin noted that the claimant had undergone an MRI that revealed a small disc protrusion at L5-S1 "that may be causing some L5-S1 nerve root irritation," and he recommended the claimant try a one-time epidural steroid injection. Dr. Ogin also indicated to the claimant that he needed to "get stronger" and directed the claimant to continue with his exercise program.

On December 29, 2009, Dr. Tentori noted the claimant was scheduled to see Dr. Ogin later in the day, and that he was "awaiting specialist recommendations."

On December 29, 2008, Dr. Ogin noted that he intended to set the claimant up for "an electrodiagnostic evaluation to see if he has any physiologic evidence of radiculopathy." On December 29, 2008, Dr. Ogin issued a script for an EMG to rule out radiculopathy. Dr. Ogin also noted that the claimant had undergone an epidural steroid injection, but this had not provided significant relief of the claimant's symptoms.

The evidence in this case contains a series of computer-generated documents bearing the title "Claim Notes." Although respondents' counsel initially objected to these notes on grounds of "foundation" and hearsay, that objection was withdrawn and the notes were admitted without objection. The ALJ infers from the evidence in the record that these notes were authored by Ms. Sandra Shefman (Shefman). Shefman testified that she was the insurance adjuster on the claim until it was reassigned to someone else in September 2009. The notes refer to events that occurred while Shefman was still adjusting the claim in January 2009. As noted below, Shefman testified concerning her participation in some of these events, and during her testimony referred to "her" notes.

There is no credible or persuasive evidence that Dr. Ogin's December 29, 2008, script for an EMG reached the insurance adjuster, Shefman. However, the Claim Notes reflect that on January 8, 2009, "Nancy," a staff member at Dr. Ogin's office, telephoned Shefman concerning an EMG scheduled with Dr. Ogin on January 9, 2009. Ms. Shefman's note concerning this telephone conversation reflects that she advised "Nancy" that "if EMG then we would want NCV also and to have it done thru One Call; she said that it is directing care and I told her that it is for quality assurance."

Shefman credibly testified that One Call (OC) is a "gatekeeper" organization that the insurer uses for the purpose of authorizing medical providers to administer diagnostic tests such as EMG's, ultrasound examinations, and MRI's. Shefman explained that the insurer uses OC to control the "quality" of medical tests administered to claimants and to insure that the test results are sent by email to the medical providers and the insurer on the same date they are obtained. Shefman explained that OC promotes quality control of medical tests by "vetting" medical providers and the facilities where tests are performed. Shefman explained that the insurer has a policy requiring providers to go

through OC when requesting medical tests, but stated the insurer would authorize tests to be performed by some other provider if there was written documentation of a referral by an ATP.

Consistent with the Claim Notes, Shefman testified that she recalled the January 8, 2009, telephone conversation with Dr. Ogin's office. She advised Dr. Ogin's office that she would authorize the EMG through OC and directed that Dr. Ogin's office telephone OC to get clearance for the EMG.

On January 9, 2009, Dr. Ogin telephoned Ms. Shefman and left a message that, in his opinion, Ms. Shefman was dictating care by refusing to authorize the EMG. As reflected in her note of January 9, 2009, Ms. Shefman returned the call to Dr. Ogin's office and left a message with "Susan" stating that, "EMG runs through One Call is not directing care; told them not auth by them and will not be paid for if they do it, not emergency." Ms Shefman admitted in her testimony that she authored this note, that she had received the message from Dr. Ogin's office, that she returned the call and advised "Susan" that running the referral through OC was not "dictating care," and that the EMG would not be paid for because it was not an emergency.

Dr. Ogin's office note of January 9, 2009, reflects that he had scheduled the claimant for the EMG but "was not authorized to perform it." Dr. Ogin further stated that he discussed the case with Dr. Tentori and that Dr. Tentori had "sent in a referral once again for the electrodiagnostic evaluation to be performed by myself."

On January 9, 2009, the claimant returned to Dr. Tentori. Dr. Tentori noted the claimant was "examined earlier in the day by the involved physiatrist, Dr. Ogin." Dr. Tentori further stated that, "it was felt that an EMG/nerve conduction study could have [sic] performed." However, Dr. Tentori stated there "was some kind of issue regarding authorization" and it was "being looked into." Dr. Tentori then wrote a referral to Dr. Ogin for an electrodiagnostic evaluation of the left lower extremity radicular complaints, and recommendations for additional treatment. The referral for the EMG was purportedly faxed to someone named "Katherine" at the insurer.

Shefman denied that she had ever seen Dr. Tentori's January 9, 2009, written referral to Dr. Ogin. She further testified on cross-examination that she had reviewed Dr. Tentori's "chart notes" and that they contained a referral to Dr. Ogin. However she also testified that that she would not interpret Dr. Tentori's January 9, 2009, office note as a referral to Dr. Ogin for purposes of conducting an EMG study. Ms. Shefman's note from January 9, 2009, states that she received an incoming medical report from Dr. Tentori and that, "Dr. Odgin [sic] saw earlier; EMG/NCV needed, working but ER not respecting limitations." Shefman testified that she contacted Dr. Tentori's office and gave them the telephone number for OC, but did not obtain a written referral from Dr. Tentori that he wanted the EMG to be performed through OC.

Shefman admitted that her notes do not document any instance in which she requested Dr. Ogin or Dr. Tentori to provide written documentation of a referral from Dr. Ogin to Dr. Tentori.

At some date after January 9, 2009, Annabelle Ruiz (Ruiz), a representative of the claimant's attorney's law firm, contacted Shefman and advised her that Dr. Tentori had referred the claimant to Dr. Ogin for an EMG. Shefman replied that she would authorize and EMG only through OC. Ruiz advised Shefman that in her opinion Shefman was dictating care by refusing to authorize an EMG with Dr. Ogin. The exact date of this conversation is not clear from the record.

On January 21, 2009, Shefman's Claim Notes state that she had received a letter from the claimant's attorney alleging that she was denying medical care by requiring that the EMG be conducted through OC.

On January 26, 2009, Dr. Kathy McCranie, M.D., performed the EMG that Dr. Ogin originally intended to perform on January 9, 2009. The ALJ finds that this delay in the performance of the EMG is attributable to Shefman's refusal to authorize Dr. Ogin to perform the EMG unless he went through OC, and Shefman's insistence that the EMG be authorized through OC.

The claimant proved it is more probably true than not that on January 9, 2009, Shefman, while acting as the insurer's representative adjusting the claim, refused to authorize Dr. Ogin to perform the EMG on the claimant. Specifically, the ALJ finds that the weight of the evidence establishes that on January 8, 2009, Dr. Ogin's office contacted Shefman to ascertain that the insurer would authorize the EMG. However, Shefman advised Dr. Ogin's office that he was not authorized to perform an EMG without first contacting OC and securing its approval to perform the EMG. Shefman's position concerning the EMG was consistent with the insurer's policy requiring that all medical testing procedures be authorized through OC in its role as the insurer's designated "gatekeeper." On January 9, 2009, Shefman reiterated the insurer's position when she left a message with Dr. Ogin's office advising that the EMG would be authorized only if it was "run through" OC, and that the insurer would not pay for the EMG if Dr. Ogin failed to act accordance with the requirement that he procure approval from OC.

The claimant proved it is more probably true than not that by January 9, 2009, Shefman knew that Dr. Ogin was an ATP based on the referral from Dr. Tentori. Shefman acknowledged that she was privy to Dr. Tentori's "chart notes." At least by December 29, 2009, Dr. Tentori's notes refer to Dr. Ogin as the "involved physiatrist." The December 29 notes further state that the claimant had received an injection from Dr. Ogin, that the claimant was scheduled to see Dr. Ogin on December 29, and Dr. Tentori was awaiting Dr. Ogin's recommendations. The weight of the evidence establishes that Shefman refused to authorize Dr. Ogin to perform the EMG not because she doubted or questioned whether Dr. Ogin was authorized to treat the claimant's industrial injury, but because Dr. Ogin had not "gone through" OC in accordance with the insurer's "gatekeeper" policy. Indeed, Shefman never asked either Dr. Tentori or Dr. Ogin to provide a copy of a "written referral" by Dr. Tentori authorizing Dr. Ogin to perform the EMG. Further, Shefman admitted that she had no reason to doubt that Dr. Ogin was competent to perform the EMG.

The ALJ finds t the claimant proved it is more probably true than not that Shefman, as representative of the insurer, violated § 8-43-503(3), C.R.S., by dictating the "duration" of the claimant's treatment. Specifically, on January 9, 2009, Shefman refused to grant authorization to Dr. Ogin to perform the EMG. At that time Shefman knew that Ogin was an ATP. The ALJ infers that Shefman knew that refusal of authorization for the EMG and imposition of the "gatekeeper" requirement on Dr. Ogin would delay performance of the EMG. In fact, Shefman desired to delay the EMG as evidenced by her threat not to pay for it unless Dr. Ogin first contacted OC and secured its approval. There is no credible or persuasive evidence that Shefman ever explained or told Dr. Ogin that he could circumvent the "gatekeeper" procedure by providing a written referral from Dr. Tentori, and the ALJ finds that Shefman did not tell Ogin of this procedure. Shefman admitted that the Claim Notes do not document that she ever communicated such a procedure to Dr. Tentori or Dr. Ogin.

The ALJ finds that Shefman's conduct was not objectively reasonable. Shefman did not present any credible or persuasive testimony or evidence that her actions with respect to the EMG were predicated on a rational argument concerning the law or evidence. In her testimony Shefman did not point to any statute, rule or other authority that authorizes, or arguably authorizes, an insurer to require a legally designated ATP to be "vetted" by an insurer-designated "gatekeeper" prior to performing medically necessary diagnostic procedures. Neither did Shefman cite any unique factual circumstances, other than the gatekeeper policy, that would support the conclusion that Dr. Ogin was not authorized to perform the EMG.

The ALJ finds that the claimant proved it is more probably true than not Shefman's conduct was in violation of § 8-43-503(3). The claimant proved it is more probably true than not that Shefman dictated the duration of the claimant's treatment by delaying the medically necessary EMG requested by ATP Ogin. By imposing the requirement that Dr. Ogin go through the "gatekeeper" process the duration of the claimant's treatment was lengthened.

In the respondent's position statement the insurer advances the theory that there was no violation of § 8-43-503(3) because diagnostic procedures, including the EMG prescribed by Dr. Ogin, do not constitute "treatment" for purposes of the statute. First, the ALJ finds that prior to the hearing Shefman never advanced this legal theory as a basis for refusing to authorize the EMG on January 9, 2009. Second, the ALJ finds that this theory does not constitute a rational or reasonable argument justifying the refusal to authorize the EMG.

On August 21, 2009, the claimant's counsel filed an Application for Hearing. As one of the issues counsel checked a box next to the word "Penalties." Counsel described the alleged penalty as: "Dictated care in violation of § 8-43-503(3)."

CONCLUSIONS OF LAW

The claimant seeks the imposition of penalties on the insurer, pursuant to § 8-43-304(1), C.R.S., for "dictating" the "type or duration" of medical treatment in violation § 8-

43-503(3), C.R.S. Essentially, the claimant argues that Dr. Ogin was authorized to perform the EMG, and that the insurer's refusal to authorize it on January 9, 2009, amounted to improper dictation of medical treatment within the meaning of statute. The insurer argues that the evidence demonstrates that the insurer did not dictate any facet of the care including the physician, type or duration of treatment. The respondent further argues that an EMG does not constitute "treatment" for purposes of § 8-43-503(3), but is instead a "diagnostic procedure." The ALJ agrees with the claimant.

GENERAL PRINCIPLES CONCERNING IMPOSITION OF PENALTY FOR DICTATING CARE IN VIOLATION OF SECTION 8-43-503(3), C.R.S.

As the moving party, the claimant bears the burden of proof by a preponderance of the evidence to establish the right to penalties under § 8-43-304. *Pioneer Hospital v. Industrial Claim Appeals Office,* 114 P.3d 97 (Colo. App. 2005); § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

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

The question of whether the insurer's conduct was objectively reasonable ordinarily presents a question of fact for the ALJ. *Pioneers Hospital v. Industrial Claim Appeals Office,* 114 P.3d 97 (Colo. App. 2005). A party establishes a prima facie showing of unreasonable conduct by proving that an insurer violated the Act or a rule of procedure. If the claimant makes such a prima facie showing the burden of persuasion shifts to the insurer to show its conduct was reasonable under the circumstances. *Pioneers Hospital v. Industrial Claim Appeals Office, supra, Human Resource Co. v. Industrial Claim Appeals Office,* 984 P.2d 1194 (Colo. App. 1999).

POOF OF VIOLATION OF ACT AND REASONABLENESS OF CONDUCT

The claimant contends the insurer is subject to penalties under § 8-43-304(1) because the refusal of Shefman to authorize an EMG to be performed by Dr. Ogin violated § 8-43-503(3), a provision of the Act. That statue provides as follows:

> Employers, insurers, claimants, or their representatives shall not dictate to any physician the type or duration of treatment or degree of physical impairment. Nothing in this subsection (3) shall be considered to abrogate any managed care or cost containment measures authorized in articles 40 to 47 of this title.

The ICAO has held that § 8-43-503(3) precludes an insurer or its representative from "issuing commands to a treating physician concerning the type or duration of treatment to be provided to the claimant." *Williams v. City of Colorado Springs,* W.C. No. 4-565-576 (ICAO February 15, 2008). Evidence that the conduct of the insurer or its representative influenced an ATP to "engage in a specific course of conduct because of the actions of the respondents," or that treatment "was delayed or that course of treatment was altered because of the actions of the respondents" may be considered in determining whether treatment was dictated. *Gianzero v. Wal-Mart Stores, Inc.,* W.C. no. 4-669-749 (ICAO July 14, 2009). Further, an insurer's determination that a referral was not authorized might form the basis for a finding that the insurer dictated the "duration" of treatment. *Williams v. City of Colorado Springs, supra.*

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).

It is possible for an ATP to refer a claimant to another medical provider for a limited examination or course of treatment without the provider also becoming an ATP in the overall sense. *See Kilwein v. Industrial Claim Appeals Office,* 198 P.3d 1274 (Colo. App. 2008). Such limited referrals may occur when the purpose of the examination is limited to issuing an impairment rating or obtaining an opinion relevant to pending litigation. *See* § 8-43-404(1), C.R.S. However, if in the normal progression of authorized treatment an ATP refers the claimant to a specialist for the purposes of examination, diagnosis, and treatment the specialist becomes an ATP authorized to "treat" the claimant. *Cabela v. Industrial Claim Appeals Office,* 198 P.3d 1277 (Colo. App. 2008); *Town of Ignacio v. Industrial Claim Appeals Office, supra.*

As determined in Findings of Fact 18 through 20, the ALJ concludes that the insurer, through adjuster Shefman, violated § 8-43-503(3) by dictating the "duration" of the claimant's treatment. As found, Shefman knew that Dr. Ogin was an ATP because he was treating the claimant on referral from Dr. Tentori. Indeed, Shefman has never actually disputed that Ogin was, in a legal sense, an ATP. As an ATP, Ogin was authorized to provide treatment and receive payment from the insurer. However, Shefman unilaterally attempted to modify Dr. Ogin's status as an ATP by dictating that before he performed the EMG he was required to go through "vetting" by OC, the insurer's "gatekeeper." Shefman knew that by imposing this policy on Dr. Ogin the performance of the EMG would be delayed, and consequently so would the claimant's treatment. Nevertheless, Shefman required Dr. Ogin to adhere to the "gatekeeper" policy or face the consequence that he would not be paid for performing a test that he believed was reasonable and necessary to diagnose the claimant's condition. In so doing, the ALJ concludes that Shefman effectively commanded Dr. Ogin to take an action that Dr. Ogin was not legally required to take in order to secure payment for the EMG. In so doing Shefman prolonged the duration of the claimant's treatment by influencing Dr. Ogin not to perform the EMG on January 9, 2009, as scheduled.

As determined in Finding of Fact 21, Shefman did not persuasively or credibly testify that she had any rational or reasonable basis for believing there was a legal justification for refusing Dr. Ogin, an ATP, permission to proceed with an EMG before he underwent the vetting process with the "gatekeeper." Neither did Shefman cite any unique factual circumstances, other than the gatekeeper policy, that would support the conclusion that Dr. Ogin was not authorized to perform the EMG. Therefore, the ALJ concludes Dr. Ogin was legally "authorized" to perform the EMG without "going through OC," and to receive pay for such treatment. The ALJ concludes there is not any rational or reasonable basis for Shefman's action in refusing to authorize the EMG on January 9, 2009.

In the respondent's position statement the insurer advances the theory that there was no violation of § 8-43-503(3) because diagnostic procedures, including the EMG prescribed by Dr. Ogin, do not constitute "treatment" within the meaning of the statute. The insurer asserts that the EMG "was performed for diagnostic purposes only and did not provide treatment to cure and relieve from the work injury."

First, the ALJ notes that Shefman never advanced this legal theory as a justification for refusing to authorize the EMG on January 9, 2009. Second, even if Shefman had justified her actions based on this theory, the ALJ concludes it does not constitute a rational or reasonable argument that Shefman was not violating § 8-43-503(3).

Statutes should be interpreted in a manner to give effect to the legislative intent. Consequently, the words and phrases in a statute should be given their plain and ordinary meanings without resort to forced, subtle or strained interpretations. *Jones v. Industrial Claim Appeals Office,* 87 P.3d 259 (Colo. App. 2004). The statutory scheme should be read a whole and to give consistent, harmonious, and sensible effect to all its parts. *Peregoy v. Industrial Claim Appeals Office,* 87 P.3d 261 (Colo. App. 2004). Stat-

utes pertaining to the same subject matter should be construed together. *Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176 (Colo. App. 2002).

Section 8-42-101(1)(a), C.R.S., provides as follows:

> Every employer, regardless of said employer's method of insurance, shall furnish such medical, surgical, dental, nursing, and hospital treatment, medical, hospital, and surgical supplies, crutches, and apparatus as may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee of the effects of the injury."

This statute has not been interpreted as distinguishing between medical "treatment" that tends to cure or relieve symptoms or pathology (such as surgery or medications), and medical "treatment" (such as x-rays and EMG's) performed to identify the claimant's medical condition and clarify what specific procedures are likely to cure or relieve the effects of the injury. As a general matter our courts have held that medical "treatment" for purposes of § 8-42-101(1)(a) includes expenses for "medical or nursing treatment or incidental to obtaining such medical or nursing treatment," provided the expenses are "reasonably needed to cure and relieve the effects of the injury and related to claimant's physical needs." *See Bellone v. Industrial Claim Appeals Office,* 940 P.2d 1116 (Colo. App. 1997) (holding child care expenses constituted medical treatment under facts of the case). Moreover, the cases suggest that medical "treatment" encompasses both diagnostic and curative medical procedures. *See Merriman v. Industrial Commission,* 120 Colo. 400, 210 P.2d 448 (1949) (exploratory surgery held compensable even where it revealed non-industrial condition); *Public Service Co v. Industrial Claim Appeals Office,* 979 P.2d 584 (Colo. App. 1999) ("The record must distinctly reflect the medical necessity of any such treatment and any ancillary service, care or treatment as designed to cure or relieve the effects of such industrial injury."); *Villela v. Excel Corp.,* W.C. No. 4-400-281 (ICAO February 1, 2001) (reasonable diagnostic procedures are a prerequisite to MMI if they have reasonable prospect for defining claimant's condition and suggesting further treatment).

These cases interpret or imply that the term medical "treatment" encompasses both diagnostic and curative procedures that are reasonably necessary in light of the industrial injury. It is difficult to imagine that any layman or physician contemplating the ordinary meaning of the term "medical treatment" would conclude that it does not include the myriad of diagnostic examinations and tests that must necessarily be administered to arrive at a diagnosis and determine what specific therapies, medications and procedures are likely to benefit the injured worker. At a minimum diagnostic tests constitute medical "treatment" when they are incidental to the provision of therapeutic procedures. Thus, the plain and ordinary meaning of medical "treatment" includes diagnostic tests and procedures.

Finally, it would make no sense, and would contravene the principle that the Act should be read as a whole, to hold that the term "treatment" is used differently in § 8-42-101(1)(a) than it is in § 8-43-503(3). Therefore, the ALJ concludes that the word "treat-

ment" as used in § 8-43-503(3) includes reasonable and necessary diagnostic procedures designed to define the claimant's medical condition and suggest treatment. The statute does not contemplate that there is a distinction between diagnostic procedures and curative procedures as argued by the insurer, and the insurer has cited no legal authority that would support a rational or reasonable argument that such a distinction does or should exist.

The ALJ concludes the insurer violated § 8-43-503(3) by dictating the duration of the claimant's care commencing January 9, 2009, and continuing until January 26, 2009, when Dr. McCranie performed the EMG.

SPECIFICITY OF REQUEST FOR PENALTIES IN APPLICATION FOR HEARING

The insurer contends that the claimant's application for hearing failed to specifically identify the grounds on which the claim for penalties was based. Therefore, it alleges that the claim for penalties must be dismissed. The ALJ disagrees with the insurer's argument.

Section 8-43-304(4), C.R.S., provides that in "any application for hearing for a penalty pursuant to subsection (1) of this section, the applicant shall state with specificity the grounds on which the penalty is being asserted." The statute then creates a procedure for the alleged violator to cure the alleged violation within twenty days after the mailing of the application. If the violation is cured, the proponent of the penalty bears an increased burden of proof to establish by clear and convincing evidence that the violator knew, or reasonably should have known, that "such person was in violation."

The ICAO has held that the purposes of the specificity requirement are to provide notice of the basis of the alleged violation so as to afford the putative violator an opportunity to cure the violation, and to provide notice of the legal and factual bases of the claim for penalties so that the violator can prepare its defense. *Davis v. K Mart,* W.C. No. 4-493-641 (ICAO April 28, 2004); *Gonzales v. Denver Public School District Number 1,* W.C. No. 4-437-328 (ICAO December 27, 2001). In essence, the notice aspect of the specificity requirement is designed to protect the fundamental due process rights of the alleged violator to be "apprised of the evidence to be considered, and afforded a reasonable opportunity to present evidence and argument in support of" its position. *Matthys v. City of Colorado Springs,* W.C. No. 4-662-890 (ICAO April 2, 2007). Of course, the statute does not prescribe a precise form for pleading penalties, and an ALJ may consider the circumstances of the individual case to determine whether the application for hearing was sufficiently precise to satisfy the statute. *See Davis v. K Mart*, W.C. No. 4-493-641 (ICAO April 28, 2004) (factual allegations contained in pleading were sufficiently specific to notify the respondent to rule of procedure that was allegedly violated, and to extent respondent was unsure of precise nature of allegations discovery was available to assist in clarifying the issues).

The ALJ concludes that there was no violation of the specificity requirement that would warrant denial of the claim for penalties. First, the insurer has never contended that it was denied any opportunity to cure the alleged violation § 8-43-503(3). Rather, the insurer's position, as reflected in the notes and testimony of Shefman, as well as the defense at hearing, has always been that the insurer never dictated treatment and that the EMG performed by Dr. McCranie on January 26, 2009, complied with the law.

In any event, the ALJ concludes that under the circumstances of the case the Application for Hearing complied with the specificity requirements of § 8-43-304(4). The application explicitly alleges that the claimant is seeking penalties because the insurer "dictated care" in violation of § 8-43-503(3). Thus, the application for hearing alleges a factual event, the dictation of care, and the violation of a specific statute, as the bases of the claim for penalties.

Moreover, the language of the penalty allegation contained in the Application for Hearing must be considered in the context of several preceding events. On January 9, 2009, Dr. Ogin advised Shefman that in his opinion her refusal to approve the EMG constituted the dictation of care. Soon thereafter Ruiz, acting in her capacity as a representative of the law firm representing the claimant, advised Shefman that she believed Shefman's refusal to authorize the EMG with Dr. Ogin constituted the dictation of care. By January 21, 2009, Shefman had contact with claimant's counsel and was aware that he was taking the position that she was denying medical treatment by requiring that the EMG be conducted through OC. Thus, by the time the Application for Hearing was filed in August 2009 the insurer, through Shefman, was more than aware of the specific factual and legal bases of the claim for penalties, and was already in a position to prepare its defense and present arguments concerning the issue. To the extent the insurer needed additional information concerning specific factual matters, it was free to conduct discovery in order to obtain such information.

AMOUNT OF PENALTY

The claimant seeks the imposition of penalties of $400 per day commencing January 9, 2009, and continuing until January 26, 2009, (a period of seventeen days) when Dr. McCranie performed the EMG.

The ALJ has discretion to assess a penalty of up to $500 per day for each day the Act was violated. The ALJ may consider a "wide variety of factors" in determining an appropriate penalty. *Adakai v. St. Mary Corwin Hospital,* W.C. No. 4-619-954 (ICAO May 5, 2006). However, any penalty assessed should not be excessive in the sense that it is grossly disproportionate to the conduct in question. When determining the penalty the ALJ may consider factors including the "degree of reprehensibility" of the violator's conduct, the disparity between the actual or potential harm suffered by the claimant and the award of penalties, and the difference between the penalties awarded and penalties assessed in comparable cases. *Associated Business Products v. Industrial Claim Appeals Office,* 126 P.3d 323 (Colo. App. 2005).

The ALJ concludes that the insurer shall be assessed a penalty of $250 per day for seventeen days (total of $4250) for the seventeen day violation of § 8-43-503(3). In arriving at this amount the ALJ concludes that Shefman's action in delaying the EMG for a period of 17 days, while insisting on the insurer's non-existent legal right to use a "gatekeeper" to "vet" an ATP's ability to perform necessary diagnostic tests, is a serious violation of the claimant's rights under the Act. This is particularly true where the impropriety of the action was promptly drawn to Shefman's attention by an ATP and the claimant's counsel. However, in mitigation the ALJ notes that the delay in treatment was relatively brief, and infers that Shefman never intended to prevent the claimant from undergoing the EMG. Finally, the ALJ finds there is no credible or persuasive evidence concerning penalties assessed in comparable cases.

ORDER

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

1. The insurer shall pay a penalty of $4250. Seventy-five percent of the penalty shall be paid to the claimant and twenty-five percent of the penalty to the subsequent injury fund.

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

DATED: December 30, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-779-613

ISSUES

1. Has Claimant has proven by a preponderance of evidence that she suffered an "accident" on October 5, 2007, that resulted in a compensable "injury"?

2. If so, has Claimant proven by a preponderance of evidence that her neck condition and need for medical treatment after September 2008 was causally related to a compensable work injury on October 5, 2007?

3. If so, was Claimant's neck surgery with her physicians at Kaiser authorized?

FINDINGS OF FACT

1. Claimant was working for Employer on October 5, 2007, when a coworker pushed open a door and hit Claimant's elbow. Claimant was jostled and pushed up against a locker. She did not fall.

2. Claimant had a bruise on her elbow as a result of this incident. Claimant did not seek any medical treatment for the injury. She continued performing her normal job duties following the incident for almost a year.

3. Claimant testified that she immediately developed neck pain as a result of the incident on October 5, 2007, and that she treated this condition at home without the need for formal medical treatment. The First Report of Injury does not mention a neck injury. The First Report of Injury states: ". . . the EE was in the hallway between the driver's room and dispatch walking past a door, when someone pushed the door open causing the door to strike her right elbow and causing a contusion."

4. Claimant received her personal medical care through Kaiser. The first record from Kaiser after the incident is dated April 21, 2008 (approximately six months after the work incident) and contains the following history:

> Her nephew handed her a case of water on 4/17/08. When he let go she felt a pull in her left upper arm and shoulder area. . . . With different positions of her neck and shoulder she feels a sharp pain in the upper back, around the spine of her scapula.

5. There is no mention of any work injury from October 2007 in the first medical record from Kaiser. There is no indication from the Kaiser physician in his report that Claimant had any ongoing neck problems due to a work injury with the employer.

6. Claimant did not request any medical treatment for the alleged work injury in October 2007 for more than a year. During this time, Claimant received medical treatment on several different occasions and made no mention of a work injury or ongoing neck pain due to a work injury in October 2007.

7. Claimant did suffer an injury away from work in September 2008 as detailed in the following medical history from a Kaiser report dated September 24, 2008: "Recurrence of pain she had earlier this yr R upper back, this time after swinging on a track rider at a playground 2 wks ago." Claimant started taking a muscle relaxer after this incident.

8. Claimant first developed severe radicular pain in her right arm requiring hospitalization shortly after the incident where she was swinging on a track rider at a playground. Claimant first developed radiculopathy in her right arm in mid to late September 2008.

9. An ambulance record from September 28, 2008, contains the following history:

> [F]ound 54 y/o female sitting in chair with c/o severe right arm pain and cramping. States pain began atraumatically approx 1 week ago . . . [diagnosed] with pinched nerve and muscle spasm by pvt physician and given muscle relaxants to control pain. Woke up this a.m. with 10/10 arm pain & called 911 without any attempted rx.

10. A medical record from the emergency room at the University of Colorado on September 28, 2008, contains the following history: "Pt with one week of progressive right shoulder pain that is described as tearing muscle pain starting in the anterior shoulder."

11. Claimant confirmed this history of a recent development of radicular pain to her Kaiser physicians on October 2, 2008: "Pt c/o 2 weeks of progressive R shoulder pain. Also noted arm-finger burning pain. Felt like arm was on fire. The sensation has resolved but pt continues to have tingling of 3rd and 4th fingers."

12. This history of Claimant first developing radiculopathy in her right arm in October 2008 is also contained in a Kaiser record dated October 30, 2008: "Pt has cervical radiculopathy with pain and weakness in Rt shoulder and arm for the past month."

13. There is no history in any of these medical records that Claimant was relating these neck and arm symptoms to the incident involving a bruise to her elbow in October 2007.

14. Claimant started missing work after she was hospitalized with radicular pain on September 28, 2008. Claimant has not returned to work since the hospitalization.

15. A medical record from Kaiser dated November 21, 2008, contains the following history:

> Pt walked in today requesting return to work note without restrictions. She drives a bus . . . I reviewed with pt that with her cervical lesions – she may be at risk for motor problems – inability to drive, steer – and be a danger to herself and others as a bus driver. Pt requested note stating she cannot work until she has seen Neurosurgery and been evaluated, and that this should be done urgently.

16. Claimant reported her neck pain was work-related to Concentra on November 26, 2008. A note from Concentra states:

> A year ago she was hit by a door from across the room and she was slammed into a locker. She was doing her own therapy for a year and then on 09/28/2008 she felt that her arm was paralyzed and she went to the University Hospital.

17. There a medical record from Kaiser dated December 3, 2008, in which Claimant reported that her neck symptoms were work-related:

> The patient is a 54-year-old righthanded woman who comes in today for evaluation of neck pain with radiation into her right upper extremity. These symptoms initially began back in June when she was at work and someone opened the door hitting her in the right arm. She states that she had a lot of bruising and some arm pain as well as some neck pain at that time, but this is not nearly as severe as it was starting September 20, 2008, when she awoke with more intense pain in her neck with radiating down into her right triceps, forearm, with some tingling in her index and middle finger, which has persisted.

18. Claimant failed to report to her medical providers that the neck pain was workrelated until after she learned she could not return to work. The medical records do not relate Claimant's neck pain to the work incident in October 2007 until more than a year after the event.

19. Respondents filed a general admission of liability on December 24, 2008, and admitted to ongoing temporary total disability (TTD) benefits. Respondents admitted to TTD benefits starting on September 28, 2008, and ongoing. Claimant has received ongoing TTD benefits to the present. She did have a period of time when she did not receive the checks but these periods were subsequently paid and she is continuing to receive checks from Respondents.

20. Insurer did not have the medical records from Kaiser and other providers when the admission was filed. The medical records from Kaiser demonstrate that they were sent to opposing counsel by Insurer on May 13, 2009. The medical records from the University of Colorado Hospital and Rural Metro Ambulance were sent to opposing counsel on May 18, 2009.

21. Claimant began treating at Concentra once she alleged her neck condition was work-related. Dr. Quick at Concentra noted that Claimant would probably require a discectomy and fusion surgery.

22. Claimant had her surgery with Kaiser. Claimant underwent surgery from Dr. Watts at Kaiser on February 3, 2009. Claimant reported that her surgery costs have been paid for through Kaiser, other than some co-payments. She is continuing to receive TTD benefits from Insurer now almost ten months after the surgery.

23. Claimant reported to Concentra that her elbow condition had resolved. Concentra indicated that Claimant should be discharged from medical care if her neck condition is not considered work-related:

> If the claim for the neck is denied, then she should be discharged as there is no documented elbow injury and she has had no complaints of elbow pain from the alleged contusion two years ago.

24. Dr. Pitzer examined Claimant and determined that Claimant did not suffer any significant injury or any neck condition. Dr. Pitzer stated:

> It is unlikely that there was any significant injury and certainly did not cause her cervical spine problems. Given what appears to only be a contusion to the elbow and no evidence of any medical treatment sought, there would be no permanent impairment or permanent restrictions.

25. Dr. Pitzer testified that there was no evidence of any neck pain or problems related to the work incident in October 2007. Dr. Pitzer's opinions were based in part on the following: (1) Claimant only had evidence of an elbow bruise at the time of the alleged work injury in October 2007; (2) there was no medical treatment requested for the injury for an extended period of time and when the Claimant did finally request treatment, she related her condition to other non-work-related incidents; (3) Claimant suffered an injury when she lifted a case of water in April 2008; (4) Claimant had another incident in mid-September when Claimant was sliding or swinging on a track rider at a playground; (5) Claimant did not develop radiculopathy or right arm pain until September 2008 (shortly after the track rider incident that occurred away from work); and (6) Claimant did not relate her neck condition to the work incident when talking to her medical providers until more than a year after the incident when she found out she could not return to work.

26. Dr. Pitzer also testified that even if Claimant actually suffered a work injury in October 2007 that this neck condition was not work-related after September 2008 due to an intervening injury. Claimant had an intervening injury at the park in September 2008. Claimant did not develop radiculopathy or the need for surgery until after this non-work-related incident. Claimant's condition changed markedly after this nonwork-related incident as Claimant developed radiculopathy for the first time and required hospitalization and subsequent surgery.

CONCLUSIONS OF LAW

Although Claimant Had an "Accident" at Work, She Failed to Prove the Occurrence of a Compensable "Injury"

1. The Court of Appeals has held that employers and insurance companies do not have to make any type of specific showing to withdraw an admission of liability. The Court of Appeals has held: "We agree with the Panel that the employer did not have to show the admission was improvidently filed in order to contest liability, and we reject Claimant's assertion that, without such a showing, the admission had conclusive and binding effect." *Pacesetter Corporation v. Collett*, 33 P.3d 1230, 1232 (Colo. Ct. App. 2001); *see, also, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 884 (Colo. Ct. App. 2000).

2. The Court of Appeals has also held that the burden of proof to establish compensability remains on a claimant even when a respondent is seeking to withdraw

an admission of liability. “It is well-established that claimant must prove the existence of a compensable injury.” *Pacesetter Corporation v. Collett,* 33 P.3d 1230, 1232 (Colo. Ct. App. 2001).

3. The Colorado Workers’ Compensation Act was recently amended to change the burden of proof when respondents are attempting to withdraw admissions of liability. The Act provides that it is respondents’ burden to withdraw the admission of liability. Section 843-201, C.R.S. This amendment, however, only applies to dates of injury or claims filed after August 5, 2009. Therefore, it still remains Claimant’s burden of proof to prove that this claim is compensable.

4. 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 of 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. Ct. App. 1990). All other “accidents” are not compensable injuries. *See Ramirez v. Safeway Steel Products Inc.,* W.C. No. 4-538-161 (ICAO, September 16, 2003).

5. Claimant has failed to demonstrate that she suffered a compensable “injury.” Moreover, even if it could be deemed that the recent amendment to Section 8-43-201, C.R.S. applies to this claim, Insurer has met the burden as Claimant has not suffered a compensable injury based on the following facts:

- Claimant admittedly had a bruise on her elbow as a result of this incident. Despite this bruise, Claimant did not seek or require any medical treatment for the injury. The “accident” at work in October 2007 did not result in the need for medical treatment and, as a result, there was no resulting “injury.”

- There was no disability caused by the “accident” at work. Claimant did not miss any work for almost a year despite this incident and bruise to her elbow. She performed her normal job duties with Employer. There was no need for medical treatment or any resulting disability following the “accident” that would establish the occurrence of a compensable “injury.”

- Claimant’s allegation of the onset of immediate neck pain following the “accident” was not corroborated by either the First Report of Injury or any medical records over the first year following the incident.

- Claimant reported other non work-related incidents to her medical providers in April and September 2008 when discussing her neck pain.

- There was no evidence of any radiculopathy or right arm pain until after a non work-related incident at a playground in September 2008. This development of new symptoms cannot be causally related to the work accident in October 2007.

- Claimant did not allege to her medical providers that her neck condition was work-related until November 2008, immediately after she learned that she would not be able to return to work.

- Claimant's elbow condition resolved and Concentra noted that her case should be closed if the neck condition is not considered work-related.

- Dr. Pitzer credibly testified that Claimant did not suffer an injury in October 2007 that resulted in any disability or need for medical treatment.

6. Claimant has failed to establish by a preponderance of the evidence that her "accident" in October 2007 resulted in a compensable work "injury." Insurer has shown that it should be permitted to withdraw its admission of liability. The claim is denied and dismissed.

7. Other issues are not reached.

ORDER

The claim is denied and dismissed.

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-779-078

ISSUES

- Temporary Total Disability (TTD) from June 11, 2008, to June 15, 2009;
- Whether Claimant's TTD should be reduced by 50 percent based upon a willful violation of a safety rule;
- Whether the Prehearing Administrative Law Judge (PALJ) Eley's order dated June 11, 2009, should be overturned;
- If PALJ Eley's order is overturned, whether Claimant is responsible for termination of her employment; and
- Average weekly wage.

FINDINGS OF FACT

Based on the evidence presented at hearing, the Judge finds:

PALJ Eley's Order

1. On June 9, 2009, the parties convened for a prehearing conference before PALJ Craig Eley. Claimant raised, *inter alia*, a motion to strike Respondents' affirmative defense of application of the termination statutes as they relate to Claimant's eligibility for temporary benefits. Claimant did not file a motion for summary judgment pursuant to OACRP 17.
2. On June 11, 2009, PALJ Eley entered a prehearing order striking Respondents' affirmative defense of the applicability of the termination statutes. PALJ Eley found that it was undisputed that Employer terminated Claimant's employment based upon a safety rule violation and that the safety rule violation resulted in Claimant's injury. PALJ Eley ruled as a matter of law that the evidence was insufficient to support the affirmative defense based upon the decision in *Colorado Springs Disposal v. ICAO*, 58 P.3d 1061 (Colo. App. 2002), which held that termination statutes are inapplicable where the employer terminates an employee because of the injury producing conduct.
3. The determination of whether Respondents may prevail on their affirmative defense requires findings of fact and conclusions of law. Here, the Judge finds that disputed issues of material fact existed when PALJ Eley entered the order. Specifically, the issue of whether Claimant's injury was a result of a safety rule violation had yet to be decided. Thus, the Judge cannot conclude as a matter of law that Respondents are not entitled to pursue the affirmative defense of application of the termination statutes. PALJ Eley's order as it relates to this issue is overturned.

Safety Rule Violation/Responsibility for Termination/TTD

4. Claimant began working for Employer in October 2007 in non-qualified positions. In July 2008, Claimant began working as a forklift operator. Claimant worked in the trash area on the B shift for approximately the first six weeks in this new position.
5. Approximately one month before her work injury, Claimant switched from B shift to A shift. On A shift, Claimant was required to load and unload trailers, a job duty she had never performed on the B shift.
6. Sometimes she loaded trailers at the dock and other times she loaded trailers in the yard. When trailers are loaded in the yard, a movable ramp is used.
7. A movable ramp is a feature in the loading dock area that the employees have to control and lock, so that the ramp does not move during the loading and unloading process.
8. Claimant sustained an industrial injury on November 10, 2008, when she was unhooking a movable ramp and the tractor trailer driver pulled out causing the ramp to fall onto her.
9. Claimant's physician restricted Claimant from standing, kneeling, and squatting as a result of the injury. Such restrictions would have prevented Claimant from doing her normal job because her job required her to stand nearly 100 percent of the time.
10. In order to work as a forklift operator, Employer required Claimant to undergo training in the following areas: Disciplinary Policy, Powered Industrial Truck Program, Lift Operator Skills, Loading Dock Policy, Loading Dock Control Procedures, Battery

Changing Procedures for Forklift Shop Charging Area, Standard Operating Procedures for Refueling Gasoline Equipment, Standard Operating Procedures for Refueling Diesel Equipment, Standard Operating Procedures for Propane Tank Exchange, and Pedestrian Safety. Claimant completed all of the aforementioned training on July 23, 2008.

11. As part of the training on July 23, 2008, Claimant also took a test on the Powered Industrial Truck procedures and underwent an evaluation on Lift Operator Skills. Claimant scored 100 percent on both examinations. Neither examination tested the Claimant on the specific procedures for loading and unloading trailers using a movable ramp.

12. Employer has a Loading Dock Policy (the "Policy") which dictates the steps an employee must take in order to prevent the movement of a vehicle. The first paragraph entitled, "Physical Control" states that, "All trailers or vehicles at a loading dock shall be physically controlled from movement by means of the following mandatory methods." There is no specific procedure for unloading trailers in the yard using a movable ramp.

13. Also in the Policy, in the section entitled, "Operation of the Vehicle" it states, "No person shall be under or between any part of the vehicle or loading dock if the driver is in the cab of the vehicle or tractor."

14. Claimant received no "hands on" training for loading and unloading trailers in the yard using the movable ramp. Claimant testified that the only verbal training she received was from a co-worker on the B shift who told her never to load or unload a trailer without a lock mechanism. According to Enfield who is the assistant safety and health manager, this same co-worker, who did not testify, reported that Claimant had observed him loading and unloading the ramp. This same co-worker worked only on B shift during which Claimant never loaded or unloaded a trailer.

15. After the injury, Claimant completed a handwritten statement regarding the mechanism of the accident. Claimant wrote that she had just removed the candlestick and lock from the trailer and had started removing the chains from the trailer. She thought the driver had seen her under the ramp removing the chains. When she realized the driver had not seen her, she tried to get out, but the driver pulled away and the ramp fell knocking her to the ground. Enfield testified that while Claimant gave the written statement Claimant also verbally stated the correct procedure for unloading and loading the trailer.

16. Claimant had unloaded or loaded a trailer attached to ramp approximately three or four times prior to her work injury. Claimant testified that it was physically impossible for her to remove the chains from the ramp without being underneath it.

17. Employer suspended Claimant pending its investigation into the injury. The Greeley Beef Management Disciplinary Committee (the Committee) convened on November 13, 2008, regarding the Claimant's accident and whether she violated a safety rule. The Committee consists of various department managers and other personnel who review the results of the investigation and interview the alleged violator.

18. Enfield prepared a typewritten report following the Committee's meeting on November 13, 2008. Enfield noted that Claimant explained to the Committee that on November 10, 2008, she removed the glad hand lock and candlestick, the shag truck backed up to the trailer, and she walked back to the ramp to unhook the chains. Claimant thought the shag driver knew she at the ramp. Claimant reported that she unhooked the chain on the left side of the ramp then crawled under the ramp to unhook

the right side. This version of the events is consistent with Claimant's handwritten statement provided on November 10, 2008, after the accident.

19. Enfield also noted that the correct procedure for detaching a ramp was: 1. Use forklift w/pallets to raise ramp. 2. Remove chains. 3. Remove forklift w/pallets to lower ramp. 4. Remove candlestick. 5. Remove gland hand lock. 6. Ask driver to remove trailer.

20. None of the policies, procedures, training materials or written examinations offered into evidence contains a list of these specific steps.

21. Enfield also included in her report that Claimant stated to the Committee that she had followed the correct procedure at other times. Enfield's report is undated and was written based upon her handwritten notes she took while observing the Committee's meeting on November 13, 2008. Enfield testified that she destroyed her handwritten notes. Claimant denied that she told the Committee she had followed the correct procedure at other times.

22. The Committee recommended termination of Claimant's employment for her violation of a safety rule.

23. Employer officially terminated Claimant's employment effective November 18, 2008, based upon its determination that Claimant violated a safety rule.

24. It is apparent that Claimant performed the required steps to remove the ramp from the trailer in the wrong order. The evidence, however, is less than persuasive that Claimant received proper training on the procedures for loading and unloading or attaching and detaching the movable ramp. Further, there is no persuasive evidence that Claimant willfully violated any rule by being underneath the ramp. Claimant's testimony that she needed to go under the ramp to disconnect the chains was credible, persuasive and undisputed. Finally, there is no persuasive or credible evidence that any of Claimant's actions were willful. Accordingly, Respondents have failed to establish that Claimant willfully committed a safety rule violation and any TTD benefits may not be reduced by 50 percent.

25. Respondents have also failed to establish that Claimant was responsible for her termination from employment within the meaning of the termination statutes in the Workers' Compensation Act. While it is true that Claimant acted volitionally when she used the incorrect procedure for detaching the ramp and that she was aware that safety rule violations could result in discipline, there is no persuasive evidence that Claimant knew that such procedure was incorrect and that she was violating a safety rule. Respondents did not establish that Claimant underwent training on these specific procedures or that she knew her actions were likely to result in her termination. Based upon the totality of the circumstances, Claimant did not commit a volitional act that led to the termination and did not exercise a sufficient degree of control over the circumstances of her termination. Claimant is not barred from receiving TTD.

26. Claimant has established that she is entitled to TTD from November 11, 2008, through June 15, 2009. Following her work injury, she had physical restrictions that prevented her from performing her normal job.

Average Weekly Wage

27. Respondents admitted for an average weekly wage of $536.58 by allegedly averaging one year of Claimant's gross earnings; however, the evidence submitted by Re-

spondents does not support this admitted wage. Claimant's average weekly wage based upon the twelve weeks prior to her injury is $593.31.

28. Respondents agree that Claimant's average weekly wage should have included replacement cost for health insurance.

29. Pursuant to COBRA, Claimant was entitled to elect continuation coverage within 60 days of the termination of her employment. Thus, Claimant had until January 17, 2009, to elect such coverage which she declined to do because she could not afford the monthly premium.

30. On April 9, 2009, Employer sent a notice to Claimant that advised her that under the American Recovery and Reinvestment Act (ARRA) which was signed on February 17, 2009, she may be entitled to a reduced premium and another 60-day election period. Accompanying this notice is a document entitled, "Summary of the COBRA Premium Reduction Provisions under ARRA" which explains how certain individuals may be eligible for reduced COBRA premiums.

31. Employer also sent another enrollment form which reflected the total monthly premium as $537.05 and the premium after application of ARRA as $187.97. This form indicated that after receipt of the completed form, the plan administrator would determine whether Claimant would be entitled to the premium assistance. Claimant had until June 7, 2009, to elect coverage that would begin on March 1, 2009. The premium computation form advised Claimant that her premium would be $537.05 if the enrollment form was signed and received by March 31, 2009.

32. None of these forms indicated that Claimant was indeed eligible for the premium assistance and no persuasive evidence suggested that Employer or the plan administrator had determined that Claimant was eligible for the premium assistance. Further, in order to be eligible for the reduction, Claimant would be required to elect coverage. Accordingly, the 65 percent reduction in the replacement cost is inapplicable and Claimant's health and dental insurance replacement cost is $537.05 per month rendering the weekly cost $123.93.

33. Claimant's average weekly wage is $593.31 plus $123.93 for a total of $717.24.

CONCLUSIONS OF LAW

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

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a con-

flicting 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).

Challenge to Prehearing Administrative Law Judge Order Striking the Respondents' Termination Defense

4. Section 8-43-207.5, C.R.S., authorizes a PALJ to issue "interlocutory orders," among other things. The statute remained silent on any appeals from PALJ orders. In *Industrial Claim Appeals Office v. Orth*, *965 P.2d 1246* (Colo. 1998), the Supreme Court noted, "a PALJ's order relating to a prehearing conference is interlocutory (i.e., not immediately appealable) because a prehearing conference, by definition, is followed by a full hearing before the director or an ALJ. . . . Thus, the propriety of a PALJ's prehearing order may be addressed at the subsequent hearing." *Id.* The court in *Dee Enterprises v. Industrial Claim Appeals Office*, 89 P.3d 430 (Colo. App. 2003) affirmed that the hearing ALJ could alter prehearing orders by the PALJ. This power fairly flows from the authority of the hearing ALJ to control the course of the hearing and to handle motions and dispose of procedural requests. Section 8-43-207, C.R.S. Here, because PALJ Eley's order necessarily deals with the conduct of the hearing, the ALJ has considered the issues determined therein *de novo*.

5. As found, disputed issues of material fact existed at the time PALJ Eley entered the prehearing order. Specifically, the issue of whether Claimant's injury was a result of a safety rule violation had yet to be decided and was the primary issue for this hearing. Thus, the Judge cannot conclude as a matter of law that Respondents are not entitled to pursue the affirmative defense of application of the termination statutes. PALJ Eley's order as it relates to this issue is overturned.

Safety Rule Violation

6. Sections 8-42-112(1)(a) and (b), C.R.S., permits imposition of a 50 percent reduction in compensation where respondents prove either that claimant's injury was caused by the willful failure to use safety devices provided by the employer or that the injury resulted from the employee's willful failure to obey any reasonable rule adopted by the employer for the safety of the employee. In order to impose the reduction of compensation it is not enough for the employer to demonstrate that the claimant failed to obey safety rule. *Johnson v. Denver Tramway Corp*. 115 Colo. 214, 171 P.2d 410 (1946). It is also necessary to show that there was a "willful" violation of the rule. *City of Las Animas v. Maupin*, 804 P.2d 285 (Colo. App. 1990). The term "willful" connotes de-

liberate 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).

7. Respondents have not established that Claimant acted willfully when she applied the incorrect procedure for unloading and loading a trailer or detaching the movable ramp. As found, Claimant was unaware of the correct procedure and had not received adequate training in performing this task. The testimony of Enfield that Claimant had stated the correct procedure to her and to the Committee is not evidence that Claimant knew the correct procedure *before* the accident. Enfield's testimony and report that Claimant stated that she had used the correct procedure prior to the accident lacks credibility. Finally, Claimant also provided uncontested testimony that removing the chains required her to go under the movable ramp. Respondents, therefore, are not entitled to impose a 50 percent reduction in Claimant's compensation.

Responsibility for Termination

8. Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., (termination statutes) provide that, where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury. Respondents shoulder the burden of proving by a preponderance of the evidence that claimant was responsible for his or her termination. *See Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 20 P.3d 1209 (Colo. App. 2000). An employee is "responsible" if the employee precipitated the employment termination by a volitional act, which an employee would reasonably expect to result in the loss of employment. *Patchek v. Colorado Department of Public Safety*, W.C. No. 4-432-301 (September 27, 2001). Thus, the fault determination depends upon whether claimant performed some volitional act or otherwise exercised a degree of control over the circumstances resulting in termination. *See Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1994), *opinion after remand*, 908 P.2d 1185 (Colo. App. 1995).

9. Respondents have failed to establish that Claimant was responsible for her termination from employment within the meaning of the termination statutes in the Workers' Compensation Act. It is true that Claimant acted volitionally when she used the incorrect procedure for detaching the ramp. Claimant was also aware that safety rule violations could result in discipline. The evidence, however, failed to establish that Claimant knew that the procedure she used was incorrect or that she was violating a safety rule when using the incorrect procedure. Respondents did not establish that Claimant underwent training on these specific procedures or that she knew her actions were likely to result in her termination. Based upon the totality of the circumstances, Claimant did not commit a volitional act that led to the termination and did not exercise a sufficient degree of control over the circumstances of her termination. Claimant is not barred from receiving TTD.

Average Weekly Wage

10. Section 8-42-102(2), C.R.S., requires the ALJ to base claimant's AWW on her earnings at the time of injury. Because Claimant's job title and wages appear to have changed over the course of her employment, the Judge concludes that it is appropriate to base her average weekly wage on her twelve weeks of earnings immediately prior to the injury. Moreover, Respondents admitted for an average weekly wage of $536.58 by allegedly averaging one year of Claimant's gross earnings; however, the wage records submitted by Respondents do not support this admitted wage. As found, Claimant's average weekly wage based upon the twelve weeks prior to her injury is $593.31.

11. The claimant's cost of continuing an employer's group health insurance plan must be included in the average weekly wage and then, upon expiration of the allowed term for continued coverage, the cost of conversion to a similar or lesser plan must be included in the average weekly wage, even if claimant does not actually purchase replacement health insurance. *Industrial Claim Appeals Office v. Ray*, 145 P.3d 661 (Colo. 2006). Claimant is not required to elect the continuation health insurance. The COBRA amount is included in the wage unless the employer decides to continue to provide the health insurance to claimant after the injury. The employer here did not decide to continue to provide the benefit to claimant after the injury thus the COBRA premium amount shall apply. Here, the COBRA monthly premium amount is $537.05.

12. While the Judge agrees that Claimant's average weekly wage should only be increased by what it would cost her to continue her health insurance, there is no persuasive evidence that Claimant was eligible for the COBRA premium assistance offered by the ARRA. Accordingly, the full amount of the COBRA premium shall apply rendering Claimant's total average weekly wage $717.24.

Temporary Total Disability

13. To prove entitlement to TTD benefits, claimant must prove that the industrial injury or disease 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. Section 8-42-103, C.R.S.; *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). 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 her regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998). As found, Claimant's physical restrictions as a result of her injury included no standing, kneeling or squatting. Claimant's regular job involved a significant amount of standing. Accordingly, Claimant would have been unable to perform her regular job had Employer not terminated her employment. Claimant is entitled to TTD commencing on November 11, 2008.

ORDER

It is therefore ordered that:

1. PALJ Eley's order dated June 11, 2009, as it pertains to striking Respondents' affirmative defense of application of the termination statutes, is overturned.
2. Claimant did not commit a willful violation of a safety rule.
3. Claimant was not responsible for termination of her employment.
4. Claimant's average weekly wage is $717.24.
5. Respondents shall pay TTD at the average weekly wage rate of $717.24 commencing on November 11, 2008, through June 15, 2009.
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.

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: December 30, 2009

Laura A. Broniak
Administrative Law Judge