ISSUES

I. Whether Claimant established that he suffered a compensable injury on February 19, 2018.

II. Whether Claimant established that he is entitled to reasonable, necessary, and related medical treatment.

III. Whether Claimant established he is entitled to temporary total disability benefits.

IV. Claimant's average weekly wage.[1]

V. Whether David Yamamoto, M.D., is an authorized treating provider.

VI. Penalties:

a) Penalties against Respondents.

b) Penalties against Claimant.

FINDINGS OF FACT

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

1. Claimant was born on April 18, 1975, and was 48 years of age at the time of the hearing.
2. Pro Logistics – Employbridge - (i.e., Employer) is an employee staffing company.
3. On July 20, 2016, Claimant was hired by Pro Logistics – Employbridge Holding Company – to work as a mail sorter, at a UPS (United Parcel Service) facility.
4. Claimant performed his job duties at a UPS facility. Claimant's job duties included going into a delivery truck with a pallet jack and removing pallets of boxes. Once the boxes were removed from the truck and were inside the UPS facility, Claimant would sort the mail.
5. Claimant's supervisor, who also worked for Pro Logistics – Employbridge - was Aaron Grimes. Mr. Grimes, however, did not work at the UPS facility with Claimant.

[1] The issue of Claimant's average weekly wage based on his concurrent employment is reserved for future determination - if the Claim is found compensable.

6. Mark Mathies also works for Pro Logistics – Employbridge – and worked at the UPS facility. Mr. Mathies was responsible for supervising the Pro Logistics' – Employbridge – employees, which included Claimant, who were working at the UPS facility. Mr. Mathies, however, worked under the supervision of Mr. Grimes.

7. On February 19, 2018, Claimant was working and unloading a UPS truck with a pallet jack. Claimant testified that while moving a pallet, a box weighing at least 100 pounds fell off the top of a load because it was not shrink wrapped and landed on him. Claimant testified that after the 100-pound box landed on him, two coworkers, Gabe and Lance, had to come over and physically lift the 100-pound box off of him.

8. Claimant testified that he did not feel pain until about 15 minutes later when he started sorting mail at his station. Claimant testified he felt pain in his neck, right side of his neck, right shoulder, right side of his back, and the lower right side of his back. Claimant testified that approximately 40 minutes after the incident, he went to his supervisor, Mr. Mathies, and told him that he was not feeling well and was going to leave work. Claimant did not, however, tell Mr. Mathies he was leaving because he had just been injured.

9. Claimant further testified that after the incident, he left work between 5 and 6 a.m. and walked to a light rail station in order to go straight to the Emergency Room at Denver Health. However, the medical report from Denver Health indicates Claimant arrived at 10:50 a.m. It does not seem reasonable for it to have taken Claimant approximately 5 hours to get to the emergency room. Therefore, Claimant's testimony that he left work and went straight to Denver Health is inconsistent with the medical records from Denver Health. Consequently, Claimant's testimony regarding this issue is not found to be credible.

10. According to the medical records, Claimant arrived at the Denver Health Emergency Room at 10:50 a.m. Claimant was seen by Physicians Assistant William Drew at 11:35 a.m. The history documented by PA Drew indicates a package weighing 50-100 pounds fell on Claimant's right shoulder. PA Drew also documented that Claimant denied any neck pain or back pain. Claimant's testimony at hearing that the box weighed at least 100 pounds and that he developed pain in his neck and low back after the incident is inconsistent with the medical records from Denver Health. Therefore, Claimant's testimony regarding the weight of the box and the symptoms he felt after the box fell and hit him is not found to be credible.

11. PA Drew physically examined Claimant's right shoulder. The only findings he noted was some tenderness on the posterior of Claimant's right shoulder girdle.[2] PA Drew specifically noted Claimant's right shoulder had normal range of motion and there was no swelling or deformity. X-rays were taken, and they were normal. At discharge, Claimant was diagnosed with a contusion. He was prescribed ibuprofen (Advil/Motrin) and was told to take it as needed for mild

[2] These findings are similar to those noted when Claimant presented to Denver Health on July 13, 2016, approximately 2 weeks after Claimant was involved in an automobile accident.

pain, which was specifically noted to be only a 1-2. Claimant was also instructed to call his employer in order to see to which workers' compensation facility he should follow up with and to file a claim. As found above, despite Claimant's testimony to the contrary, there was no indication in the medical records from that date that Claimant was also complaining of neck and low back pain on February 19, 2018.

12. On February 19, 2018, a To Whom It May Concern letter was prepared by PA Drew which states, "Doron Foster was seen and treated in our emergency department on 2/19/2018. He may return to work on 02/21/18." There was no indication in the letter why Claimant could not work for one day and there was no indication Claimant might have been injured at work.

13. Claimant testified he called his supervisor Mr. Mathies and then sent him a text with a picture of the note taking him off work for one day. Claimant testified Mr. Mathies said he would call Mr. Grimes and discuss the matter with him.

14. Mr. Mathies also testified at hearing. Mr. Mathies testified Claimant did tell him on February 19, 2018, that he was not feeling well and wanted to go home. Mr. Mathies also testified that Claimant did not tell him that he was injured due to a box falling on him at work or due to any other incident at work.

15. Mr. Mathies testified that Claimant did send him a text with the letter from Denver Health excusing Claimant from work. He also testified that once he found out Claimant was alleging he was hurt by a box falling on him at work, he investigated the matter by talking to various co-workers. After investigating the matter, it was his understanding that a box did fall off a pallet, but yet it grazed Claimants' shoulder. This was confirmed by another co-worker, or manager, Kyle, who told Mr. Mathies he heard a box hit the floor the morning of the incident. Mr. Mathies' testimony is found to be credible and persuasive. Moreover, his testimony discredits Claimant's testimony that the box fell on Claimant and two co-workers, Lance and Gabe, had to lift the 100-pound box off of Claimant. If the box fell directly on Claimant, as he described during his testimony, and two co-workers had to lift the box off of him, Kyle would not have heard the box fall to the ground since it would have landed on Claimant instead of the floor.

16. On or about June 30, 2016, prior to being hired by Employer, Claimant was involved in a motor vehicle accident in which he injured his right shoulder.

17. On July 13, 2016, approximately two weeks after the motor vehicle accident, Claimant sought medical treatment at Denver Health for his right shoulder injury. Claimant complained of right shoulder pain for the last 2 weeks. The chart note also indicates Claimant had a "GSW (gunshot wound)" under past medical history. At the July 13, 2016, evaluation, Claimant's musculoskeletal examination demonstrated decreased range of motion, tenderness and pain and spasm in the right shoulder. Moreover, review of the pain diagram shows Claimant's pain to be in the right back scapula area.

18. At hearing, Claimant was questioned about the extent of the injuries he sustained in the 2016 motor vehicle accident. Claimant testified that he was not hurt in the accident, but that he just went to the doctor to make sure he was not hurt. Claimant also added that the 2016 motor vehicle accident resulted in "just pain in back." First, it does not make sense that Claimant felt he was not hurt in the motor vehicle accident, but without any symptoms, went to the emergency room to make sure he was not hurt. Moreover, the July 13, 2016, medical report from Denver Health is in stark contrast to Claimant's hearing testimony. As found above, the July 13, 2016, medical report demonstrates Claimant complained of hurting his right shoulder and that he also had pain in the back of his right scapula. The clinic notes also indicate Claimant had decreased range of motion, tenderness, pain, and spasm in his right shoulder. In addition, the pain diagram showed Claimant's pain to be in the right back scapula area. Claimant's misrepresentation that the 2016 automobile accident only caused back pain, but not right shoulder pain, severely discredits Claimant's testimony as well as the statements he made to various medical providers and Employer about the incident that occurred on February 19, 2018.

19. On March 16, 2018, Claimant returned to Denver Health. At this visit, Claimant sought treatment for a rash. And, despite Claimant's contention that he suffered a significant shoulder, neck, and back injury, after a 100-pound box fell on him – there was no notation made that Claimant was having any other medical problems. The report from that visit indicates Claimant:

    a. Was in no apparent distress,

    b. His neck had normal range of motion, and

    c. All other musculoskeletal systems had normal range of motion.

    Claimant also testified at hearing that due to his work accident, he is in pretty bad shape. Such testimony is inconsistent with going to Denver Health's emergency department for treatment of a rash, without any notation being made about what Claimant contends is quite a debilitating work injury that effects his neck, right shoulder, and low back. Although Claimant testified that Denver Health told him they do not treat work injuries, and appears to be contending that is why they did not note any pain complaints related to his alleged work injury in the March 16, 2018, medical note, such contention is not found to be credible. If Claimant complained of other musculoskeletal problems, such complaints would have most likely made it into the medical record from that visit. Therefore, Claimant's presentation to Denver Health on March 16, 2018, for a rash, without concurrent complaints of the symptoms he contends were caused by the work accident, discredits Claimant's contention that he suffered a compensable injury at work and that such injury requires ongoing treatment.

20. On March 26, 2018, Claimant was evaluated by Dr. Yamamoto. Claimant was directed to Dr. Yamamoto by his attorney. Although the Denver Health records note Claimant's reported pain on the date of the accident was 1-2/10, Claimant reported to Dr. Yamamoto that his shoulder and upper back pain was 8/10. Claimant also complained of low back pain, although it is not clear if he indicated

that his low back pain was also 8/10. Dr. Yamamoto ultimately diagnosed Claimant with strain of the right shoulder, strain of the upper back, and strain of the lumbar region. He also placed Claimant on modified duty and gave Claimant restrictions of no reaching overhead with right arm, a lifting limit of no more than 10 pounds, no repetitive lifting more than 5 pounds, no carrying over 5 pounds, and no pushing or pulling more than 10 pounds.

21. On April 26, 2018, Dr. Yamamoto evaluated Claimant again and noted that based on Claimant's persistent complaints, Claimant needs an MRI of his right shoulder and physical therapy for his upper and lower back. Dr. Yamamoto also continued Claimant's restrictions.

22. On May 21, 2018, Dr. Yamamoto again evaluated Claimant and indicated Claimant started experiencing increased pain going down his right arm and numbness in his right arm and hand. Dr. Yamamoto recommended Claimant receive an EMG.

23. On July 18, 2018, Dr. Yamamoto evaluated Claimant and diagnosed Claimant with a strain of the right shoulder muscle, strain of the back wall thorax, strain of the cervical muscle, paresthesia of the right arm, and thoracic outlet syndrome. He again opined that Claimant's need for treatment is due to his work related injury.

24. On August 20, 2018, respondents took the deposition of Dr. David Yamamoto. Dr. Yamamoto opined Claimant suffered a work related injury on August 19, 2018 and opined Claimant needs ongoing care and has ongoing restrictions. Dr. Yamamoto opined Claimant's report of injury has been consistent throughout treatment and Claimant's report of injury was also consistent with the medical records from Denver Health. However, the ALJ does not find Dr. Yamamoto's opinions to be reliable or persuasive because he relied upon the statements of Claimant in formulating his opinions and the ALJ has found Claimant's statements regarding the incident and the development of his symptoms after the incident to not be credible.

25. Mr. Grimes testified at hearing. He testified he called Claimant on February 20th and informed him that he had to come into the office and fill out some paperwork regarding his workers' compensation claim. He further testified that Claimant never returned to work or came into the Pro Logistics office to complete any paperwork regarding his alleged workers' compensation claim.

26. Claimant testified he notified Employer of the injury via a text message to Mr. Grimes. Claimant submitted various text messages between himself and Mr. Grimes. *See Ex. 5.* On February 21, 2018, the day Claimant was able to return to work, pursuant to the letter from PA Drew, there are some text messages indicating he called in and said he could not work because his back was sore. There is also a text message in which Claimant states he went to the doctor and they said "I need to do work comp." *See Ex. 5.*

27. However, Mr. Grimes also testified that the text messages submitted by Claimant do not appear to contain all of their communications via text. The text messages

provided by Claimant in Exhibit 5 do not appear to be complete regarding the conversations between Mr. Grimes and Claimant. The ALJ finds Mr. Grimes' testimony regarding this issue to be credible and persuasive.

28. Mr. Grimes also testified that he attempted to follow up with Claimant a number of times, but was never able to get in touch with him to discuss in detail the alleged accident and to have Claimant come in and fill out the proper paperwork. The ALJ also credits this portion of Mr. Grimes' testimony.

29. Allison M. Fall, M.D. performed an Independent Medical Examination on behalf of Respondents. She issued a report and testified via deposition.

30. As set forth in her report, Dr. Fall noted that Claimant's physical examination at Denver Health's emergency department was benign. She also indicated that despite escalating pain complaints, her examination of Claimant was unremarkable. She concluded by stating that Claimant's escalating pain complaints with high levels of reported pain involving multiple areas of his body were non-physiologic and were not supported by objective findings. Dr. Fall's findings and conclusions are found to be credible and persuasive.

31. During her deposition, Dr. Fall was offered and accepted as a medical expert in physical medicine and rehabilitation. Dr. Fall testified, and her testimony is found to be credible and persuasive, that there is no objective medical evidence to support any diagnosis other than a contusion to the back of the right shoulder as of February 19, 2018.

32. Dr. Fall testified, and her testimony is found to be credible and persuasive, that there were no residual findings of the contusion when she evaluated Claimant in August of 2018. Dr. Fall further testified based upon the objective medical evidence, Claimant may not have required any treatment for the contusion.

33. Dr. Fall specifically testified, and her testimony is found to be credible and persuasive, there is no objective medical evidence to support any type of lumbar spine diagnosis as it relates to the incident of February 19, 2018, nor is there any objective medical evidence to support neck pain as a result of the alleged incident, right arm numbness, or thoracic outlet syndrome.

CONCLUSIONS OF LAW

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

General Provisions

The purpose of the Workers' Compensation Act of Colorado (Act), C.R.S. §§ 8-40-101, et seq., is to assure the quick and efficient delivery of benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. C.R.S. § 8-40-102(1). Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. C.R.S. § 8-43-201. 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. C.R.S. § 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 Eng'g, Inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

In deciding whether a party 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 Bodensleck v. ICAO*, 183 P.3d 684 (Colo. App. 2008). The ALJ determines the credibility of the witnesses. *Arenas v. ICAO*, 8 P.3d 558 (Colo. App. 2000). The weight and credibility assigned to evidence is a matter within the discretion of the ALJ. *Cordova v. ICAO*, 55 P.3d 186 (Colo. App. 2002). The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant*, 24 Colo. App. 131, 134 P. 254 (1913); see also *Heinicke v. ICAO*, 197 P.3d 220 (Colo. App. 2008). 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). A workers' compensation case is decided on its merits. C.R.S. § 8-43-201.

Compensability

Claimant was required to prove by a preponderance of the evidence that at the time of the alleged injury he was performing service arising out of and in the course of the employment, and that the alleged injury or occupational disease was proximately caused by the performance of such service. Section 8-41-301(1)(b) & (c), C.R.S. The Act creates a distinction between an "accident" and an "injury." The term "accident" refers to an "unexpected, unusual, or undesigned occurrence." Section 8-40-201(1), C.R.S. In contrast, an "injury" contemplates the physical or emotional trauma caused by an "accident." An "accident" is the cause and an "injury" is the result. No benefits flow to the victim of an industrial accident unless the accident causes a compensable "injury." A compensable injury is one that causes disability or the need for medical treatment. *City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967). *Soto-Carrion v. C & T Plumbing, Inc.,* W.C. No. 4-650-711 (ICAO February 15, 2007).

Moreover, 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).

As set forth above, Claimant's testimony was not found to be credible or reliable for a number of reasons. First, Claimant testified that although he was involved in a motor vehicle accident in 2016, he did not injure his right shoulder in that accident. According to Claimant's testimony, the only injury or pain that resulted from the motor vehicle accident was back pain. However, as set forth in the medical records from 2016 involving treatment for the motor vehicle accident, Claimant was treated for a right shoulder injury.

Second, not only did Claimant deny hurting his shoulder during the 2016 motor vehicle accident, Claimant's right shoulder symptoms which resulted from the 2016 motor vehicle accident are very similar to the symptoms he relates to the February 19, 2018, work incident.

Third, Claimant testified that after the incident, and before he was seen at Denver Health, he developed pain in his neck, right shoulder, and right lower back. However, despite this testimony, Claimant's medical records from Denver Health indicate Claimant denied neck and back pain.

Fourth, on the day of the accident, Claimant's pain complaints were minimal. His pain complaints were a 1-2 and Claimant was prescribed Motrin/Advil. Then, on March 16, 2018, Claimant returned to Denver Health due to a rash. The medical records from this visit are silent as to any ongoing shoulder or other musculoskeletal pain complaints. Thereafter, on March 26, 2018, Claimant presented to Dr. Yamamoto with 8/10 shoulder and upper back pain complaints as well as ongoing low back pain.

Fifth, Dr. Fall evaluated Claimant. As set forth in her report, Claimant's physical examination at Denver Health's emergency department was benign. Moreover, despite escalating pain complaints, her examination of Claimant was unremarkable. She also opined that Claimant's escalating pain complaints with high levels of reported pain involving multiple areas of his body are nonphysiologic and are not supported by objective findings. Dr. Fall also testified that Claimant might not have required any medical treatment. Dr. Fall's opinions are consistent with the medical records from Denver Health and the testimony of the Employer witnesses and therefore the ALJ found her opinions to be credible and persuasive.

Sixth, there was testimony at hearing that another co-worker or manager heard a box hit the ground the morning of February 19, 2018. However, there was no credible corroborating evidence presented that the box landed on Claimant and that two co-workers had to lift the box off of him- as alleged by Claimant. Had such occurred, it would be unlikely a co-worker would have heard the box hit the floor.

Seventh, Claimant indicated that after the accident occurred, he left work approximately 30 minutes later and went straight to Denver Health. However, medical records from Denver Health indicate Claimant did not arrive at Denver Health until approximately 5 hours after Claimant left work. Although it is not uncommon for someone to make an honest mistake when trying to remember exactly what time an incident occurred and the timing of events after the incident, this is an additional inconsistency which caused the ALJ to find Claimant was not a credible or reliable witness or historian.

Because Claimant is not found to be credible or reliable, any diagnoses which flow from Claimant's statements as to what happened, when it happened, and the extent of his symptoms are not found to be credible or persuasive. Therefore, this ALJ does not find Dr. Yamamoto's reports and testimony to be persuasive regarding Claimant's current condition, need for treatment, restrictions, and the cause of such because he relied upon the unreliable statements of Claimant in formulating and rendering his opinions.

Moreover, the mere fact that Claimant presented to Denver Health and Dr. Yamamoto and both provided medical treatment and work restrictions does not automatically require a finding that Claimant suffered a compensable work injury. The medical treatment and work restrictions were provided to Claimant based on Claimant's statements, which again, this ALJ did not find credible or reliable. Therefore, Claimant failed to establish by a preponderance of the evidence that the incident at work caused the need for medical treatment. Moreover, Claimant failed to establish by a preponderance of the evidence that the incident at work caused any disability.

A compensable injury is one that causes disability or the need for medical treatment. The ALJ concludes Claimant failed to establish by a preponderance of the evidence that he suffered an injury at work that caused any disability or the need for medical treatment. Therefore, Claimant failed to establish that he suffered a compensable injury.

Based on the above, the remaining issues raised by the parties are moot.

ORDER

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

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

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, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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. 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: January 3, 2019

/s/ Glen Goldman

Glen B. Goldman
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

ISSUES

- Did Claimant prove she suffered a compensable injury on February 28, 2018?
- If the claim is compensable, was treatment Claimant received from Valley Wide Health Systems, Rio Grande Hospital clinic, San Luis Valley Health, and Parkview Medical Center reasonably necessary to cure and relieve the effects of a compensable injury?
- At the hearing, Respondents agreed the aforementioned providers are authorized if the claim is compensable.
- Did Claimant prove entitlement to TTD benefits commencing May 7, 2018?
- The parties agreed to reserve the issue of average weekly wage pending receipt of further documentation.

FINDINGS OF FACT

1. Claimant has worked at Employer's potato processing operation in the San Luis Valley for many years. She has performed several jobs during her tenure, most recently working as a ticket person. The job entails placing a paper "ticket" inside shrink-wrapped pallets of potatoes, which identifies the type of potatoes and other inventory-related information. The potatoes are inside 5- or 10-pound mesh bags, which are placed into a larger bag to make a 50-pound "bale." The bales are stacked on pallets in rows eight bales high. A worker wraps the completed pallet several times with clear plastic shrink-wrap, essentially an industrial version of Saran Wrap. Different workers wrap the pallets slightly differently. Employer generally requires each pallet to be wrapped twice, but some workers wrap each pallet up to four times.

2. When the pallets are complete, Claimant pulls back the shrink-wrap with her right arm and places the ticket inside. Claimant referred to this process as "tagging pallets." The number of pallets processed during each shift varies depending on the season. Most shifts, Claimant processed up to four loads, with each load containing 20 pallets. During a "slow" shift, she processed approximately one and one-half loads. September through February are Employer's busy months.

3. Claimant worked the overnight shift, from 7:00 PM to 5:00 AM. During her shift starting the evening of February 28, 2018, Claimant felt progressive pain in her right upper back and shoulder while tagging pallets. After placing one specific ticket, she felt a burning sensation and increased pain in her right shoulder and right upper back.

4. Sometime around 1:00 AM, Claimant's supervisor, Travis Vigil, noticed Claimant was crying from pain. Mr. Vigil asked what was wrong and Claimant said her

shoulder and upper back were hurting badly. Claimant said she did not know why she was hurting. Mr. Vigil sent Claimant home early because she was obviously in severe pain.

5. Later that day (March 1), Claimant saw her PCP, Dr. Mary Mebane, for an already-scheduled appointment regarding a mammogram. The main complaint is listed as right breast pain for "3 weeks." The report references no shoulder or upper back exam, but the "assessment" section notes Claimant's right-sided pain was "more in infraspinatus than in breast." Also, on March 7, 2018, Dr. Mebane referred Claimant to physical therapy for "scapula tenderness, with slight winging." The ALJ infers the March 1, 2018 report provides incomplete documentation of what transpired at the corresponding office visit, and credits Claimant's testimony she discussed the upper back pain with Dr. Mebane at that visit.[1]

6. Claimant returned to work the night of March 1, but only completed part of her shift due to the pain, and Mr. Vigil sent her home early. Claimant did not tell Mr. Vigil the thought the pain was triggered by her work duties.

7. On March 8, 2018, Claimant went to the Valley Wide urgent care clinic for ongoing right upper back pain. The intake nurse noted Claimant was "having right-sided scapula pain. Had been to PCP and they were supposed to send referral . . . . Has been going on x 1 month. Thought it would go away." The physical exam documented mild winging of the left[2] scapula and focal pain over the scalenes. The urgent care physician diagnosed "strain of muscle and tendon of back wall of thorax." He gave Claimant a Toradol injection and advised her to follow-up with physical therapy as planned.

8. Claimant began physical therapy on March 13, 2018. The history section of the report states Claimant started having symptoms January 26, 2018 after recovering from bronchitis. The report states she developed "poking" pain in her mid-back at work around the right scapula. Claimant said she had seen her PCP on March 1, 2018, and was told she had a "torn muscle." The therapist further noted Claimant "works in pulling and tagging at a potato warehouse writing and taking inventory and occasionally lifts, she reports that a coworker can assist her at work to reduce the stress to the painful area when [I] asked if someone could help her to have a break from pulling activity." Claimant was noticeably uncomfortable, continually moving and repositioning her shoulder when sitting or standing. Physical examination showed muscle tightness and "ropiness" in the

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[1] The Valley Wide Health treatment records contain several errors and inconsistencies that convince the ALJ they are not entirely accurate or reliable. For example, as noted, Dr. Mebane's March 1 note references no shoulder or upper back exam, but she subsequently referred Claimant to physical therapy for "scapula tenderness, with slight winging." Additionally, the March 8 report inconsistently describes Claimant's pain level as 5/10 and 8/10, and the physical exam section incorrectly refers to "left" scapula pain. The May 7, 2018 report contains numerous erroneous references to "left" scapular and pain. In light of these inconsistencies, the ALJ has relied on the Valley Wide records primarily for "big picture" information rather than individual details.

[2] The ALJ finds the reference to "left" is a typographical error, because the rest of the report focuses on the right side. Claimant has never complained of left-sided pain.

right upper thoracic and right scapular area. The therapist diagnosed “acute” tenderness of the right midthoracic paraspinal musculature.

9. Claimant followed up with Dr. Mebane on March 15, 2018, and reported “persistent” and “worsening” pain in her upper and middle back. For unknown reasons, the physical exam section of the report documents multiple “normal” findings in unrelated areas, but references no examination of the musculoskeletal symptoms that prompted the appointment. Dr. Mebane diagnosed a “muscle tear,” which she opined was a “work-related injury.” She prescribed a muscle relaxer and Norco, advised Claimant to continue with physical therapy, and recommended three weeks of “light duty.”

10. The next day, on March 16, 2018, Claimant reported the injury to Steven Trujillo (Employer’s safety manager) and Adam Gutierrez (the facility general manager. This conversation was probably prompted by Dr. Mebane having restricted Claimant to light duty. Mr. Trujillo was uncertain how to proceed since it had been over two weeks since the claimed date of injury. Mr. Trujillo did not refer Claimant to a physician or clinic. He discussed the matter with his superiors at the corporate office and then reported the accident to Insurer.

11. Claimant completed an accident report with Mr. Vigil on March 21, 2018, describing an injury to “the upper right side of my back.” She described the mechanism of injury as, “I was tagging a pallet when I felt a sharp pain on the right side of my back.” Mr. Vigil did not refer Claimant to a medical provider.

12. The right of selection passed to Claimant on March 16, 2018, and she elected to continue receiving care under the direction of Dr. Mebane and Valley Wide.

13. Sometime after the right of selection had passed to Claimant, Mr. Trujillo gave her a list of providers, which included the Rio Grande Hospital Clinic. Shortly after that, Claimant received a packet of information from Insurer, which led her to believe the claim was approved. Based on that assumption, Claimant scheduled an appointment with the RGH Clinic. But a few days before the appointment, Claimant received a call from the claims adjuster informing her the claim was denied.

14. Claimant kept the appointment with the RGH Clinic for a “second opinion.” She saw Kimberly Woodke, PA-C on Monday, April 16, 2018. The documented injury history was:

> First hurt at work went to pull pallet. Felt burning sensation on back. She mentioned to foreman and was crying with it. 3/1/18 had an apt with pcp for referral for mammogram. Apparently there wasn’t documentation on 3/1/18. On 3/15/18 was seen and was given tizanidine and Norco 7.5.325 didn’t seem to help. Friday evening she was notified that work man’s comp denied. She has been using neighbors’ Voltaren gel which seems to help for 6-8 hours.

15. PA-C Woodke diagnosed “dorsalgia.” She gave Claimant a Toradol injection, prescribed Voltaren gel and Naprosyn, and advised her to continue physical therapy.

16. Claimant did not return to the RGH Clinic because her claim was denied. Instead, she continued pursuing treatment already initiated through Dr. Mebane’s office.

17. Claimant had a right shoulder MRI on April 27, 2018. It showed a small supraspinatus tendon attachment point tear, moderate AC joint DJD, and subacromial/subdeltoid bursal edema.

18. On May 7, 2018, Dr. Mebane took Claimant off work for seven days “to see if therapy works.” She gave Claimant a steroid injection in the shoulder and noted Claimant would need to see a specialist if her symptoms did not resolve soon.

19. Claimant took the off-work note to Employer later that day to discuss her options. Ultimately, Employer placed Claimant on unpaid FMLA leave effective May 7. She has not returned to work since then.

20. On May 9, 2018, Claimant went to the San Luis Valley Health Regional Medical Center emergency department for a pain flare. The steroid injection had helped for a few hours but the pain returned and intensified. The physical examination showed pain and muscle spasm in the right rhomboid rather than the rotator cuff. The ER physician noted, “pt presents with right shoulder pain that she attributes to a rotator cuff tear given the recent MRI results. However, on exam it appears to be more rhomboid muscle spasm pain as she has point tenderness in inferior rhomboid with palpated knot.”

21. On May 15, 2018, Claimant saw Dr. Jason Defee, an orthopedic specialist at San Luis Valley Health, on referral from Dr. Mebane’s office. Claimant told Dr. Defee, “She was pulling something at work when she felt a pull in her shoulder then a sudden burning.” Shoulder range of motion was full but painful, and the right scapula was tender to palpation. r. Defee diagnosed right shoulder pain and a “very small supraspinatus tendon tear.” He gave Claimant another steroid injection and kept her off work for the rest of the week.

22. Claimant followed up with Brian Jackson, PA-C in Dr. Defee’s office on June 5, 2018. She reported that the cortisone injection helped for a day and a half, but the pain returned. The most significant exam finding was significant spasm and tenderness of the infraspinatus muscle under the scapula, consistent with the burning sensation and pain she had been describing. Mr. Jackson opined, “This is not a surgical problem and this is more musculature of the infraspinatus muscle that is causing the pain.” He recommended massage therapy and gentle stretching with a therapy ball. He gave Claimant a trigger point injection, which provided immediate relief.

23. Claimant started treating with Dr. Kevin Rice, a physiatrist at SLV Health, on July 5, 2018. Dr. Rice noted Claimant’s pain was primarily emanating from the infrascapular rhomboid musculature.

24. Claimant saw Dr. Rice again on August 3, 2018. Dr. Rice noted it was difficult to discern whether Claimant's symptoms were primarily related to her right shoulder or upper thoracic area. Claimant explained she has always had mid back and scapular pain since the accident, but not any true regional shoulder pain. On the other hand, Dr. Defee documented a painful arc of abduction and the shoulder MRI showed a small supraspinatus tear. Dr. Rice recommended a thoracic MRI to further investigate the pain generator.

25. On August 17, 2018, Claimant saw Alan Garcia, PA-C at the orthopedic clinic at Parkview Medical Center, on referral from Valley Wide. She said her problem started in February 2018 while doing her regular work duties. Impingement testing was equivocal, with a positive Hawkin's sign but negative Neer's. Shoulder range of motion was full bilaterally. Claimant exhibited diffuse tenderness to palpation along the trapezius down to approximately the T6-T7 area. Mr. Garcia opined,

> [I]t is hard to delineate between potential spine issues that may be causing radicular symptoms down into her arm. Based upon this, she has done everything asked of her, in terms of treatment options. If she had an isolated shoulder injury only, recommend a right shoulder arthroscopy and subacromial decompression, possible repair as needed, but since she does have radicular symptoms coming from her spine and mid back, recommend that she follow up with her Workmen's Compensation to have further evaluation done on this. Once they resolve that issue, if she continues to have isolated shoulder issues, she can follow up and we will discuss further treatment options to include arthroscopy.

26. The final medical report in the evidentiary record is an August 21, 2018 clinic note from Valley Wide, referring Claimant for thoracic and cervical MRIs.

27. Claimant proved by a preponderance of the evidence she suffered a compensable injury on February 28, 2018.

28. The treatment Claimant has received since March 8, 2018 from Valley Wide Health System, Rio Grande Hospital Clinic, San Luis Valley Health, and Parkview Medical Center was reasonably necessary to cure and relieve the effects of her compensable injury. The May 9, 2018 emergency room visit was reasonably necessary emergency treatment for a severe pain flare.

29. The cervical and thoracic MRIs are reasonably necessary diagnostic procedures to investigate the nature and scope of her compensable injury.

30. Employer received information sufficient to trigger its obligation to designate a treating provider no later than March 16, 2018. Employer did not timely refer Claimant to an authorized provider, so all treatment she received through her personal physicians since March 16, 2018 is authorized.

31. Claimant is entitled to TTD benefits commencing May 7, 2018, when she stopped work as a proximate result of her compensable injury.

CONCLUSIONS OF LAW

A. Claimant proved a compensable injury on February 28, 2018

To receive compensation or medical benefits, a claimant must prove she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *Pacesetter Corp. v. Collett*, *33 P.3d 1230* (Colo. App. 2001). The claimant must prove that an injury directly and proximately caused the condition for which she seeks benefits. *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 compensable injury is one that requires medical treatment or causes a disability. *E.g., Montgomery v. HSS, Inc*., W.C. No. 4-989-682-01 (August 17, 2016). Even a minor "strain" can be a sufficient basis for a compensable claim if it was caused by a claimant's work activities and caused her to seek medical treatment. The ICAO's decision in *Garcia v. Express Personnel*, *supra*, is instructive regarding the minimal extent of an injury that can satisfy the basic threshold requirement of compensability. In *Garcia*, the claimant felt pain in her abdomen and hip while lifting a piece of glass at work. The employer referred the claimant to Dr. Caughfield, who diagnosed a lumbar strain, but opined she had already reached MMI. The ALJ found that the claimant suffered a "minor back sprain," but also found the sprain had "resolved" within five days of the incident. The ALJ denied the claim on the theory that the claimant suffered no "injury." The ICAO reversed and held that the claimant had established a compensable injury as a matter of law:

> Where pain triggers the claimant's need for medical treatment, the claimant has established a compensable injury if the industrial injury is the cause of the pain. The term medical treatment includes diagnostic procedures required to ascertain the extent of the industrial injury.
>
> Here, the ALJ found there was an industrial accident which caused a minor lumbar strain. Further, the ALJ determined that when the injury was reported to the employer, the employer offered the claimant medical services from Dr. Caughfield, which the claimant accepted. Although Dr. Caughfield placed the claimant at MMI based upon his [ ] examination, the ALJ found with record support that Dr. Caughfield diagnosed a lumbar strain. Thus, the ALJ's findings compel the conclusion the claimant established a compensable injury which entitled her to an award of medical benefits. (Citations omitted).

As found, Claimant proved she suffered a compensable injury on February 28, 2018 while tagging pallets. Although there are some discrepancies in the record as to the description of the injury, the totality of evidence demonstrates Claimant's back pain was triggered by her work activities. Claimant has attributed the onset of symptoms to tagging pallets at work to multiple providers, her supervisors, and in the March 21, 2018 accident report. Admittedly, it is puzzling why Claimant did not mention any mechanism of injury when she spoke with Mr. Vigil the night of February 28. But Claimant's testimony was

largely credible, and the balance of persuasive evidence corroborates her allegations. Even though the force required to pull the plastic shrink-wrap is not dramatic, Claimant's relatively diminutive stature renders the force proportionally greater for her than for a more robust individual such as Mr. Trujillo. Whatever the level of force required, the persuasive evidence shows it was injurious for Claimant. The evidence shows Claimant at least suffered a strain of the thoracic and periscapular musculature. The extent to which her right shoulder is also involved is less clear, subject to further workup as recommended by her authorized providers.

B. The treatment provided to date has been reasonably necessary

The respondents are liable for medical treatment reasonably necessary to cure and relieve the effects of an industrial injury. Section 8-42-101(1)(a); *Snyder v. Industrial Claim Appeals Office*, 942 P .2d 1337 (Colo. App. 1997). Compensable medical treatment includes evaluations or diagnostic procedures to investigate the existence, nature, or extent of an industrial injury. *Garcia v. Express Personnel*, W.C. No. 4-587-458 (August 24, 2000). Where the respondents dispute the claimant's entitlement to medical benefits, the 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).

As found, Claimant proved the treatment she has received since March 8, 2018 from Valley Wide Health System, Rio Grande Hospital Clinic, San Luis Valley Health, and Parkview Medical Center was reasonably necessary to cure and relieve the effects of her compensable injury. The initial post-injury appointment with Dr. Mebane on March 1 was already scheduled and not prompted by the injury, but subsequent medical appointments commencing March 8, 2018 were directly related to the compensable injury. The various modalities provided, such as therapy, medications, imaging studies, and injections, are well within the standard conservative treatment protocol for a suspected shoulder or back injury.

C. Dr. Mebane and her referrals were authorized after March 16, 2018

Section 8-43-404(5)(a)(I)(A) gives the employer the right to select an authorized treating physician "in the first instance." If the employer does not designate a treating physician "forthwith" upon receiving notice of the injury, the right of selection passes to the claimant. *Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565, 567 (Colo. App. 1987). The employer's obligation to offer medical treatment is triggered by "some knowledge of accompanying facts connecting the injury or illness with the employment and indicating to a reasonably conscientious manager that the case might involve a potential compensation claim." *Jones v. Adolph Coors Co*., 689 P.2d 681, 684 (Colo. App. 1984). Notice of an injury can be given to "employee's foreman, superintendent, manager," or "other person in charge." Section 8-43-102(1.5)(a); *Frank v. Industrial Commission*, 43 P.2d 158 (Colo. 1935); *Ferris v. King Soopers, Inc.*, W.C. No. 3-884-707 & 3-895-561 (April 5, 1990); *Zanini v. King Soopers*, W.C. No. 3-870-72 & 3-887-766 (December 4, 1989).

Although Mr. Vigil knew Claimant was having back pain on February 28, 2018, he did not know it was a work-related condition because Claimant did not inform him of such. The persuasive evidence shows Employer had sufficient information to trigger the duty to designate by March 16, 2018 at the latest, but did not provide a referral until after the right of selection passed to Claimant. As a result, the treatment she received after March 16, 2018 was authorized.

D. Claimant is entitled to TTD benefits commencing May 7, 2018

A claimant is entitled to TTD benefits if the injury causes a disability, the disability causes the claimant to leave work, and the claimant misses more than three regular working days. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The claimant must establish a causal connection between a work-related injury and the wage loss to obtain TTD benefits. *Id*. 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). Impairment of earning capacity may be evidenced by a complete inability to work, or by restrictions that 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 is entitled to TTD benefits commencing May 7, 2018. Dr. Mebane took Claimant off work that date so she could try therapy without the confounding influence of work. Dr. Defee subsequently extended her off work status. Ultimately, Employer placed Claimant on unpaid FMLA leave due to the injury, and Claimant has not returned to work since then. The persuasive evidence shows she left work as a proximate result of her injury and suffered a wage loss commencing May 7, 2018.

ORDER

It is therefore ordered that:

1. Claimant’s claim is compensable.

2. Insurer shall cover reasonably necessary medical treatment from authorized providers after March 16, 2018, including but not limited to, charges from Valley Wide Health System, Rio Grande Hospital Clinic, San Luis Valley Health, and Parkview Medical Center.

3. Insurer shall cover the cervical and thoracic MRI recommended by Claimant’s ATPs.

4. Claimant is entitled to TTD benefits commencing May 7, 2018 and continuing until terminated by law. Because the parties reserved the issue of average weekly wage, no specific order regarding TTD may issue.

5. All issues 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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. 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: January 4, 2019

s/Patrick C.H. Spencer II
Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 5-078-666-001

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

Claimant,

v.

Employer,

and

Insurer / Respondents.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on December 18, 2018, in Denver, Colorado. The hearing was digitally recorded (reference:) 12/18/18, Courtroom 3, beginning at 8:30 AM, and ending at 11:00 AM). The official Spanish/English Interpreter was Portia Berrey.

Claimant's Exhibits 1 through 10 were admitted into evidence, without objection. Respondents' Exhibits A through F were admitted into evidence, without objection.

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to counsel for the Claimant, which was filed, electronically, on December 24, 2018. Respondent was given two working days within which to file objections as to form. No timely objections were filed. After a consideration of the proposed decision, the ALJ has modified it and hereby issues the following decision.

ISSUES

The issues to be determined by this decision concern compensability; if compensable, temporary partial disability (TPD) benefits from March 23, 2018 through June 22, 2018. At the commencement of the hearing, the parties stipulated that the Claimant's average weekly wage (AWW) is $547.40, and the ALJ so finds.

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 33-year old woman employed by the Employer. Prior to March 23, 2018, she worked as a waitress on the "Event" staff, and as a busser in the restaurant. Her stipulated AWW is $547.40.

2. The Claimant has had no prior injuries to her cervical spine or right shoulder.

3. Prior to the date of the Claimant's industrial injury she was able to perform her full work duties as both a waitress and busser.

The Compensable Event of March 23, 2018

4. The Claimant sustained a work-related injury on Friday March 23, 2018. The incident happened around 11:00 AM on the Employer's property as the Claimant was walking into her place of employment. The Claimant was roughly 12-15 feet from the Employer's entrance when the wind randomly blew a nearby plastic "A-Frame" sign into a 3 to 4 foot tall light post; the top of which broke off and sent debris into the air. The Claimant was talking on her cell phone when she noticed the debris was flying toward her. This caused the her to quickly turn away from the debris and attempt to protect herself with her bag which was draped over her right shoulder. Despite the attempt to protect herself, the Claimant was stuck in the right side of the face by the debris. She quickly developed facial pain, headache, and vision issues with her left eye.

First Reporting of the Work Injury

5. The Claimant's manager, Cassandra Dunning, was walking behind the Claimant and witnessed the incident. Dunning approached the Claimant immediately thereafter to check on her wellbeing. Dunning then escorted the Claimant into the Employer's offices and helped the Claimant report a work injury.

6. An "Employer's First Report of Injury" was filed on March 23, 2018 at approximately 11:00 AM. Cassandra Dunning is listed as a witness. The incident as described in paragraph 4 above, is described as the mechanism of injury in the First Report.

Medical Treatment

7. The Claimant had an initial evaluation at Concentra around 1:00 PM on March 23, 2018. She was treated for an injury to her left eye, facial pain, and headache. She was given eye drops, instructed to wear protective eye wear while at work, and she scheduled for a follow-up appointment for Monday March 26, 2018.

8. After being discharged from Concentra, the Claimant returned to work for the Employer as a busser for the night. While working, the Claimant began experiencing pain in her neck and right shoulder. She did not work the next two days but continued to have issues with her neck and right shoulder.

9. The Claimant was evaluated at Concentra on Monday March 26, 2018 and she reported neck and right shoulder pain that began a few hours after being discharged on March 23, 2018. The Claimant was diagnosed with a cervical strain, prescribed medication, and referred for physical therapy (PT).

10. Thereafter, the Claimant underwent a course of cervical and right shoulder treatment inclusive of evaluations, work restrictions, PT, massage therapy, acupuncture, and injections.

11. The Claimant was placed at maximum medical improvement (MMI) on June 22, 2018.

Temporary Partial Disability

12. The Claimant suffered temporary, partial wage loss resulting from her work injury. The wage loss was in part due to temporary work restrictions, and in part due to her inability to buss tables after injuring work injury on March 23, 2018. TPD benefits are as follows

- Pay Period 3/20/18 – 4/2/2018: Only 11 days are counted from this pay period (3/23/2018 to 4/2/2018). The Claimant earned $591.91 for these 11 days (14 days wages = $753.53; 11 days wages = $591.91; AWW = $547.40; 11 days is $860.20). This produces a temporary wage loss of $268.12 per week, and yields a TPD rate of $178.74 per week for this pay period.
- Pay Period 4/3/2018 – 4/16/2018: The Claimant earned $531.38 per week. This produces a temporary wage loss of $16.02, and yields a TPD rate of $10.68 per week for this pay period.
- Pay Period 4/17/2018 – 4/30/2018: The Claimant earned $177.79 per week. This produces a wage loss of $369.61, and yields a TPD rate of $246.41 per week for this pay period.
- Pay Period 5/1/2018 – 5/14/2018: The Claimant earned $750.40 per week. The Claimant is not entitled to TPD for this pay period.
- Pay Period 5/15/2018 – 5/28/2018: The Claimant earned $214.81 per week. This produces a wage loss of $332.59 per week, and yields a TPD rate of $221.73 per week for this pay period.
- Pay Period 5/29/2018 – 6/11/2018: The Claimant earned $363.31 per week. This produces a wage loss of $184.09 per week, and yields a TPD rate of $122.73 per week for this pay period.
- Pay Period 6/12/2018 – 6/25/2018: Only 11 days are counted from this pay period (6/12/2018 – 6/21/2018). The Claimant earned $281.15 for these 11 days (14 days wages = $357.83; 11 days wages = $281.15; AWW = $547.40; 11 days is $860.20). This produces a temporary wage loss of $579.05, and yields a TPD rate of $386.03 for this pay period.

The Claimant is entitled to a grand total of $923.11 in TPD benefits.

Ultimate Findings

13. The ALJ has considered the opinions regarding causation submitted by the Claimant's IME, Dr. Stephen Gray, Respondents' IME, Dr. William Ciccone, and Dr. Robert Kawasaki. Dr. Ciccone's opinions do not support a work-related injury and largely rely on his perceived inconsistent statements by the Claimant regarding the mechanism of injury. Dr. Kawasaki's opinions do not support a work related injury in large part due to the findings on the Claimant's MRI. However, when presented with knowledge that Dunning witnessed the incident Dr. Ciccone refused to appropriately consider this new information in his assessment of how the alleged work incident

happened. Therefore, his ultimate opinions lack credibility. Further, Dr. Kawasaki gives no credence to the notion of aggravation and/or acceleration of a preexisting medical condition. This substantially detracts from his causation opinions. Dr. Gray's opinions support a work-related injury, and are based on Claimant's credible statements and supporting medical documents. The ALJ accepts Dr. Gray's opinions on causation and rejects any conflicting opinions concerning causation.

14. Between conflicting medical opinions, the ALJ makes a rational choice, based on substantial evidence, to accept Dr. Gray's causation opinions and to reject opinions to the contrary.

15. The ALJ finds that the Claimant suffered a work-related injury to her head, cervical spine, and right shoulder area on March 23, 2018, thus, sustaining compensable injuries on that date.

16. The Claimant has sustained her burden of proof, by a preponderance of the evidence, that she sustained compensable work injuries on March 23, 2018.

17. The ALJ further finds that the medical treatment the Claimant received to her cervical spine, right shoulder was authorized, reasonably necessary, and causally related to her compensable work injuries of March 23, 2018.

17. The Claimant has also sustained her burden of proof, by preponderant evidence, that she suffered a partial loss of wages from the date of her injuries, March 23, 2018, through June 21, 2018, both dates inclusive. During this period of time, she had not been released to return to full duty, and she had not reached maximum medical improvement (MMI). The Claimant is entitled to TPD benefits in the aggregate grand total amount of $923.11, as detailed in Finding No. 12 herein above.

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 Bodensleck v. Indus. Claim Appeals Office,* 183 P.3d 684 (Colo. App. 2008);*Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Rockwell International v. Turnbull,* 802 P.2d 1182, 1183 (Colo. App. 1990); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The ALJ determines

the credibility of the witnesses. A*renas v. Indus. Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000). The weight and credibility to be assigned evidence is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Youngs v. Indus. Claim Appeals Office,* 297 P.3d 964, **2012 COA 85.** The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913); *also see Heinicke v. Indus. Claim Appeals Office,* 197 P.3d 220 (Colo. App. 2008). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential Ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). The ALJ has broad discretion to determine the admissibility and/or weight of evidence based on an expert's knowledge, skill, experience, training and education. *See* § 8-43-210, C.R.S; *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P.2d 501 (Colo. App. 1995). As found, the ALJ considered the opinions regarding causation submitted by the Claimant's IME, Dr. Stephen Gray, Respondents' IME, Dr. William Ciccone, and Dr. Robert Kawasaki. Dr. Ciccone's opinions do not support a work-related injury and largely rely on his perceived inconsistent statements by the Claimant regarding the mechanism of injury. Dr. Kawasaki's opinions do not support a work related injury in large part due to the findings on the Claimant's MRI. However, when presented with knowledge that Dunning witnessed the incident Dr. Ciccone refused to appropriately consider this new information in his assessment of how the alleged work incident happened. Therefore, his ultimate opinions lack credibility. Further, Dr. Kawasaki gives no credence to the notion of aggravation and/or acceleration of a preexisting medical condition. Under the present circumstances, this substantially detracts from his causation opinions and renders his opinions lacking in credibility. As found, Dr. Gray's opinions support a work-related injury, and are based on Claimant's credible statements and supporting medical documents. As further found, the ALJ accepted Dr. Gray's opinions on causation and rejected any conflicting opinions concerning causation.

<u>Substantial Evidence</u>

b. An ALJ's factual findings must be supported by substantial evidence in the record. *Paint Connection Plus v. Indus. Claim Appeals Office,* 240 P.3d 429 (Colo. App. 2010); *Leewaye v. Indus. Claim Appeals Office,* 178 P.3d 1254 (Colo. App. 2007); *Brownson-Rausin v. Indus. Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005). *Also see Martinez v. Indus. Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007). Substantial evidence is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of

conflicting evidence." *Metro Moving & Storage Co.v. Gussert,* 914 P.2d 411 (Colo. App. 1995). Reasonable probability exists if a proposition is supported by **substantial evidence** which would warrant a reasonable belief in the existence of facts supporting a particular finding. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985). It is the sole province of the fact finder to weigh the evidence and resolve contradictions in the evidence. See *Pacesetter Corp. v. Collett,* 33 P. 3d 1230 (Colo. App. 2001). An ALJ's resolution on questions of fact must be upheld if supported by substantial evidence and plausible inferences drawn from the record. *Eller v. Indus. Claim Appeals Office,* 224 P.3d 397, 399-400 (Colo. App. 2009). As found, between conflicting medical opinions, the ALJ made a rational choice, based on substantial evidence, to accept Dr. Gray's causation opinions and to reject opinions to the contrary.

Compensability

c. A compensable injury is one that arises out of and in the course of employment. § 8-41-301(1) (b), C.R.S. The "arising out of" test is one of causation. If an industrial injury aggravates or accelerates a preexisting condition, the resulting disability and need for treatment is a compensable consequence of the industrial injury. Thus, a claimant's personal susceptibility or predisposition to injury does not disqualify the claimant from receiving benefits. *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). An injured worker has a compensable new injury **if the employment-related activities aggravate, accelerate, or combine with a pre-existing condition to cause a need for medical treatment or produce the disability for which benefits are sought.** § 8-41-301(1) (c), C.R.S. *See Merriman v. Indus. Comm'n,* 120 Colo. 400, 210 P.2d 448 (1949); *Anderson v. Brinkoff,* 859 P.2d 819 (Colo. 1993); *National Health Laboratories v. Indus. Claim Appeals Office,* 844 P.2d 1259 (Colo. App. 1992); *Snyder v. Indus. Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). An injury resulting from the concurrence of a preexisting condition and a hazard of employment is compensable. *H & H Warehouse v. Vicory*, *supra*. *Duncan v. Indus. Claims App. Office*, 107 P.3d 999 (Colo. App. 2004). Even where the direct cause of an accident is the employee's preexisting disease or condition, the resulting disability is compensable where the conditions or circumstances of employment have contributed to the injuries sustained by the employee. *Ramsdell v. Horn*, 781 P.2d 150 (Colo.App. 1989). *Also see* § 8-41-301(1) (c), C.R.S; *Parra v. Ideal Concrete,* W.C. No. 4-179-455 [Indus. Claim Appeals Office (ICAO), April 8, 1998]; *Witt v. James J. Keil Jr.,* W.C. No. 4-225-334 (ICAO, April 7, 1998). As found, the Claimant suffered work-related injuries to her head, cervical spine, and right shoulder area on March 23, 2018, thus, sustaining compensable injuries on that date.

Medical

d. To be a compensable benefit, medical care and treatment must be causalld related to an industrial injury or occupational disease. *Dependable Cleaners v. Vasquez,* 883 P. 2d 583 (Colo. App. 1994). As found, Claimant's medical treatment is

causally related to the compensable aggravation and acceleration of her compensable inuries of march 23, 2018. Also, medical treatment must be reasonably necessary to cure and relieve the effects of the industrial occupational disease. § 8-42-101 (1) (a), C.R.S. *Morey Mercantile v. Flynt,* 97 Colo. 163, 47 P. 2d 864 (1935); *Sims v. Indus. Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). As found, the Claimant's medical care and treatment was and is reasonably necessary. As found, the medical treatment the Claimant received for her cervical spine, right shoulder was authorized, reasonably necessary, and causally related to her compensable work injuries of March 23, 2018.

Temporary Partial Disability Benefits

e. To establish entitlement to temporary disability benefits, a claimant must prove that the industrial injury has caused a "disability," and that he has suffered a wage loss that, "to some degree," is the result of the industrial disability. § 8-42-103(1), C.R.S; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Disability from employment is established when the injured employee is unable to perform the usual job effectively or properly. *Jefferson Co. Schools v. Headrick*, 734 P.2d 659 (Colo. App.1986). This is true because the employee's restrictions presumably impair his opportunity to obtain employment at pre-injury wage levels. *Kiernan v. Roadway Package System*, W.C. No. 4-443-973 [Indus. Claim Appeals Office (ICAO), December 18, 2000]. There is no statutory requirement that a claimant must present medical opinion evidence from of an attending physician to establish her 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." *Id*. As found, the Claimant was temporarily and partially disabled from March 23, 2018, through June 21, 2018, both dates inclusive.

f. Once the prerequisites for TPD are met (*e.g.,* no release to return to full duty, MMI has not been reached, and a temporary wage loss is occurring in modified employment, TPD benefits are designed to compensate for temporary wage loss. As found, the Claimant suffered a partial loss of wages from the date of her injuries, March 23, 2018, through June 21, 2018, both dates inclusive. During this period of time, she had not been released to return to full duty, and she had not reached MMI.She is entitled to TPD benefits in the aggregate grand total amount of $923.11, as detailed in Finding No. 12 herein above.

Burden of Proof

g. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Indus. Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Indus. Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000). *Kieckhafer*

v. Indus. Claim Appeals.Office, 284 P.3d 202, 205 (Colo. App. 2012). 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 [Indus. Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). "Preponderance" means "the existence of a contested fact is more probable than its nonexistence." *Indus. Claim Appeals Office v. Jones*, 688 P.2d 1116 (Colo. 1984). As found, the Claimant has sustained her burden with respect to compensability, medical benefits and TPD benefits.

ORDER

IT IS, THEREFORE, ORDERED THAT:

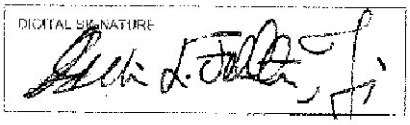
A. Respondents shall pay the costs of all authorized, reasonably necessary and causally related medical care and treatment, arising out of the compensable injuries of March 23, 2018, subject to the Division of Workers Compensation Medical Fee Schedule.

B. Respondents shall pay the Claimant temporary partial disability benefits in the aggregate grand total amount of $923.11, which is payable retroactively and forthwith.

C. Any and all claims for temporary disability benefits from June 22, 2018, through December 18, 2018, the date of hearing, are hereby denied and dismissed.

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

DATED this_____day of January 2019.



_____
EDWIN L. FELTER, JR.
Administrative Law Judge

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts,**1525 Sherman Street, 4th Floor, Denver, CO 80203.** You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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* § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, *see* Rule 26, OACRP. You may access a form for a petition to review at** *http://www.colorado.gov/dpa/oac/forms-WC.htm*.

ISSUES

I. What is the appropriate burden of proof to be applied to the DIME opinion of Dr. Hall regarding Claimant's admitted right shoulder injury?

II. Applying this burden of proof, what is Claimant's Impairment Rating for her right shoulder?

FINDINGS OF FACT

Based upon the evidence received at Hearing, the ALJ makes the following Findings of Fact:

1. Claimant has worked for Employer for several years, in part as an airline baggage handler. On June 1, 2013, Claimant sustained a compensable industrial injury to her right shoulder.

2. Respondents filed a General Admission of Liability ("GAL") on December 10, 2013.

3. At some point, Claimant was authorized for treatment by orthopedist John Pak, MD. However, the ALJ is in possession of exactly two reports prepared by Dr. Pak, to wit: his postoperative report dated 11/2/16. (Ex. 3), and his "Letter of MMI" dated 3/29/16 (Ex. A, p. 2). Thus, the ALJ is otherwise entirely dependent upon the interpretations of what Dr. Pak said, and did, by the DIME physician, Dr. Timothy Hall, and Respondents' IME physician, Dr. Eric Ridings.

4. Clamant suffered a torn rotator cuff, and underwent an initial repair surgery by Dr. Pak on 8/5/2015. Dr. Hall describes the procedure as: Right shoulder arthroscopy, subacromial decompression, **acromioplasty,** *and* rotator cuff repair (Ex. 2, p. 13). Dr. Ridings describes the procedure as a subacromial decompression, **acromioplasty,** *and* rotator cuff repair. (Ex. C, p. 10) (emphasis added).

5. According to Dr. Hall, Claimant was initially placed at MMI by Dr. Pak on 3/**29**/2016. (Ex. 3, p. 14). In fact, Dr. Pak's letter (dated 3/29/16) says MMI was reached on 3/**21**/2016). (Ex. A, p. 2). Dr. Ridings does not address the initial MMI date-although according to Dr. Hall, Dr. Ridings performed an initial IME (not in evidence herein), wherein he acknowledged causation of her work injury (Ex. 3, p. 14).

6. Following this first surgery, on August 12, 2016, Respondents filed a Final Admission of Liability admitting to a 6% scheduled right shoulder rating pursuant to authorized treating provider John Pak, M.D.'s opinion of March 29, 2016. (Ex. A).

7. However, Claimant's condition worsened. By accounts of both Drs. Hall and Ridings, Claimant had a new MRI. (Dr. Hall dates the MRI at 8/15/16-Ex. 3, p. 14) (Dr. Ridings

does not date the MRI at all-Ex C. p. 11). In any event, this MRI showed a re-tear of the same rotator cuff.

8. Dr. Hall then references a revision surgery occurring on 4/3/2016 (Ex. 3, p. 14). The ALJ finds this to be in error; the revision surgery, according to Dr. Pak, occurred 11/2/2016. (Ex. 3, p. 18). (This better fits the logical timelines; the ALJ notes that this surgery would not have occurred four months **before** the MRI took place.)

9. Dr. Pak's own surgical notes indicate what the revision surgery involved: "Right shoulder arthroscopy, removal of hardware and sutures, debridement, lysis of adhesions, and rotator cuff repair" (as well as **left** shoulder subacromial cortisone injection) (Ex. 3, p. 18).

10. According to Dr. Ridings, Claimant was again placed at MMI by Dr. Pak on 7/9/17 at the time of a Functional Capacity Exam ("FCE"); however, Dr. Ridings goes on to say that Dr. Pak issued a "letter of MMI" dated 10/30/17, wherein Dr. Pak performs range of motion measurements. At this time Dr. Pak assigns a 4% right extremity rating. (Ex. C, p. 11). (The ALJ notes that this report by Dr. Pak is not in evidence).

11. Dr. Hall, in contrast, references a "closing note" from Dr. Pak, placing Claimant at MMI on 8/18/17. (Ex. 3, p. 14).

12. The procedural record thereafter is silent; however, the ALJ infers that Claimant took exception to this second Impairment Rating assigned by Dr. Pak, and requested a DIME examination.

13. Claimant underwent this Division Independent Medical Examination by Dr. Hall, on July 11, 2018. Dr. Hall noted in his review of records that the second MRI was consistent with a large "read as re-tear" of the rotator cuff. Dr. Hall noted Claimant once again underwent a right shoulder arthroscopy with debridement, subacromial decompression, acromioplasty, rotator cuff repair and arthroscopic biceps arthrodesis.

14. Dr. Hall further noted Claimant returned to Dr. Pak, who placed Claimant back at MMI as of July 19, 2017. Based upon the FCE and repeat range of motion measurements, Dr. Pak this time determined Claimant's range of motion loss was 4% right upper extremity.

15. Under 'History of Present Illness' Dr. Hall documented the Claimant returned to doing the same work she did that "created these injuries." Dr. Hall further noted, "she had surgery, went back to work, released to full duty, re-injured the shoulder, had a subsequent surgery, and now is better than she had been following the re-injury, but not quite as good as she was after the first surgery". (Ex. B, p. 8).

16. With regard to Claimant's pain profile, Dr. Hall noted, "she does have some upper extremity symptoms, which are transient including tingling in the arm and hands and aching in the hand distally. She has more of these symptoms on the right than the left but no reports of focal weakness." *Id.*

17. Dr. Hall's assessment was rotator cuff tear x2 with two surgeries, myofascial pain and transit neurologic symptoms.

18. At Dr. Hall's evaluation he noted, "the bulk of her problem is the rotator cuff tear itself, which is what is rated. Range of motion reveals a 5% impairment per the worksheet. *She did have the* ***acromioplasty*** *which is the additional 5% which adds to 10 percent impairment."* (Ex. 2, p. 15) (emphasis added).

19. Claimant was evaluated by Eric O. Ridings, M.D. on two separate occasions. The first on October 19, 2014 and the second on September 10, 2018. Dr. Ridings noted, "This is an occupational disease claim in which Ms. Ford injured her right shoulder moving luggage at the airport working at the ticket counter and the gate for Delta Airlines." (Ex. C).

20. According to the second IME report, Claimant told Dr. Ridings, "when I was taking the chronological history and discussing her Division Independent Medical Examination, she stated that the entire visit in the room with her by Dr. Hall lasted only about 5 minutes. She also offered that she did not recall Dr. Hall using any measuring device to determine her right shoulder range of motion. She volunteered that she recalled at her last IME with me that she remembered having done so (about 3 yrs. ago) but really did not think that Dr. Hall had taken specific measurements at the Division IME (2 months ago). (Ex. C, pp. 12-13).

21. On physical examination Dr. Ridings found Claimant's upper extremity reflexes were 2 plus and symmetric, strength was 5/5, sensation to pin prick was intact. Structurally, although Claimant had some tenderness to palpation she did not have a painful ark, Hawkins Impingement maneuver was negative and right shoulder range of motion was fluid.

22. Based upon Dr. Ridings measurements at his IME on that date Claimant had a 7% impairment of the right upper extremity. He opined that this should remain a scheduled impairment rating only. Dr. Ridings prepared a range of motion worksheet in support of his findings. (Ex. C, p. 15).

23. With regard to Dr. Hall's addition of a 5% impairment rating for "acromioplasty," Dr. Ridings noted:

> The Division examiner in this case assigned an additional 5% impairment in addition to the range of motion impairment (which he found to be somewhat less, as 5% of the right upper extremity) for **"acromioplasty",** which is shaving off some of the underside of the acromion superior to the supraspinatus tendon. I do not recall ever seeing a rotator cuff repair surgery that also did not include this procedure as a routine part of the process. As taught in the Division of Workers' Compensation Level II Reaccreditation Courses, and as discussed in Desk Aid No. 11-Impairment Rating Tips, Page 7, routine rotator cuff arthroscopic surgery is rated simply based on range of motion impairment. The AMA Guides,

> Third Edition Revised include consideration of expected residual symptoms at a joint and assigned a certain percentage impairment for a certain degree of range of motion loss. As it says in the Impairment Rating Tips on Page 7 the "AMA Guides Fourth and Fifth Additions continue to suggest that **subacromial arthroplasty** should be rated using ROM, and when appropriate "joint crepitation with motion" from the "Other Disorders" section. In general, when any additional rating for subacromial arthroplasty is deemed appropriate in a case with or without crepitus because …**other factors** have not adequately rated the extent of the impairment it should not exceed 10%." (Ex. C, p. 14) (emphasis added).

24. Dr. Ridings explained that Dr. Hall did not make any argument in his DIME report why, in this case, Claimant should have any additional impairment beyond the decreased range of motion, instead simply noting that she had an acromioplasty. Dr. Ridings further opined in this case the Claimant had a typical outcome for a rotator cuff repair surgery and successfully returned to her previous job with the ability to lift 50 pounds. Given the absence of unusual circumstances indicating a worse than typical outcome, the Division Examiner is in error in assigning an additional 5%.

25. At hearing, Dr. Ridings was offered and accepted as a medical expert in physical medicine and rehabilitation with education, training and experience to examine, diagnosis and treat patients who have shoulder injuries. In addition, Dr. Ridings has been Level II Accredited since 1997.

26. Dr. Ridings opined that undergoing an acromioplasty does not cause increased functional limitation. Dr. Ridings further testified an acromioplasty does not cause permanent medical impairment.

27. Dr. Ridings testified that undergoing an acromioplasty is not ratable pursuant to the AMA Guides Evaluation of Permanent Medical Impairment Third Edition Revised. Dr. Ridings explained, as the whole purpose of the acromioplasty is to improve function and as part of that improved range of motion its purpose is to decrease not increase impairment.

28. Dr. Ridings reviewed Dr. Hall's report, and his deposition testimony. Dr. Ridings opined that Dr. Hall's citation to the AMA Guides Page 48, Section 3.1(j) as support for providing the additional 5% for the acromioplasty was in error. Not only did Dr. Hall not provide documentation justifying application for the additional 5% rating, his [Dr. Hall's] own physical examination did not support providing an additional 5% for the acromioplasty.

29. Dr. Ridings explained that Dr. Hall's attempt to use increased myofascial tone as justification was erroneous. So to, were complaints of pain.

30. At hearing, and without objection, Dr. Ridings testified-consistent with his IME report-that Claimant told him about the five-minute DIME with Dr. Hall, and her lack of recall of any formal range of motion testing.

31. Dr. Hall was deposed on October 23, 2018. Dr. Hall had read Dr. Ridings' second IME report, and when asked why he disagreed with it, he stated:

> A. Because I didn't think the range of motion impairment, in and of itself, completely described her impairment…..And the point of adding this five percent, even though we do it under this heading of acromioplasty, it's generally given when the rating does not adequately relate the extent of the impairment….." So I thought she deserved additional impairment due to those additional problems around the shoulder girdle.
>
> And it is the case that she did have acromioplasty. I mean, one can argue what exactly that means, but either way, I felt she deserved more than just a range of motion impairment, because her only problem was not range of motion. She also had this *pain* around the shoulder girdle that was *impairing*, as well. (Hall depo, pp. 6-7) (emphasis added).

32. Dr. Hall later clarified that he was referring not to the 3rd Edition of the AMA guidelines directly, but to **page 7 of the Impairment Rating Tips** issued in connection therewith (Hall depo. Pp. 9-10) (emphasis added).

> In general, when any additional rating for *subacromial arthroplasty* is deemed appropriate in a case *with or without crepitus* because, quote, **other factors** have not adequately rated the extent of the impairment, end quote, it should not exceed ten percent. (Hall depo, p. 10) (emphasis added).

33. When asked if Claimant's rating should be as an extremity or whole person, Dr. Hall stated:

> You know, I didn't get any report of neck symptoms. She does have some periscapular pain, but I don't—I mean, I don't see why this would necessarily be converted to whole person. No, I think it's essentially an extremity rating. (Hall depo, pp. 7-8).

CONCLUSIONS OF LAW

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

Generally

A. The purpose of the Workers' Compensation Act of Colorado is to assure 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).* 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).

B. 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. The ALJ, as the fact-finder, is charged with resolving conflicts in expert testimony. *Rockwell Int'l v. Turnbull,* 802 P.2d 1182, 1183 (Colo. App. 1990) Moreover, the ALJ may accept all, part, or none of the testimony of a medical expert. *Colorado Springs Motors, Ltd. v. Industrial Commission,* 165 Colo. 504, 441 P.2d 21 (1968); *see also Dow Chemical Co. v. Industrial Claim Appeals Office,* 843 P.2d 122 (Colo. App. 1992) (ALJ may credit one medical opinion to the exclusion of a contrary medical opinion). In this instance, the ALJ finds that both Dr. Hall (through his deposition testimony and DIME report) and Dr. Ridings (through his hearing testimony and IME report) are sincere, credible, and professional. In the end, they simply have certain differences in medical opinions, which the ALJ must resolve.

C. In accordance with Section 8-43-215, C.R.S., this decision contains Specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. See *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). This decision does not address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Burden of Proof

D. The findings of a DIME physician concerning the Claimant's medical impairment rating shall be overcome by clear and convincing evidence. *Qual-Med., Inc. v. ICAO,* 134 P.3rd 475, 482 (Colo. App. 1998). However, the heightened burden does not apply to scheduled injuries. *Maestas v. American* Furniture *Warehouse,* WC 4-662-369, 2007 (ICAO 2007). While not an issue formally endorsed for hearing, the ALJ, therefore, must still determine whether Claimant's injuries will remain scheduled, or converted to the whole person. Only then can the ALJ determine the deference to be given the DIME opinion, and thus apply the proper burden of proof.

E. In resolving whether Claimant sustained a "loss of an arm at the shoulder" within the meaning of 8-42-107(2)(a) or a whole person impairment under 8-42-107(8), the trier of fact must determine the situs of the functional impairment which is not necessarily the location of the injury. *See Newsome v. King Soopers,* W.C. 4-941-297-02 (October 14, 2016). In this instance, Claimant did not testify. Dr. Pak's records, with the exceptions noted, are not in evidence. Dr. Ridings opined that this injury should be

scheduled, and not converted. By his deposition testimony, Dr. Hall concurred. Based upon the record, the ALJ concludes that there is insufficient evidence to convert Claimant's shoulder injury to the whole person; thus Claimant bears the burden of proof, by a preponderance of the evidence, to show entitlement to her impairment rating.

Range of Motion

F. Respondents urge that Dr. Pak's range of motion figures be accepted. In this case, Dr. Pak assigned a 4% range of motion rating to Claimant's shoulder after the revision surgery. However, neither Dr. Pak's worksheet, nor his narrative report are in evidence when he placed Claimant at MMI following the *revision* surgery. The range of motion worksheet following the *initial* surgery (Ex. A, pp. 2-4) (6% extremity) is of little value herein. The ALJ simply cannot rely upon the 4% figure, without evidence in support. Thus, the ALJ must compare Dr. Hall's range of motion to that of Dr. Ridings, both of which are supported by their respective worksheets.

G. Dr. Ridings conducted his second IME with Claimant on 9/10/18. In his narrative report, Dr. Ridings notes that Claimant told him that Dr. Hall spent only "about five minutes" with her during her entire DIME exam. Further, that she told Dr. Ridings that she does not recall Dr. Hall using any measuring device during the DIME exam to measure her range of motion. Dr. Ridings testified at hearing, without objection, to essentially the same two things.

H. The ALJ makes the following observations. First, Dr. Ridings accurately recorded, and then truthfully testified, about what Claimant told him during his IME. Secondly, Claimant's statements to Dr. Ridings as noted in his narrative are admissible, as being an integral part of his *medical report*. Third, Dr. Ridings' *testimony* in this regard drew no objection. If objected to, Claimant's statements to Dr. Ridings would not have been admissible as a "Declaration against Interest", under C.R.E. 804(b)(3), since Claimant was legally 'available' to testify. Interestingly, Claimant would not have known *at that moment* that her statements were *against her own interest*-in fact, Dr. Ridings eventually produced a more generous range of motion rating than did Dr. Hall.

I. Nonetheless, under a broad reading of C.R.E. 801(d)(2), such statements would be admitted as "non-hearsay"- despite the wording of the caption of this Rule ostensibly labelling such statements as "Admissions" by a party-opponent. Such statement was hardly an "admission," since, as noted, Claimant had no understanding of the possible effect of her "admissions" on these proceedings. However, the text of this Rule is more broadly written, and Claimant is plainly a "party-opponent".

J. While her statements are thus admitted, Claimant was not called by either side to clarify what she may have actually meant, nor her degree of certainty of her recall of the DIME exam. As such, the ALJ places comparatively little weight to what Claimant told Dr. Ridings about the DIME exam. It is further noted that Claimant's statements to Dr. Ridings were known by both parties at the time Dr. Hall was deposed

on 10/23/18, yet Dr. Hall himself was not asked about the "five-minute DIME" by either party.

K. Nonetheless, the ALJ must choose. Due to the aforementioned issues, and the fact that Dr. Ridings' measurements were actually taken later in time, the ALJ will adopt Dr. Ridings' range of motion figures of 7% upper right extremity, not converted to the whole person, and with no apportionment.

Dr. Hall's Assignment of an Additional 5% Rating, Under the Ratings Tips

L. Dr. Hall's DIME report, standing alone, simply states that Claimant had an acromioplasty, for which he added an additional 5% to the 5% range of motion, for a total of 10%. His report does nothing further to justify this additional 5%, beyond the fact of the surgery itself. Had Dr. Hall not testified, this would have been inadequate to assign this additional 5%. The Desk Aid #11, Impairment Rating Tips (for which the ALJ takes administrative notice), however, was referenced by Dr. Hall in his deposition. During his deposition, Dr. Hall then clarified that he was supplying the additional 5% for shoulder *pain*- an *"other factor"* beyond the fact of the surgery itself. The pertinent part of the Rating Tips, reads, in pertinent part:

> The AMA Guides 4th and 5th Editions continue to suggest that subacromial **arthroplasty** should be rated using ROM, and *when appropriate*, 'joint crepitation with motion' from the "Other Disorders" section. In general, when any additional rating for subacromial arthroplasty is deemed appropriate in a case **with <u>or without</u> crepitus** because "…**other factors** have not adequately rated the extent of the impairment," it should not exceed 10%. (AMA Guides 3rd Edition (rev.) p. 48). (Desk Aid #1, Ratings Tips, p. 7) (emphasis added).

M. Parsing the above language, it appears that the Tips contemplate that there can be "other factors" *besides crepitus* which, if articulated, can justify an additional rating *of up* to 10%. It appears to be a "catch-all", vesting discretion in the rating physician. Dr. Hall assigned 5%, on the basis of **pain** following these procedures. Respondents argue that pain, being subjective, is not ratable. However, in the context of these Rating Tips, there appears to be no such exclusion for pain. Had the authors intended to exclude pain, it would have been easy for them to so state. The ALJ concludes that Dr. Hall had sufficient discretion, under the Rating Tips, to assign the additional 5% for Claimant's pain.

N. However, to qualify for an additional impairment rating under these Tips, the above section contemplates that a **subacromial arthroplasty** has occurred. Dr. Pak's notes from his *revision* surgery do not appear to describe such a procedure. Dr. Pak's surgical notes from the *first procedure* are not in the record. However, the first procedure has been described by both Dr. Hall and Dr. Ridings as an **acromioplasty.** The term **arthroplasty** does not appear to be defined in the AMA Guidelines, 3rd

Edition. However, the *American Heritage Stedman's Medical Dictionary* defines the term thusly:

> 1. The creation of an artificial joint. 2. The surgical restoration of the integrity and functional power of a joint.

O. This second definition of arthroplasty encompasses an acromioplasty. Dr. Ridings himself appears to concede this definitional point in his discussion, using acromioplasty and subacromial arthroplasty in the same context. Dr. Ridings' real issue is Dr. Hall's use of ***pain*** *as an "other factor" besides crepitus.* He reasons that there is no residual, ratable, impairment from this surgery beyond her diminished range of motion. He describes Claimant's current condition as an expected result of a routine rotator cuff repair.

P. However, once at MMI, one would not expect the patient to suffer ongoing pain. The point of the surgery is not merely to restore function; rather it is to alleviate the patient's *pain* as well. For whatever reason, even at MMI, Claimant still has pain-in apparent contrast to others similarly situated. For this reason, the ALJ does not concur with Dr. Ridings' interpretation of the Tips by excluding consideration for pain.

Q. For the foregoing reasons, the ALJ finds, by a preponderance of the evidence, that there is ample evidence in support of Dr. Hall's 5% additional impairment rating for pain in her right upper extremity.

ORDER

It is therefore Ordered that:

1. Claimant's Impairment Rating for her upper right extremity is 12%, not converted to whole person, and with no apportionment.

2. 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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. 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: January 7, 2019

/s/ William G. Edie

William G. Edie
Administrative Law Judge
Office of Administrative Courts
2864 South Circle Drive, Suite 810
Colorado Springs, Colorado 80906

ISSUES

The issue raised at hearing involves Claimant's entitlement to medical benefits. The question answered by this decision is:

I. Whether Claimant established, by a preponderance of the evidence, that a L4-S1 fusion surgery, as recommended by Dr. Stanton is reasonable, necessary, and related to Claimant's July 8, 2015 injury.

FINDINGS OF FACT

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

1. Claimant, who was employed as an HVAC installer, was injured on July 8, 2015, when he fell through an unfinished ceiling and landed on his left hip injuring his left shoulder and low back.

2. The claim for injury was admitted and Claimant subsequently initiated treatment with the physicians at EmergiCare medical clinics. On July 25, 2015, Claimant underwent an MRI of the lumbar spine without contrast secondary to complaints of "leg weakness and low back pain." The MRI was completed at Peak Medical Imaging and was interpreted by Dr. Shawn Cory. Per Dr. Cory's report, the MRI revealed the following:

> A "3mm anterolisthesis, right foraminal annular tear, mild central spinal stenosis, moderate bilateral lateral recess stenosis, and moderate bilateral neural foraminal narrowing at L4-L5. Moderate to severe facet joint arthropathy and surrounding marrow edema at the same level" consistent with a degenerative etiology and at L5-S1, "a small to medium-sized left lateral recess/foraminal disc herniation . . . that displaces the traversing left S1 nerve roots and contribute to moderate left neural foraminal narrowing.

3. Given the MRI findings, Claimant was referred to Dr. Paul Stanton for orthopedic evaluation. Dr. Stanton evaluated Claimant on August 20, 2015. Dr. Stanton documented the following history:

> On 7-8-2015, [Claimant] was walking through a job site in a roof area, slipped through the roof and landed [some] number feet down onto the ground on a concrete floor. Since that time he has had increasing pain and weakness in his lower extremities.

* * *

> He reports increasing symptoms in both legs especially with overhead activity and lumbar extension. He feels shifting and clicking in his spine and at times it feels unstable with certain maneuvers.

4. Dr. Stanton performed a physical examination, obtained a set of flexion/extension x-rays and reviewed Claimant's July 25, 2015 MRI. He opined that Claimant's imaging supported a finding of a Grade I spondylolisthesis with angular motion, primarily left sided disc herniation and significant foraminal stenosis bilaterally. In combination, the imaging studies and Claimant's pronounced symptoms while upright and moving lead Dr. Stanton to opine that Claimant was suffering from dynamic instability at the L5-S1 segment in addition to the spondylolisthesis at L4-5. Dr. Stanton diagnosed Claimant with L5-S1 end stage disc disease with large left lateralizing disc bulge causing foraminal stenosis and nerve root contact; L4-5 Grade I spondylolisthesis with fluid in the facets; and left greater than right lower extremity radiculopathy and weakness. He explained that Claimant's spinal problem was "complex" and as he did not have any significant symptoms before the fall, he likely exacerbated the noted pathology at L4-5 and L5-S1 by plunging through the ceiling to the concrete below.

5. Dr. Stanton recommended conservative care to begin, including epidural steroid injections at L4 through S1. However, he opined that if Claimant failed to improve with conservative care, he would likely require stabilization surgery at L4-5 and L5-S1. He did not feel as if a discectomy would be in Claimant's best interests, primarily due to Claimant's symptoms that pointed to the presence of dynamic instability at L5-S1 as well as the existence of the spondylolisthesis at the L4-5 spinal segment.

6. In addition to his low back injury, Claimant sustained a left shoulder injury as part of his July 8, 2015 fall. This injury required surgical intervention and effected Claimant's ability to participate in low back treatment. As of June 15, 2016, Claimant had undergone 43 physical therapy appointments for his shoulder, which was doing well. But it was also reported that Claimant's "back [was] killing him." Claimant underwent a second lumbar spine MRI on June 16, 2016 at Southwest Diagnostic Centers. This MRI, per the radiologist's reading, demonstrated "moderate bilateral facet arthropathy with minimal anterolisthesis and disc bulge with mild central canal and mild bilateral foramina stenosis" at L4-5 in addition to "mild disc [bulging] with shallow left foraminal protrusion resulting in mild to moderate left foramina stenosis with no central canal or right foramina stenosis" at L5-S1. No comparison to the July 25, 2015 MRI was made.

7. Claimant was referred to Dr. Michael Rauzzino for further surgical evaluation on August 17, 2016. As of this appointment, it was noted that Claimant had SI joint injections, but no other injections for his lower back, despite the recommendation by Dr. Stanton a year prior. Claimant reported continued achy 2/10 pain in his low back aggravated by standing, walking, sitting, driving and climbing stairs.

He reported numbness in the left thigh radiating down to his left foot at times. Dr. Rauzzino referenced the June 16, 2016 MRI noting that he did not have the film available for review. He requested that Claimant obtain the films for review. He also noted a need to obtain new flexion and extension x-rays of the back to address Claimant's "stability".

8. Claimant returned to Dr. Rauzzino for follow-up on September 26, 2016. In his report from this encounter, Dr. Rauzzino references that an August MRI "showed L4-L5 anterolisthesis with left sided L5-S1 protrusion and multilevel degenerative changes. Based upon the evidence presented, the ALJ finds Dr. Rauzzino's reference to an August MRI a likely error. There is no convincing evidence to support a finding that Claimant underwent magnetic resonance imaging in August. Careful review of the MRI findings from July 25, 2015 and June 16, 2016 leads the ALJ to find that Dr. Rauzzino was probably referencing the findings of the June 16, 2016 MRI in his September 26, 2016 report. The ALJ finds no record support to indicate that Dr. Rauzzino ever reviewed the findings of Claimant's July 25, 2015 lumbar MRI.

9. Claimant's flexion and extension x-rays, as performed in Dr. Rauzzino's office and reviewed by him, revealed retrolisthesis of L5 on S1 that did not change from neutral position in flexion/extension. He agreed with Dr. Stanton's assessment that there was a Grade I spondylolisthesis at L4-5 which he (Dr. Rauzzino), did not feel changed in flexion but had some reduction in extension. Dr. Rauzzino explained to Claimant that there is not a "easy" surgery that one would do that would have a high likelihood of success." He recommended facet injections and ESIs to avoid surgery, "if at all possible." Contrary to Respondents' assertion, the ALJ does not interpret Dr. Rauzzino's statements concerning surgery as an absolute indication that Claimant is a non-surgical candidate. Rather, the ALJ finds that Dr. Rauzzino simply indicated that any surgery contemplated would not be "easy" and should be avoided if possible because the chances of success were not great.

10. Post examination with Dr. Rauzzino, Claimant underwent injections with Dr. Simon Blau, additional care at Concentra, and was subsequently placed at maximum medical improvement (MMI) on December 23, 2016, by Dr. Nicholas Kurz. Claimant contested the findings/conclusions of Dr. Kurz and requested a Division Independent Medical Examination (DIME). Claimant underwent the requested DIME with Dr. Timothy Hall on April 10, 2017. Dr. Hall found that Claimant was not at MMI and recommended further treatment with Dr. Blau.

11. Claimant returned to Dr. Blau on September 5, 2017 for bilateral medial branch blocks at L4-5 and L5-S1. Dr. Blau documented on September 11, 2017 that Claimant continued to have back pain, noting that it can be sharp in nature at times. On physical examination, Claimant was tender to palpation of the bilateral lumbar vertebral muscles and that there was pain with facet loading bilaterally. It was documented that Claimant had a diagnostic response to the blocks and Dr. Blau recommended repeating them to confirm.

12. Claimant underwent a second set of bilateral medial branch blocks at L4-5, L5-S1 on October 31, 2017. It was noted that Claimant's pain was a level 3 out of 10 at the time, but he reported his pain shoots up to around 8/10 with aggravating activities, such as traversing stairs. Claimant subsequently underwent bilateral L4-5, L5-S1 radiofrequency neurotomies with Dr. Blau on November 28, 2017. Claimant reported 100% relief of his symptoms 30 minutes after the procedure. Claimant followed up with Dr. Blau on December 21, 2017 reporting about 40% improvement in his lower back symptoms. Nonetheless, Claimant continued to have left sided lower back pain radiating into his left iliac crest, buttock, and posterior thigh, as well as some right-sided lower back pain that was not radiating. Dr. Blau recommended physical therapy and core strengthening as post lumbar RF protocol. At Claimant's next visit with Dr. Blau on January 12, 2018, he recommended continued physical therapy and low back trigger point injections. The aforementioned trigger point injections were administered on January 26, 2018. The trigger point injections provided no relief and Claimant reported continued left sided lower back pain with internal rotation of his left hip. Consequently, Dr. Blau recommended a left hip MRI to see if Claimant's pain was emanating from the hip. A left hip MRI was performed February 22, 2018 and was interpreted as unremarkable for hip pathology.

13. On March 15, 2018, Claimant reported to Concentra with complaints of severe 10/10 pain that occurred "while he was just sitting there". Claimant complained of radicular pain. Straight leg raise on the left was positive on physical examination. Consequently, Dr. Natasha Deonarain recommended a repeat MRI, along with a referral to an orthopedic spine surgeon. The aforementioned MRI was performed immediately following Dr. Deonarian's evaluation and demonstrated minimal spondylosis of the L4-5-disc space with a small annular fissure in the right foraminal portion of the disc associated with mild to moderate arthropathy of the facet joints. The radiologist could not rule out a small fracture of the facets. The radiologist also noted minimal spondylosis of the L5-S1 disc space without evidence of nerve root impingement or cauda equina syndrome, along with a small annular fissure in the left foraminal portion of the disc.

14. On April 11, 2018, Claimant underwent a follow-up DIME with Dr. Hall, who recorded that he reported that the procedures performed by Dr. Blau had led to 50%-60% improvement in low back pain. "This is in the area of the belt line. Lower and out to the right, he still has a lot of symptoms". Dr. Hall reviewed the March 15, 2018 MRI scan and opined that he did not find it to be all that different from the original MRI. He also noted that his examination on this date was not that much different than his prior examination and that neurologic examination of the lower extremities reveals no specific motor weakness. No wasting, reflexes were symmetrical, straight leg raise (SLR) caused some tightness and pulling in his back, but no leg symptoms. Dr. Hall opined that Claimant had reached MMI as of January 8, 2018, and provided impairment ratings for both his injured shoulder and low back. He also recommended ongoing maintenance care for Claimant's lumbar spine for at least the next three years.

15. On April 20, 2018, Claimant returned to Dr. Blau noting that he continued to have pain along his lateral lower back region bilaterally. Dr. Blau recorded that "[Claimant] states that the pain feels as if he was wearing at tight belt." At hearing Claimant testified that at this appointment, he advised Dr. Blau, that he was experiencing radiculopathy down his legs. He further stated that he had as he had repeatedly advised Dr. Blau of these symptoms in the past. On this date, Dr. Blau issued a report noting that upon examination claimant's neurologic examination was negative, and that he had reviewed the March 15, 2018 MRI scan, and "this does not appear to be surgical". Dr. Blau agreed with Dr. Hall's opinions regarding MMI, and his impairment ratings.

16. Respondents filed a Final Admission of Liability (FAL) admitting to the impairment rating provided by Dr. Hall. The FAL also admitted to reasonable, necessary and causally related medical benefits by an authorized treating physician post MMI.

17. As noted, Dr. Deonarain referred Claimant for additional orthopedic evaluation after he experienced an increase in his pain on March 15, 2018. Claimant returned to Dr. Stanton for said evaluation on April 24, 2018. Dr. Stanton documented that Claimant had undergone a lot of non-surgical care for his back, including rhizotomy, all without providing long-term relief. Claimant reported continued "shifting and clicking" in his spine with lifting, bending, and twisting, and stated that he felt better while lying in the supine position. On physical examination, Dr. Stanton appreciated a "step off" in the spinous process of the lumbar spine. He performed additional flexion and extension x-rays in his office on the date of this visit and "opined that these x-rays demonstrated significant collapse at the L5-S1 disc space with bone on bone contact posteriorly and retrolisthesis, facet spondylosis, and resultant foraminal stenosis. Dr. Stanton measured the L4-5 spondylolisthesis to be approximately 4mm. He indicated further that the MRI of Claimant's lumbar spine demonstrated a reduction in his spondylolisthesis at L4-5 when lying supine indicating mobility of the lumbar spine.

18. Dr. Stanton opined, "At this point, I think [Claimant's] symptoms are mainly one of dynamic instability." He indicated that Claimant had obvious signs of instability at the L4-5 level in tandem with significant collapse at his L5-S1 level, which was consistent with Claimant's dermatomal symptomatology. Dr. Stanton felt a discectomy and laminectomy would only destabilize Claimant's spine further, so he proposed a reconstruction of Claimant's L4 through S1 segments to fully address the instability and stenosis. Dr. Stanton formally requested authorization to perform an L4-S1 anterior-posterior fusion for spondylolisthesis, stenosis, and lumbar degenerative disc disease on April 27, 2018. Respondents subsequently denied the request on May 10, 2018 and sought an independent medical examination (IME) with Dr. Brain Reiss.

19. Dr. Reiss completed a records review, took a history from Claimant and completed a physical examination as part of his IME. His review of the records documented only one mention of a complaint of back pain and stiffness prior to the July 8, 2015 industrial injury. Following his IME Dr. Reiss authored a report in which he

opined that the findings at L4-5 on the September 14, 2016 flexion/extension x-rays represented a "degenerative spondylolisthesis" that was "probably" minimal and "probably" not meeting the definition of instability. Nonetheless, he indicated that he was unable to accurately measure the extent of the spondylolisthesis from this x-ray. In review of the MRIs, Dr. Reiss opined that, as of the 2018 MRI, he did not believe the foraminal stenosis at L5-S1 was clinically significant enough to cause nerve root irritation. He felt it possible, though not probable, that a fusion at L4-5 may improve Claimant's symptomatology, but he did not see a reason for the L5-S1 to be fused.[1] Dr. Reiss felt Claimant needed nothing more than core strengthening exercises to address his ongoing symptoms. Despite his acknowledgement of Claimant's lack of pre-existing symptoms or treatment for his lower back condition, Dr. Reiss opined that surgery for Claimant's spondylolisthesis would be unrelated to the work incident where Claimant fell through a ceiling and injured his back. Similar to his prior reports to Dr. Stanton, Claimant reported to Dr. Reiss that he felt better while lying down, and that if he moved, he would get a sharp pain.

20. After complete review of the medical record and the diagnostic imaging, Dr. Reiss disagrees that a fusion is indicated for the following medical reasons:

- His review of the diagnostic studies, fails to reflect presence loss of disc space height; or dynamic instability; but rather, refutes this assertion;

- The flexion/extension x-rays do not evidence sufficient movement per the Low Back Treatment Medical Treatment Guidelines to warrant consideration of a fusion; and,

- The medical record evidences that Claimant has repeatedly and consistently demonstrated a normal neurologic evaluation, which supports the conclusion that no radiculopathy exists; and hence, pursuant to the Medical Treatment Guidelines, and as admitted by Dr. Stanton in his deposition, fusion surgeries have poor outcomes for the treatment of primarily low back pain**.**

21. Dr. Timothy Hall's deposition was taken on September 26, 2018. Dr. Hall was of the opinion that if Claimant required surgery, it would certainly be work related; however, he was not confident that Claimant's pain generator had been adequately identified based on review of the records he had at the time of the DIME and the recent IME report from Dr. Reiss. (Depo. 11:8 – 12:6). Nonetheless, based upon the information he had, Dr. Hall opined that it is unlikely that this claimant will do well with a large fusion procedure. (Dr. Hall Dep., p. 8-11).

[1] However, Dr. Reiss did indicate that there is already degeneration above and below the L4-L5 level. (Clmt. Ex. 12, p. 271).

22. Dr. Stanton's deposition was taken on October 23, 2018 in his capacity as an expert in orthopedic surgery that was fellowship trained in orthopedic spine surgery. Dr. Stanton performs several surgeries of the lumbar spine per week and commonly performs the same procedure he is proposing for Claimant. (Dr. Stanton Dep., pp. 5:9 – 6:4). Dr. Stanton clarified that in his medical records, such as the August 20, 2015 note, that the diagnoses listed under assessment only have to do with coding and their software, and that his diagnoses of Claimant were numbered 1, 2, and 3 below the 7 documented diagnoses. (Dr. Stanton Dep., pp. 10:11 – 11:4). Dr. Stanton explained his first diagnosis was that of L5-S1 end stage disc disease with large lateralizing disc bulge causing foraminal stenosis and nerve root contact, meaning the disc is collapsing and bulging as a component of the collapse, and that would cause "sciatic" type pain down the leg. His second diagnosis of L4-5 Grade 1 spondylolisthesis with fluid in the facets meant that there is instability at the L4-5 level, and that the fluid collecting in the facet joint indicates there is gapping in the facet, which is also consistent with a spondylolisthesis or movement at the L4-5 level. (Dr. Stanton Dep., p. 11:5-21). Dr. Stanton based his original opinion on his examination of Claimant, flexion/extension x-rays, and the July 2015 MRI. He also made it clear that he reviews the films himself before reading the report of the radiologist. (Dr. Stanton Dep., p. 12:2-21).

23. Dr. Stanton opined that once instability or movement of the spine is found, removing the disc alone typically does not resolve the symptoms and the patient will eventually require a revision surgery in the near future. (Dr. Stanton Dep., p. 13:7-15). Dr. Stanton was asked about dynamic instability of the spine, which he explained is collapse of the disc space under physiologic load. So standing, lifting, bending, twisting, or moving causes collapse of the disc space because the disc is insufficient in strength to hold the spine stable. Typically, a patient's symptoms diminish when they are laying down on their back because there is less gravity on the spine. Dynamic instability is typically treated with a fusion surgery. (Dr. Stanton Dep., pp. 13:16 – 14:9).

24. Dr. Stanton also testified that Claimant had spondylolisthesis, which is a different type of spinal instability where one vertebral body slips forward on another. He used the analogy of dynamic instability being up and down collapse, like the shocks on a car, whereas spondylolisthesis is forward movement or slippage of the vertebra on one another. (Dr. Stanton Dep., pp. 14:19 – 15:8). As noted above, Dr. Stanton documented a "step off" of Claimant's lumbar spine during his physical examination. He testified that a step off that can be palpated is an indication that you are able to feel the instability or spondylolisthesis at the segmental level involved, i.e. the L4-5 level in this case. (Dr. Stanton Dep., pp. 15:25 – 16:9). Dr. Stanton clarified exactly what was performed in his office regarding the x-rays. There are standing x-rays, including flexion and extension, which shows the spine under the physiologic load of gravity. "When the patient moved, we saw significant collapse at the L5-S1 level or disc space with bone-on-bone contact in the back of the spine and retrolisthesis. This means the vertebral body is sliding backwards. As a result of that, there was a decrease in the nerve root window or height or foraminal stenosis. It also demonstrated again the spondylolisthesis or forward slipping of the vertebral body at L4-5." (Dr. Stanton Dep., pp. 16:16 – 17:9).

Dr. Stanton indicated that his proposed surgery would be intended to relieve Claimant of both his back pain and increase his function. (Dr. Stanton Dep., p. 18:9-14).

25. Dr. Stanton was asked questions about Dr. Reiss's report specifically. Dr. Stanton essentially agreed with Dr. Reiss's readings of the MRIs, but explained that without the context of the x-rays, the MRI alone "certainly does not provide the diagnosis" and therefore, the justification for surgery. He reiterated his opinion that the findings on imaging while lying down are not indicative of Claimant's condition while standing as there is no gravity on the spine when lying supine. Accordingly, if somebody were to read the MRI without contemporaneous comparison with the weight bearing x-rays, they would miss or not be able to diagnose Claimant's pathology correctly. (Dr. Stanton Dep., p. 19:1-22).

26. Dr. Stanton was asked about Dr. Reiss's opinion on page three of his report, paragraph 8, and his disagreement with Dr. Stanton's reading of the imaging. Dr. Stanton explained the following as to why Dr. Reiss's opinion is incorrect: "I think there is more rotational movement on the standing X-rays. I think there is more translational movement or reduction on the supine MRI, and that's why it's important to compare those two things. And as to say -- you know, contrary to my suggestion of bone on bone at L5-S1, when people think of bone-on-bone contact, they are looking at the center of the disc space. And I agree, in the center of the disc space, where you would typically look, there is not bone-on-bone contact; but at the back of that disc space, during that retrolisthesis, there is contact. And that's what generates the foraminal narrowing. Typically, that's the more common scenario in dynamic instability of this nature." (Dr. Stanton Dep., pp. 20:16 – 21:6). Dr. Stanton opined that he personally found enough instability to warrant surgery. He explained that four or more millimeters of movement is typically the accepted definition for what is approved for surgery by most insurance companies, although he would say as little as 2 to 3 millimeters of movement can be symptomatic, depending on the patient's individual anatomy. Regarding Claimant's spondylolisthesis Dr. Stanton was clear when he stated, ". . . I measured it, he had four millimeters or greater in his L4-5 level." (Dr. Stanton Dep., pp. 21:7 – 22:1).

27. Dr. Stanton also addressed Dr. Reiss's suggestion that Claimant only required additional core strengthening to treat his ongoing symptoms. Dr. Stanton testified: "At this point, I don't think it's likely to provide good results. Certainly there is a role early on for core strengthening to see if stabilizing some of the musculature is able to stop the spondylolisthesis, but the important thing to remember is that the lumbar musculature is not designed to decrease translation in a front/back position or an up/down position. The lumbar musculature's job is to contract in an up/down position; so, therefore, those muscles are not optimally aligned to stop spinal instability. So if early therapy is not successful, it's unlikely that adding additional visits is going to solve that problem." (Dr. Stanton Dep., pp. 22:2 – 23-1).

28. Dr. Stanton further disagreed with Dr. Reiss's opinion that Claimant's spondylolisthesis may not represent his pain generator. Dr. Stanton believed it was a

pain generator given Claimant's dermatomal representation of pain, meaning that the areas where he locates nerve pain on examination was consistent with the L4-5, L5-S1 issues. (Dr. Stanton Dep., pp. 23:14 – 24:1). When asked if he felt Claimant had "true instability," Dr. Stanton responded, "For sure." (Dr. Stanton Dep., p. 24:2-4). Dr. Stanton explained that the L5-S1 level should also be fused because fusing just L4-5 would stiffen the spine and make the dynamic collapse at L5-S1 even worse, which would likely precipitate a second surgery. He indicated that he would not recommend the fusion if it were limited to the L4-5 level only. (Dr. Stanton Dep., p. 24:5-23). Dr. Stanton reiterated that Claimant's examination, the location of his pain complaints, and the imaging results all supported his opinion that L4-5 and L5-S1 were the likely pain generators in this case. (Dr. Stanton Dep., pp. 24:24 – 25:10).

29. Dr. Stanton agreed with Dr. Reiss that a fusion surgery should not be performed for axial back pain alone due to arthritis, or for a disc problem without instability, However, he noted that "in the setting of instability, it's very well documented that back pain and associated neurologic symptoms are very well treated and resolved by a lumbar fusion surgery." (Dr. Stanton Dep., pp. 25:11 – 26:8). Dr. Stanton did not feel that more could be done to identify the pain generator in this case. (Dr. Stanton Dep., pp. 26:9 – 27:6).

30. On cross-examination, Dr. Stanton noted that he is not Level II Accredited and is not familiar with the Low Back Medical Treatment Guidelines published by the Division of Workers' Compensation. Regarding the Guidelines, he stated, "whatever the Workmen's Compensation Guidelines are, that has little or nothing to do with the active practice of medicine." (Dr. Stanton Dep. p. 43). Dr. Stanton would go on to state: "If the guidelines will or will not approve a fusion, that's up to the guidelines. I treat each patient individually based on what I think they medically need, based on what their symptoms are, their physical exam shows, and what their imaging shows. So I don't actually look at the insurance many times to find out if it's Workmen's Comp or private insurance or government insurance, it doesn't matter. Every patient gets treated equally using the same good treatment principles and guidelines. Whatever Work Comp has constructed to say that's appropriate for surgery, that's their business. As a board certified practicing spine surgeon, I use good medical practices to take care of all patients in the same way. The Workmen's Compensation population, for me, does not get a second set of guidelines; they don't get treated differently, everybody gets the same care." (Dr. Stanton Depo., pp. 43:13 – 44:13).

31. Dr. Brian Reiss testified at hearing as an expert in the field of orthopedic surgery. Dr. Reiss has been Board Certified in orthopedics for the past 28 years and currently limits his medical practice to disorders of the spine. He has performed a substantial number of fusion surgeries and has been Level II Accredited with the Division of Workers' Compensation since the onset of its program. He is familiar with the content of the Low Back Medical Treatment Guidelines.

32. After reviewing the pertinent records and imaging, including the x-rays obtained at Dr. Stanton's office, Dr. Reiss opined that the hard-medical evidence refutes

the basis for the performance of the surgery recommended by Dr. Stanton. Dr. Reiss opined that while Claimant is probably suffering from work-related back pain, an extensive fusion surgery is not indicated for this back pain. Rather, Dr. Reiss indicated that due to the significant amount of time that has elapsed since the date of injury, Claimant is deconditioned and should partake in core strengthening exercises, which will assist in the relief of his back pain. He explained that Claimant should have undergone core strengthening, which he described as a three-hour course of an exercise program per week for two or three months, early on in the course of his recovery from his injuries. He disagreed with Dr. Stanton's opinion that core strengthening was unlikely to provide any benefit to Claimant three plus years after the fact. Dr. Reiss finds support for his opinion that no surgery of any kind is indicated based upon the content of the reports authored by Drs. Rauzzino, Blau and Hall.

33. Dr. Reiss opined further that Claimant's spondylolisthesis would not be work related. In opining as such, Dr. Reiss noted that, more likely than not, Claimant had a spondylolisthesis prior to his injury but it was not symptomatic because he was not deconditioned. Dr. Reiss testified that he felt Dr. Stanton was "totally speculating" when he opined that Claimant's nerve root at L5 is getting compressed when he stands up. Dr. Reiss agreed that the flexion and extension x-rays taken by Dr. Stanton demonstrated slippage of the L4-5 vertebrae supporting the diagnosis of spondylolisthesis, but he measured it at about 3mm whereas Dr. Stanton measured it to be 4mm or greater. At hearing, Dr. Reiss was asked to measure the slippage at L4-5. He explained that, in order to do this, "You have to use those lovely tools on the top and place the little dot exactly in the appropriate spot and then it measures it for you. The difficulty is placing it in the exact spot." Dr. Reiss reiterated that "[d]epending on where you place your next little dot it can be difficult to measure." Dr. Reiss did admit that Claimant's slippage is "borderline" but was not jumping out as "being unstable" to him.

34. Dr. Reiss also disagrees that the alleged finding recorded by Dr. Stanton in the nature of extensor halluces longus (EHL) and tibialis anterior weakness justifies consideration of surgery. Dr. Reiss opined that Dr. Stanton hedged at his deposition that this finding may be associated with pain. Contrary to this testimony, Dr. Reiss explained that this is not a finding necessitating a fusion, and this alleged neurologic deficit in the L5 distribution was not noted by any other physician, at any other time**.** Dr. Reiss opined that Dr. Stanton's opinion regarding alleged radicular findings is pure speculation and is not supported by Drs. Rauzzino, any reading radiologist or other examining physician or other objective evidence.

35. Dr. Reiss disagrees with Dr. Stanton's opinion that the March 15, 2018 MRI evidences a large broad-based disc bulge at L5-S1 with significant tightness around the nerve root. Using the MRI images in Court, Dr. Reiss pointed to where the L5-S1 nerve root lied and opined that no compression existed to support Dr. Stanton's claim of nerve root compression. Dr. Reiss opined that without true radiculopathy, or neurologic compromise, a fusion is not indicated.

36. The ALJ finds that Claimant has established by a preponderance of the evidence that the surgery recommended by Dr. Stanton is reasonably necessary and related to the original work injury.

CONCLUSIONS OF LAW

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

Generally

A. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S. 2007, *et seq*., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. 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.

B. In accordance with §8-43-215 C.R.S., this decision contains specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. *See Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). This decision does not specifically address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

C. Assessing weight, credibility and sufficiency of evidence in Workers' Compensation proceeding is the exclusive domain of the ALJ. *University Park Care Center v. Industrial Claim Appeals Office*, 43, P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. 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); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002). The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913); *see also Heinicke v. ICAO*, 197 P.3d 220 (Colo.App. 2008). To the extent, expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting all, part or none of the testimony of a medical expert. *Colorado Springs Motors, Ltd. v. Industrial Commission,* 441 P.2d 21 (Colo. 1968); see also, *Dow Chemical Co. v. Industrial Claim Appeals Office*, 843 P.2d 122 (Colo.App. 1992) (ALJ may credit one medical opinion to the

exclusion of a contrary opinion). When considered in its totality, the ALJ concludes that the evidence in this case supports a reasonable inference/conclusion that Claimant suffers from both a L4-5 spondylolisthesis and dynamic instability at L5-S1. Here, the evidenced presented supports a conclusion that Claimant's low back symptoms are in part emanating from an L4-5 spondylolisthesis that was probably aggravated by falling through a ceiling to a concrete floor below. While Dr. Reiss opines that this pre-existing spondylolisthesis became symptomatic due to deconditioning, the ALJ concludes that deconditioning a direct consequence of his fall through the ceiling. Consequently, the ALJ agrees with Dr. Reiss that Claimant's low back pain is likely work related. Where the ALJ finds Dr. Reiss's opinions dubious is where he concludes that fusion surgery is not reasonable or necessary because core strengthening can address Claimant's ongoing symptoms because he is deconditioned. In this case, the content of the medical records demonstrates that Claimant has failed conservative care and continues to experience functional decline secondary to back pain likely originating from both the failure of the disc at L5-S1 and the forward slipping of the vertebral segment at L4-5. The evidence presented convinces the ALJ that this pathology and not merely a weak core is substantially causing Claimant's ongoing symptoms. Given the mechanism of injury coupled with the content of the treatment records as a whole, the ALJ concludes that the medical analyses and opinions of Dr. Paul Stanton are credible and more persuasive than the contrary opinions of Dr. Reiss and Dr. Rauzzino, to the extent that Dr. Rauzzino can be interpreted as indicating that Claimant is not a surgical candidate as noted above

Medical Benefits
The Proposed L4-L5, L5-S1 Spinal Surgery Recommended by Dr. Stanton

D. A claimant is entitled to medical benefits that are reasonably necessary to cure or relieve the effects of the industrial injury. *See* § 8-42-101(1), C.R.S. 2003; *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). The question of whether the need for treatment is causally related to an industrial injury is one of fact. *Walmart Stores, Inc. v. Industrial Claims Office, supra*. Similarly, the question of whether medical treatment is reasonable and necessary to cure or relieve the effects of an industrial injury is one of fact. *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002). Where the relatedness, reasonableness, or necessity of medical treatment is disputed, Claimant has the burden to prove that the disputed treatment is causally related to the injury, and reasonably necessary to cure or relieve the effects of the injury. *Ciesiolka v. Allright Colorado, Inc*., W.C. No. 4-117-758 (ICAO April 7, 2003).

E. The mere occurrence of a compensable injury does not require an ALJ to find that all subsequent medical treatment and physical disability were caused by the industrial injury. To the contrary, the range of compensable consequences of an industrial injury is limited to those which flow proximately and naturally from the injury. *Standard Metals Corp. v. Ball,* 172 Colo. 510, 474 P.2d 622 (1970); § 8-41-301(1)(c), C.R.S. 2013. Based upon the evidence presented, the ALJ concludes that Claimant has proven that L4-L5, L5-S1 fusion surgery recommended by Dr. Stanton is

reasonable and necessary. The medical reports outline persistent pain and functional decline in the face of failed conservative treatment leading Dr. Stanton to recommend surgical intervention.

F. The Medical Treatment Guidelines are regarded as the accepted professional standards for care under the Workers' Compensation Act. *Hernandez v. University of Colorado Hospital*, W.C. No. 4-714-372 (January 11, 2008); see also *Rook V. Industrial Claim Appeals Office*, 111 P.3d 549 (Colo.App. 2005). The Medical Treatment Guidelines, Rule 17-2(A), W.C.R.P. provide: All health care providers shall use the Medical Treatment Guidelines adopted by the Division. In spite of this direction, it is generally acknowledged that the Guidelines are not sacrosanct and may be deviated from under appropriate circumstances. *See*, Section 8-43-201(3) (C.R.S. 2014); *Nunn v. United Airlines,* W.C. 4-785-790 (ICAO September 9, 2011). Nonetheless, they carry substantial weight. Moreover, the MTGs have been accepted in the assessment of low back pain. While the MTGs provide for that several pre-operative surgical indications should be considered before surgery is undertaken, including assessment/definition and treatment of all likely pain generators along with x-ray, MRI or CT myelography findings consistent with spinal stenosis with instability or disc pathology, the Court is not bound by the MTGs in deciding individual cases on the guidelines or the principles contained therein alone. Indeed, § 8-43-201(3) specifically provides:

> It is appropriate for the director or an administrative law judge to consider the medical treatment guidelines adopted under section 8-42-101(3) in determining whether certain medical treatment is reasonable, necessary, and related to an industrial injury or occupational disease. The director or administrative law judge is not required to utilize the medical treatment guidelines as the sole basis for such determinations.

G. Concerning the issue presented, the MTG's indicate that "[t]here is some evidence that fusion is likely to have a higher beneficial effect compared to multidisciplinary rehabilitation for patients with isthmic spondylolisthesis, as differentiated from those without the condition who suffered from chronic low back pain." (WCRP 17 Ex. 1, p. 98). Pursuant to WCRP 17, Ex. 1(G)(4)(d)(ii), diagnostic indications may include the following: "Segmental instability: Excessive motion, as in degenerative spondylolisthesis 4mm or greater, surgically induced segmental instability." Another indication for a spinal fusion per the Guidelines is for primary mechanical back pain/functional spinal unit failure: Multiple pain generators involving two or more of the following: (a) internal disc disruption, (b) painful motion segment, as in annular tears, (c) disc resorption, (d) facet syndrome, and/or (e) ligamentous tear. WCRP 17 Ex. 1(G)(4)(d)(iii). In this case, the evidence presented supports a conclusion that Claimant meets the two of the above requirements as MRI imaging indicates that Claimant has both internal disc disruption at L4-5 and annular tearing. Moreover, the March 15, 2018 MRI raises suspicion for facet pathology consistent with instability.

H. Addressing part two of the aforementioned section of the Guidelines, fusion surgery is indicated when there is segmental instability, defined as excessive motion, as in degenerative spondylolisthesis 4mm or greater. Although Claimant's spondylolisthesis was measured by Dr. Reiss to be closer to 3mm, "give or take .2mm," the ALJ is convinced based on the testimony of Dr. Stanton, as well as objective imaging evidence, that Claimant does in fact have a "true instability" of the spine warranting surgery under the Guidelines.

I. WCRP 17 Ex. 1(G)(4)(e) addresses what the Guidelines feel are appropriate in terms of workup prior to proceeding with surgery. First, all pain generators must be adequately identified and treated. Given the results of Claimant's imaging studies coupled with Claimant's physical examinations and the treatment he has received to date, the ALJ credits Dr. Stanton's opinion that he is confident that Claimant's pain generators have been identified and treated. While the second prong of the MTG's indicates that all physical medicine and manual therapy have been completed, which was not apparently done in this case, the ALJ credits the testimony of Dr. Stanton that core strengthening is unlikely to provide any significant benefit at this point, especially considering the fact that the muscles of the spine are not optimally aligned to stop spinal instability. Prong three of the Guidelines for proceeding with surgery is satisfied as the imaging in this case documents what the ALJ concludes, based upon the persuasive testimony and examinations of Dr. Stanton, constitutes segmental instability, both laterally and vertically at L4-5 and L5-S1 respectively. Prong four is met as the spine pathology is limited to two levels. Prong five is not applicable given Claimant's diagnosis of spondylolisthesis, and prong six is merely a recommendation regarding smoking that has not been fleshed out by the parties. Taken in its entirety, the ALJ concludes that the evidentiary record contains substantial evidence to support a conclusion that the recommended procedure is reasonable and necessary to cure and relieve Claimant from the ongoing effects of his compensable injury and restore his function. Based upon the evidence presented and in keeping with the MTGs, the ALJ concludes that Claimant's surgery has been contemplated within the context of expected functional outcome and not merely for the purposes of pain relief.

ORDER

It is therefore ordered that:

1. Respondents shall authorize and pay, pursuant to the Workers' Compensation medical benefits fee schedule, for the L4-5, L5-S1 fusion and all expenses associated therewith as recommended by Dr. Paul Stanton.

2. 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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. 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: January 7, 2019

/s/ Richard M. Lamphere_____

Richard M. Lamphere
Administrative Law Judge
Office of Administrative Courts
2864 S. Circle Drive, Suite 810
Colorado Springs, CO 80906

ISSUES

1. Whether Claimant established by a preponderance of the evidence that she suffered an injury in the course and scope of her employment for Employer on November 9, 2017.

2. If the claim is found compensable, what body parts are related to the November 8, 2017, injury, did Respondents designate an authorized provider of medical treatment, did Claimant reach maximum medical improvement (MMI) and was Claimant disabled from her usual employment and therefore entitled to an award of indemnity benefits.

FINDINGS OF FACT

1. Claimant worked as a receptionist for Employer from October 17, 2017, through the date of injury, November 9, 2017.

2. Claimant claims that on the morning of November 9, 2017, she slipped on ice while exiting her vehicle. Claimant claims that she got up after her fall and proceeded into work and reported the incidence to her supervisor, Breann Moen-Alber, the office manager for Employer

3. Within hours of the alleged incident, Claimant completed and signed the Employer's First Report of Injury. Ms. Moen-Alber was present while Claimant completed the report. At that time, Claimant did not appear to Ms. Moen-Alber to be confused or groggy.

4. On the Employer's First Report of Injury, Claimant listed the following body parts as being injured: left elbow, ribs and left back. Claimant did not list a head injury in this report as an area of injury. Claimant testified, alternately, at hearing that she did not list her head as injured because at that time she did not have head symptoms and Claimant testified that she was not sure why she did not report a head injury.

5. At the time Claimant completed the First Report of Injury, Ms. Moen-Alber provided Claimant with a designated provider list. Claimant agreed to have Ms. Moen-Alber give her a ride to UC Health, one of the providers on Employer's designated provider list. Claimant received medical attention at 9:30 a.m. at UC Health by Dr. Hope Edmonds. Claimant explained to the doctor that she had fallen while getting out of her car in the parking lot. Claimant reported falling on her left side and striking the left side back of her head only slightly on the pavement. Claimant had no head injury symptoms. Claimant's speech and behavior was normal. Claimant's primary symptom was left elbow pain which she indicated was mild.

6. On November 9, 2017, Dr. Edmonds prepared a work status report and listed the following work related diagnoses: contusions of her left rib, left elbow and left shoulder. Claimant was taken off work for the day and work restrictions were imposed of no lifting over 10 lbs.

7. Claimant was released to return to work on November 10, 2017, she never returned to work after the November 9, 2017, alleged injury. Claimant did not call in or communicate with Ms. Moen-Alber after the alleged injury.

8. Claimant was scheduled to work for Employer from November 9, 2017, through August 1, 2018, in a position within her work restrictions; sitting at a computer, answering phones and scheduling patients.

9. Claimant claims that her head symptoms began on the evening of November 9, 2017, but she did not seek treatment for these symptoms until November 13, 2017. On November 13th, Claimant presented at UC Health reporting increased confusion, nausea and vomiting since her fall on November 9. Claimant reported hitting her elbow on the concrete and striking her head on the car running board. Claimant claimed at UC Health that she did not know why she presented to the clinic and she could not tell her age or employer. Claimant had resolving bruises on her bilateral forehead. Because of Claimant's presentation on November 13, 2017, she was transported to the emergency room where she had a normal neurological exam, showed orientation to person, place and time. A CT scan was also normal. Claimant was discharged from the emergency room with no additional restrictions.

10. On November 15, 2017, Claimant was evaluated again at UC Health reporting injury to her left elbow and injury to her head when Claimant's head bounced off the running board of her car. Claimant reported to Physician Assistant Michael Dietz (PAC Dietz) that Claimant was previously diagnosed with post concussive syndrome. Claimant reported that she had right sided headaches and difficulty concentrating. PAC Dietz imposed restrictions of simple office tasks, no critical data entry and no direct patient care.

11. Claimant received treatment again from PAC Dietz on November 17, 2017. Claimant reported being very ill and depressed. Claimant indicated to PAC Dietz that she had not returned to work after the incident in the parking lot because she was too unstable. Claimant was wearing sunglasses for the appointment with PAC Dietz. PAC Dietz imposed more stringent work restrictions and recommended Claimant's transport to the emergency department.

12. At the emergency department on November 17th, Claimant was described as alert and oriented to person, place and time. Claimant reported a severe headache, fuzzy vision, memory loss and body tingling. A repeat CT scan was normal and Claimant's neurological examination reflected subjective complaint. Claimant was discharged that day.

13. On November 21, 2017, Claimant had a neurological evaluation with Physician Assistant Martin Bradley (PAC Bradley). Claimant on this date was claiming increased symptoms. Claimant reported gait changes, headaches and memory

problems. PAC Bradley reported a normal affect and normal orientation. PAC Bradley ordered an MRI of Claimant's brain.

14. On December 6, 2017, Claimant had a follow-up appointment with neurology after undergoing another brain MRI that was normal. Claimant reported a headache with 10 out of 10 pain level. Claimant reported that her condition was going downhill. Claimant was using a cane, reported difficulty speaking, depression and anxiety. PAC Bradley theorized that Claimant's mental status was impacting her physical condition. On examination, Claimant was alert and oriented to self, location and year. Based on Claimant's subjective report of symptoms, PAC Bradley imposed more stringent work restrictions of no patient contact, 5 lb. lifting restriction, no driving company vehicles, no power equipment and no climbing, squatting, kneeling or crawling and walking on uneven surfaces.

15. On December 6, 2017, Claimant was referred to the emergency room and transported there. At the emergency room, Claimant was again oriented to person, place and time and released the same day. Claimant was referred for a neurology consultation and a psychology consultation.

16. Claimant was evaluated by Kimberly Siegel, M.D. at UC Health Occupational Clinic on January 8, 2018. Dr. Siegel testified at hearing as an expert in occupational medicine and served as an authorized treating physician.

17. Dr. Siegel examined Claimant on January 8, 2018, and opined that Claimant was at MMI for her left upper extremity issues on or before January 8, 2018. Dr. Siegel credibly opined that Claimant had no permanent impairment of Claimant's left upper extremity.

18. Dr. Fall testified at hearing for Respondents as an expert in physical medicine and rehabilitation. Claimant was seen by Dr. Fall for an independent medical examination on March 14, 2018. Dr. Fall opined that Claimant "likely sustained self-limited contusions to the left elbow and rib cage area." Dr. Fall opined that there was no indication for any treatment as a result of her minor contusions and noted that there was no "ecchymosis or swelling even at the elbow, which was her main complaint." Dr. Fall credibly opined that Claimant did not sustain any injuries that required medical treatment. She further opined that none of Claimant's current symptoms are related to the November 9, 2017, incident and opined that Claimant does not have any work restrictions related to the November 9, 2017 incident.

19. Drs. Fall and Siegel credibly opined that concussive symptoms appear within minutes and certainly by the time of her presentation to the urgent care on November 9, 2017. The doctors opined that concussive symptoms are generally worse immediately after the head injury and improve with time. Dr. Siegel opined that Claimant's reported symptoms were likely related to pre-existing medical and psychiatric conditions, which were not related to her November 9, 2017, slip and fall. Dr. Siegel opined that Claimant's presentation was inconsistent with a concussion and her mechanism of injury supported only a minor shoulder, elbow and rib contusion.

20. Drs. Fall and Siegel credibly testified that such late-reported cognitive symptoms are unlikely to be the result of a concussion, and are likely related to Claimant's pre-existing depression, anxiety, and other conditions. Claimant's pre-incident records document a history of cognitive complaints, fatigue, and headaches that led to several CT scans and an MRI being performed. The ALJ finds that Claimant's cognitive complaints and headaches pre-existed the November 9, 2017 incident and were not caused by the alleged slip-and-fall.

21. It is found that Claimant failed to prove by a preponderance of the evidence that she suffered a brain injury on November 9, 2017, when she slipped getting out of her vehicle in Employer's parking lot on the way in to work. In this regard, Dr. Fall's opinion is found credible. Claimant's testimony was not deemed credible since she did not develop brain injury symptoms in the medically expected manner. While medical treatment and diagnostic testing was performed, no objective evidence emerged supporting Claimant's claim of a brain injury further diminishing Claimant's credibility. Claimant's behavior, as described in medical records during her three emergency rooms visits, in combination with Drs. Siegel and Fall's examinations and opinions, causes the Judge to conclude that Claimant's report of a brain injury is without record support.

22. The Judge finds that Dr. Siegel's opinion that Claimant was at MMI for her left upper extremity problems before January 8, 2018, and Dr. Fall's opinion that Claimant did not suffer a brain injury are most credible and makes her claim for workers' compensation benefits not compensable.

CONCLUSIONS OF LAW

General Legal Principles/ Compensability

1. The purpose of the Workers' Compensation Act of Colorado, Section 8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-201, C.R.S. The claimant shoulders the burden of proving by a preponderance of the evidence that he is a covered employee who suffered an "injury" arising out of and in the course of employment. Section 8-43-301(1), C.R.S.

2. The claimant must prove by a preponderance of the evidence that his 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) and (c), 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).

3. An injury occurs "in the course of" employment when it takes place within the time and place limits of the employment relationship and during an activity connected with the employee's job-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The arising out of element is narrower and requires the claimant to show a causal connection between the employment and the injury such that the injury had 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.*

4. In rendering a decision, the ALJ must make credibility determinations, draw plausible inferences from the record, and resolve essential conflicts in the evidence. *See Davison v. Industrial Claim Appeals Office,* 84 P.3d 1023 (Colo. 2004). In determining credibility, the ALJ considers 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.

5. The ALJ finds that Claimant's testimony was incredible and unpersuasive. The ALJ credits the testimony of Drs. Siegel and Fall.

6. Drs. Fall and Siegel presented credible testimony that the symptoms of a concussion or head injury would have manifested immediately, and certainly no later than her presentation at the urgent care, where she was evaluated by Hope Edmonds, M.D. Claimant did not report cognitive symptoms, dizziness, or headache to Dr. Edmonds. She reported only mild pain in her elbow, which was her main complaint.

7. The ALJ finds that Dr. Siegel's opinion that Claimant was at MMI by January 8, 2018, for her left upper extremity condition is most credible. It is found that Claimant does not require additional medical attention for the left upper extremity. Dr. Fall noted that there was no ecchymosis or swelling even at the elbow on November 9 or shortly thereafter, and the elbow was Claimant's main complaint at the time. Dr. Fall opined that Claimant's self-limited contusions at the left elbow and rib cage did not require medical treatment.

8. Drs. Fall and Siegel credibly opined that concussive symptoms appear within minutes and certainly by the time of her presentation to the urgent care on November 9, 2017. The doctors opined that concussive symptoms are generally worse immediately after the head injury and improve with time. Dr. Siegel opined that Claimant's reported symptoms were likely related to pre-existing medical and psychiatric conditions, which were not related to her November 9, 2017, slip and fall. Dr. Siegel opined that Claimant's presentation was inconsistent with a concussion and her mechanism of injury supported only a minor shoulder, elbow and rib contusion.

9. Drs. Fall and Siegel credibly testified that such late-reported cognitive symptoms are unlikely to be the result of a concussion, and are likely related to Claimant's pre-existing depression, anxiety, and other conditions. Claimant's pre-incident records document a history of cognitive complaints, fatigue, and headaches that led to several CT scans and an MRI being performed. The ALJ finds that Claimant's cognitive complaints and headaches pre-existed the November 9, 2017 incident and were not caused by the alleged slip-and-fall.

10. Dr. Siegel credibly opined that Claimant's shoulder, elbow and rib contusions were at MMI by January 8, 2018. Claimant's elbow complaints were initially reported as mild and resolved over time. Dr. Siegel noted on Claimant's examination that her shoulders had symmetric range of motion, which supports that her left upper extremity complaints had resolved by her January 8, 2018, examination. Dr. Siegel credibly opined that Claimant had no permanent impairment of her left upper extremity.

11. It is concluded that the testimony of Dr. Siegel was most persuasive and concludes that Claimant reached MMI for her left upper extremity injuries on January 8, 2018, with no permanent impairment.

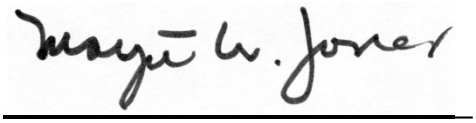
12. It is concluded that Claimant failed to establish by a preponderance of the evidence that her head injury and cognitive symptoms were caused by or aggravated by the November 9, 2017 slip and fall.

ORDER

1. Claimant reached MMI for her left upper extremity injuries on or before January 8, 2018, with no permanent impairment.

2. Claimant failed to establish by a preponderance of the evidence that her head injury and cognitive condition arose out of and in the course and scope of her employment on November 9, 2017, therefore Claimant's claim for a brain injury is denied and dismissed.

This 7th day of January, 2019.



Margot W. Jones

Administrative Law Judge

Office of Administrative Court

1525 Sherman Street, 4th Floor

Denver, CO 80203

ISSUES

- Did Claimant prove an L4-S1 fusion performed by Dr. Jamrich on June 27, 2018 was reasonably necessary treatment for his admitted injury?

FINDINGS OF FACT

1. Claimant worked for Employer as an IT professional for approximately 12 years. He suffered an admitted injury to his low back on July 24, 2017 lifting a sixty-pound box of cable locks. He felt no symptoms immediately but developed numbness in his buttock approximately 20 minutes later. Shortly thereafter, he had severe pain. Claimant discussed the matter with his supervisor, who sent him home.

2. The pain intensified that night, so Claimant called Employer at 8:00 AM the next morning and explained he needed to see a doctor. Employer did not refer Claimant to a physician, but asked him if he had a doctor in mind. Claimant knew of Dr. Eric Jamrich, an orthopedic surgeon who had treated one of his colleagues, so he made an appointment with Dr. Jamrich for later that afternoon.

3. Claimant explained to Dr. Jamrich his symptoms began shortly after lifting the box at work, and quickly progressed to become "excruciating." He described stabbing pain in his low back, aching pain in his buttock, with numbness down the back of his left leg into his foot.[1] Dr. Jamrich observed Claimant was "clearly uncomfortable." The physical examination was challenging due to the severe pain, but Dr. Jamrich appreciated decreased sensation to light touch in the left foot and an "exquisitely positive" straight leg raise on the left. X-rays showed moderate degeneration at L5-S1 with no evidence of instability. Dr. Jamrich opined Claimant probably had a herniated disc "secondary to lifting a heavy item at work yesterday." He prescribed a Medrol Dosepak, a muscle relaxer, and ordered a lumbar MRI. He asked Claimant to return "as quickly as possible" after the MRI because of his severe symptoms. The report also noted Claimant was a ¼ pack-per-day smoker "for a couple of years."

4. Claimant had the lumbar MRI the next day. The radiologist interpreted it as showing a right-sided disc protrusion at L4-5 moderately compressing the right L5 nerve root.

5. Claimant followed up with Dr. Jamrich on July 27, 2017. Claimant was feeling "significantly better" after the Medrol Dosepak. Dr. Jamrich suggested they could

[1] The exact distribution of radicular symptoms is unclear, because the patient intake form references pain and numbness in the right leg and foot, but the accompanying pain diagram indicates symptoms going down the left leg. Dr. Castro suggested Dr. Jamrich's references to the left leg were typographical errors, which seems reasonably likely.

try another Dosepak or an epidural steroid injection. He also referred Claimant for four weeks of physical therapy.

6. On September 1, 2017, Claimant had a transforaminal lumbar ESI targeting the right L5 nerve root. The injection only helped for a few days.

7. The next documented appointment with Dr. Jamrich was on January 11, 2018. Claimant was "somewhat" improved since the initial treatment with the Medrol Dosepak but still having constant pain in his low back into his leg. He also reported numb toes on the right foot. After reviewing the x-rays and MRI again, Dr. Jamrich confusingly opined, "most of his problem seems to be coming from "a markedly degenerative disc [at L5-S1]."

8. Claimant started physical therapy on February 21, 2018. He reported numbness in his feet, generally worse on the right, and a "heavy feeling" in his hips and legs. Claimant attended five therapy sessions over the following several weeks without significant improvement.

9. A repeat MRI was done on February 21, 2018. Compared to the previous MRI, there was now a disc extrusion at L4-5, whereas it was previously a protrusion. There was severe right lateral recess stenosis and moderate canal stenosis at L4-5 and severe compression of the right L5 nerve root.

10. Claimant followed up with Dr. Jamrich to review the new MRI on March 27, 2018. Dr. Jamrich noted Claimant had tried physical therapy, a lumbar ESI, pain medications, and oral steroids with minimal relief. He opined Claimant had failed conservative care and recommended an L4-S1 decompression and fusion.

11. Insurer obtained a timely Rule 16 peer review with Dr. Peter Garcia, an orthopedic surgeon. Dr. Garcia recommended denying the surgery because did not believe conservative care had been adequately exhausted. Additionally, he saw no updated physical examination findings, and Claimant had not undergone a psychological evaluation as discussed in the MTGs.

12. On April 13, 2018, Dr. Jamrich requested reconsideration of the denial. Insurer obtained another orthopedic peer review, this time with Dr. James Cain. Dr. Jamrich and Dr. Cain discussed the surgery by telephone on April 17, 2018. Dr. Cain requested an "in-depth" physical and neurological examination and flexion-extension x-rays. Dr. Cain also requested Dr. Jamrich explain why a fusion was necessary as opposed to a decompression. Dr. Jamrich "agreed that the documentation presented at this time did not reach a level to support the medical necessity for a two-level lumbar fusion in a young individual." The surgery request was denied pending the additional evaluation.

13. Dr. Jamrich re-evaluated Claimant on April 19, 2018. Claimant described severe weakness and numbness in his right leg, significant back pain, and pain radiating down his right leg. Dr. Jamrich opined the distribution of symptoms corresponded to the L4 and L5 nerve roots. On examination, Claimant had no left-sided symptoms. On the right, strength was 4/5 in the EHL, 4-/5 in the tibialis anterior, and 4/5 in the quad. Straight

leg raise was positive at approximately 40° on the right, and the right patella tendon reflex was mildly decreased as compared to the left side. Dr. Jamrich reviewed the MRI and noted a central disc herniation at L4-5 and a far lateral herniation at L4-5 in contact with the L4 nerve root. He opined, "this is giving him a combination of both L4 and L5 symptoms. Although he has a far lateral protrusion on the left side at L5-S1, this is not symptomatic." The flexion-extension x-rays showed 5 mm of retrolisthesis at L4-5 with extension that resolved with flexion. Dr. Jamrich concluded,

> This is a patient who has not responded to conservative care. He has both L4 and L5 distribution symptoms from both a far lateral and a central disc herniation at the L4-5 level. He has instability of the L4-5 level. He has weakness in the quad to the tibialis anterior and the EHL with dysesthetic pain in both an L4 and L5 distribution. He has a positive straight leg raise in a seated position at 40°.
>
> [A]lthough he has changes at the L5-S1 level, these are not symptomatic at this point. For this reason, Work Comp will certainly not want to address these. At the L4-5 level, however, he has both instability and impingement of nerve roots centrally and foraminal only that can only be addressed with a fusion. Given the fact that we are only going to address one level, I suggested an anterior interbody fusion at L4-5.

14. Based on his re-evaluation of Claimant, Dr. Jamrich submitted another request for authorization of surgery, this time a fusion at L4-5 only. The request was denied based on Rule 16 peer review by Dr. Kimberly Terry, a neurosurgeon. Dr. Terry cited the following factors in denying the surgery: (1) the MRI identified no significant stenosis at L4-5;[2] (2) Dr. Jamrich did not submit the flexion-extension x-rays to verify the 5mm of retrolisthesis he observed; and (3) Claimant had not undergone a presurgical psychological assessment as required by the MTGs.

15. Rather than wait for the litigation process to play out, Claimant elected to have the surgery under his private health insurance. On June 27, 2018, Dr. Jamrich performed an anterior interbody fusion at L4-5.

16. Claimant enjoyed immediate and substantial relief after surgery, particularly regarding his leg symptoms. His tolerance for functional activities steadily improved through the date of the hearing. Although the fusion is still consolidating and it is too early to draw a definitive conclusion about the outcome, all current indicators show the surgery was successful.

17. Dr. Andrew Castro performed an IME at Respondents' request on October 22, 2018. Dr. Castro agreed Claimant probably herniated the disc at work. He also agreed surgery at L4-5 was reasonably necessary to treat the injury. But Dr. Castro opined a fusion was not warranted, and Claimant should have had a microdiscectomy and

[2] This rationale is inconsistent with the MRI addendum report, which described "severe right lateral recess stenosis and moderate canal stenosis at L4-5." Close inspection of Dr. Terry's report suggests she did not have the addendum report.

decompression instead. He described Claimant's situation as "a very routine presentation of a disc herniation with radiculopathy or nerve root symptoms." Dr. Castro opined there was no evidence of instability to warrant arthrodesis. He based that opinion on the MRI, which showed minimal fluid in the facet joints. Dr. Castro did not acknowledge or discuss the flexion-extension x-rays showing 5 mm of retrolisthesis with extension. He also noted Claimant's smoking as a contraindication to fusion. Dr. Castro stated Claimant's symptoms had "markedly improved" since surgery and opined he was probably at MMI.

18. Claimant's testimony at hearing was credible.

19. Claimant proved by a preponderance of the evidence the L4-5 lumbar fusion performed by Dr. Jamrich was reasonably necessary to cure and relieve the effects of his industrial injury.

CONCLUSIONS OF LAW

The respondents are liable for medical treatment reasonably necessary to cure and relieve the effects of an industrial injury. Section 8-42-101(1)(a); *Snyder v. Industrial Claim Appeals Office*, 942 P .2d 1337 (Colo. App. 1997). Even if the respondents admit liability, they retain the right to dispute the relatedness of any particular treatment, and the mere occurrence of a compensable injury does not compel the ALJ to find that all subsequent medical treatment was caused by the industrial injury. *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. App. 1997); *McIntyre v. KI, LLC*, W.C. No. 4-805-040 (July 2, 2010). Where the respondents dispute the claimant's entitlement to medical benefits, the claimant must prove that an injury directly and proximately caused the condition for which he seeks benefits. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999). The claimant must prove entitlement to medical benefits by a preponderance of the evidence. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (1979). The facts in a workers' compensation case are not interpreted liberally, for either claimant or respondents. Section 8-43-201.

The Director has adopted Medical Treatment Guidelines (MTGs) to advance the statutory mandate to assure the quick and efficient delivery of medical benefits to injured workers at a reasonable cost to employers. WCRP Rule 17, Exhibit 1 addresses treatment for low back injuries. As the arbiter of disputes regarding treatment, the ALJ may consider the MTGs as an evidentiary tool but is not bound by the MTGs when determining whether requested treatment is reasonably necessary or injury-related. Section 8-43-201(3); *Logiudice v. Siemans Westinghouse*, W.C. No. 4-665-873 (January 25, 2011).

As found, Claimant proved the L4-5 lumbar fusion performed by Dr. Jamrich was reasonably necessary. The evidence convincingly shows Claimant herniated his L4-5 disc at work on July 24, 2017. Although he initially responded to oral steroids, his condition worsened over the following nine months, with progressive neurological deficits and steady decline in his functional capacity. There is no persuasive evidence of any intervening cause, and the deterioration reflected the natural progression of the industrial

injury. There is no persuasive reason to expect additional therapy or other nonsurgical measures would have resolved Claimant's condition, and further delay could have resulted in permanent nerve damage. Indeed, the MTGs suggest patients with herniated discs and radiculopathy should undergo surgical decompression within six to twelve weeks after the injury. *See* Rule 17, Exhibit 1 § (G). Dr. Castro agreed surgery was reasonable but thought a fusion inappropriate because "there is no instability." Dr. Castro's opinion in that regard is not persuasive because he overlooked the flexion-extension x-rays showing 5mm of vertebral movement. The MTGs provide that 4mm of motion is a sufficient indication for fusion surgery. *See* Rule 17, Exhibit 1 § (G)(4). Although Claimant did not have a pre-surgical psychological assessment, there were no red flags suggesting psychological unfitness for surgery. In any event, the MTGs do not strictly require a pre-surgical psychological evaluation in cases involving spondylolisthesis with radiculopathy and neurologic signs. *See* Rule 17, Exhibit 1 § (G)(4)(e)(v). The most significant contraindication for arthrodesis was Claimant's smoking habit. But the MTGs only "recommend" cessation of smoking; they do not require it. Dr. Jamrich knew Claimant smoked but decided the surgery was appropriate anyway. On balance, the ALJ is persuaded the L4-5 fusion was consistent with the MTGs and reasonably necessary to cure and relieve the effects of Claimant's injury.

ORDER

It is therefore ordered that:

1. Insurer shall cover the cost of the June 27, 2018 L4-5 fusion surgery performed by Dr. Jamrich and all ancillary charges relating to the surgery.

2. All issues 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**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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. 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: January 8, 2019

s/Patrick C.H. Spencer II
Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

ISSUES

1. Whether the claimant has demonstrated, by a preponderance of the evidence, that on April 11, 2018 she suffered an injury to her left knee arising out of and in the course and scope of her employment.

2. If the claimant proves a compensable injury, whether the claimant has demonstrated, by a preponderance of the evidence, that the left knee arthroscopy recommended by Dr. Kennan Vance is reasonable medical treatment necessary to cure and relieve the claimant from the effects of the April 11, 2018 work injury.

STIPULATIONS

At hearing the parties stipulated to the following:

1. If the claimant proves a compensable injury, her average weekly wage (AWW) is $429.95.

2. If the claimant proves a compensable injury, she is entitled to temporary total disability (TTD) benefits for the period of April 12, 2018 through May 26, 2018.

3. If the claimant proves a compensable injury, she is entitled to temporary partial disability (TPD) benefits for the period of May 27, 2018 through June 9, 2018.

FINDINGS OF FACT

1. The claimant was employed with the employer as a hair stylist. When performing a haircut, the claimant would stand on a "cutting mat". The claimant testified that April 11, 2018, she was cutting a client's hair when she stepped off the cutting mat with her right foot and slipped on some hair trimmings. While she was slipping, the claimant attempted to catch herself and in doing so she twisted and hyperextended her left knee.

2. The claimant reported the incident to the employer and was referred to St. Mary's Occupational Health for treatment. Upon contacting St. Mary's Occupational Health, the claimant was able to schedule an appointment for April 12, 2018. In addition, the claimant was informed that if she wished to seek medical treatment prior to that appointment she could go to the emergency room (ER).

3. The claimant sought treatment at the ER at Community Hospital on April 11, 2018 and was seen by Amber Carpenter, PA. At that time, the claimant described the slipping incident and reported that she twisted her left knee and experienced immediate pain and swelling. Ms. Carpenter diagnosed a knee sprain and excused the

claimant from work for two days. While at Community Hospital, x-rays were taken of the claimant's left knee and showed unremarkable soft tissues and no fracture.

4. On April 12, 2018, the claimant was seen by James Harkreader, NP at St. Mary's Occupational Health. The claimant described the April 11, 2018 incident and stated that she stepped of the mat with her right foot, which slipped, and while trying to hold herself up, her left knee twisted and flexed. Again the claimant reported that she had immediate swelling. Mr. Harkreader diagnosed a knee sprain and recommended ice, elevation, and crutches.

5. The claimant returned to Mr. Harkreader on April 17, 2018 and reported continued left knee pain, swelling, and the feeling that her knee was unstable. Mr. Harkreader recommend a magnetic resonance image (MRI) of the claimant's left knee and referred the claimant to Dr. Kennan Vance for an orthopedic consultation.

6. An MRI of the claimant's knee was performed on April 24, 2018 and showed advanced focal chondromalacia in the inferior lateral facet of the patella with subchondral cystic changes with mild lateral patellar tilt. The MRI also showed degeneration and fraying of the root of the posterior horn of the medial meniscus with mild medial meniscal extrusion.

7. On April 26, 2018, the claimant was seen by Dr. Vance. At that time, the claimant described the April 11, 2018 incident and stated that her left knee twisted. Dr. Vance completed a physical examination and reviewed the MRI images and diagnosed a tear of the medial meniscus of the left knee with synovitis and chondromalacia. Dr. Vance recommended that the claimant undergo a left knee arthroscopy with possible meniscal root repair.

8. A request for authorization of the recommended surgery was sent to the respondents on April 27, 2018. On May 7, 2018, the respondents filed a Notice of Contest.

9. The medical records entered into evidence show that the claimant received treatment for left knee related issues in April 2017 and October 2017 while she was living in California. The claimant testified that she considered these prior incidents to be minor sprains. The claimant also testified that her failure to report these prior incidents to her medical providers related to this workers' compensation claim was an oversight.

10. On April 15, 2017, the claimant sought treatment for pain in her left knee and reported that on April 14, 2017 she hyperextended her left knee. The claimant was diagnosed with a sprain and possible micro tears. The claimant testified that the April 14, 2017 incident occurred when she was hiking and "stepped wrong", which resulted in pain. The claimant also testified that the left knee pain and swelling she experienced in April 2017 resolved and she was able to perform her normal job duties.

11. On October 8, 2017, the claimant felt a pop and pain in her left knee while jogging. As a result, she sought medical treatment. The medical record dated October 9, 2017 indicates that the claimant was "running downhill when all of the sudden she had left knee pain."

12. With regard to the October 2017 left knee incident, the claimant testified that she stepped off a curb while jogging and felt pain in her left knee. On October 19, 2017, the claimant was seen by her personal physician, Dr. Michael MacMurray, for a physical. At that time, the claimant reported left knee pain and Dr. MacMurray recommended an MRI and physical therapy. Although an MRI and physical therapy were recommended, the claimant did not pursue either of these treatments. The claimant testified that her left knee pain resolved and she did not miss work related to the October 2017 incident.

13. At the request of the respondents, on August 14, 2018, the claimant attended an independent medical examination (IME) with Dr. James Lindberg. In connection with the IME, Dr. Lindberg reviewed the claimant's medical records, obtained a history from the claimant, and completed a physical examination. In his IME report Dr. Lindberg opined that the recommended arthroscopy was not indicated. In support of this opinion Dr. Lindberg noted his belief that the claimant's descriptions of the April 11, 2018 incident were inconsistent. Dr. Lindberg also pointed to the claimant's prior knee injuries in 2017. Dr. Lindberg further opined that the claimant's symptoms were due to an old injury "that just had a re-exacerbation of it." In his IME report, Dr. Lindberg indicated that he contacted the radiologist regarding the April 24, 2018 MRI and discussed the imaging and the findings and "agreed that there is no medial meniscal tear." Dr. Lindberg's testimony at hearing was consisted with his written report.

14. Dr. Vance testified by deposition in this matter and reiterated his recommendation for the left knee arthroscopy. Dr. Vance testified that his diagnosis is a tear of the claimant's left medial meniscus root. In support of this diagnosis Dr. Vance testified that the claimant's mechanism of injury is consistent with a tear and the MRI showed increased signal in the root of the medial meniscus. In addition, Dr. Vance stated that the recommended surgery is reasonable and necessary to treat the claimant's symptoms.

15. The claimant credibly testified that the left knee symptoms she experienced in April 2017 and October 2017 are different than those symptoms she has had since the April 11, 2018 incident at work. The claimant testified that her current symptoms include pain and swelling in her left knee. In addition, she feels that her left knee is not stable and it "locks", "gives out", and "catches". The claimant testified that she would like to get the recommended left knee surgery.

16. The ALJ credits the medical records, the claimant's testimony, and the opinion of Dr. Vance over the contrary opinion of Dr. Lindberg. The ALJ finds that the claimant has demonstrated that it is more likely than not that on April 11, 2018 she suffered an injury to her left knee at work.

17. The ALJ credits the medical records, the claimant's testimony, and the opinion of Dr. Vance over the contrary opinion of Dr. Lindberg. The ALJ finds that that the claimant has demonstrated it is more likely than not that the surgery recommended by Dr. Vance is reasonable medical treatment necessary to cure and relieve the claimant from the effects of the April 11, 2018 work injury. While the April 11, 2018 incident at work did not cause the claimant's torn meniscus, the slip and subsequent twisting of her left knee aggravated and accelerated the preexisting condition of the claimant's left knee, necessitating surgery.

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 8-43-201, C.R.S., 2008. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 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, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and 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 (2016).

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).

4. 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.*

5. As found, the claimant has demonstrated by a preponderance of the evidence that she suffered an injury to her left knee arising out of and in the course and scope of her employment on April 11, 2018. As found, the medical records, the claimant's testimony, and the opinion of Dr. Vance are credible and persuasive.

6. 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).

7. As found, the claimant has demonstrated by a preponderance of the evidence that the knee surgery recommended by Dr. Vance is reasonable medical treatment necessary to cure and relieve the claimant from the effects of the work injury. As found, the April 11, 2018 incident at work aggravated and accelerated the claimant's preexisting left knee condition, necessitating surgery. As found, the medical records, the claimant's testimony, and the opinion of Dr. Vance are credible and persuasive.

ORDER

It is therefore ordered:

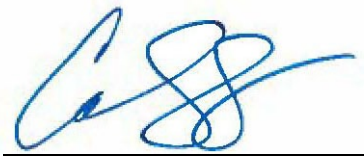
1. The claimant suffered a compensable injury to her left knee.

2. The respondents shall pay for the left knee arthroscopy recommended by Dr. Vance, subject to the Colorado Medical Fee Schedule.

3. The ALJ adopts and stipulation of the parties regarding AWW, TTD, and TPD.

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

Dated January 9, 2019



Cassandra M. Sidanycz
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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 ALJ'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 ALJ; 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. 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. **In addition, it is recommended that you send a copy of your Petition to Review to the Grand Junction OAC via email at oac-gjt@state.co.us.**

ISSUES

- Did Claimant meet his burden of proof by a preponderance of the evidence that his AWW was higher than the admitted AWW?
- Did Respondents meet their burden of proof to establish Claimant willfully violated a safety rule adopted by Employer, allowing a 50% reduction of his indemnity benefits.

FINDINGS OF FACT

1. Claimant began working for Employer on June 12, 2017. He was employed as an Installed Product Specialist. Claimant was hired at a rate of $21.00 per hour.[1]

2. Claimant was referred for this position by Rob Garner, with whom he had worked at a company called ICI. Mr. Garner received a $450.00 referral bonus when Claimant was hired by Employer.

3. Claimant's wife, Jessica testified at the hearing. They have been married three years and together for a total of five years. She testified Claimant met Mr. Garner while working at ICI. He applied to work for Employer for additional stability and security, as well as the benefits.

4. Claimant's wife testified she understood Claimant was entitled to a sign-on bonus after he completed the 90-day probationary period. Claimant's wife testified he worked overtime while he worked for Employer. It was her understanding Claimant was going to sign up for health insurance benefits before he was injured. Ms. Burd also testified Claimant took some time off in July 2017 when his son was visiting, which was why he did not work full 40-hour work week. The ALJ credited that explanation.

5. Mr. Garner testified as a witness on behalf of Employer and is employed as the production manager. He said he knew Claimant through his prior employment at ICI. Once he gave notice, Claimant contacted him to come work for Employer. Mr. Garner testified Claimant was entitled to a sign-on bonus in the amount of $600.00. The ALJ inferred Mr. Garner discussed a sign-on bonus with Claimant.

6. Mr. Garner testified Claimant was aware of the safety rule involving fall protection. This included the rule that workers were not allowed to unhook a safety

[1] Exhibit E, p. 37; Exhibit 10, p. 60.

harness while working at heights above 6 feet. Mr. Garner attended the regular safety meetings, which occurred on Tuesday. The meetings lasted thirty (30) minutes and sometimes involved hands-on class participation involving a safety harness. The fall protection training included the rule that it was a violation of company policy to untie if you are working above six (6) feet. Mr. Garner did not work at the Fort Lupton job site where Claimant was injured.

7. Mr. Garner testified that the harness system has a two-part locking process. Neither of the two locks could accidentally unclip. To unlock this mechanism, an employee had to manually open the clipping mechanism.

8. Claimant's job description (Installed Product Specialist) required that he comply with Employer's safety policies. It specified Claimant was:

> **"Summary**
>
> …Responsible for observing and following all OSHA and Company Safety policies and procedures".
>
> Complying with safety rules was an essential function of this position, as follows:
>
> **"Essential Functions**
>
> Installs product per work order, manufacturer, quality and safety guidelines".[2]

9. Employer adopted a written safety policy, which established standards for fall protection. This document was entitled TrueTeam Standard and Guideline-Fall Protection Program. More particularly, there was a section entitled General Requirements that delineated when fall protection was required. That section provided in pertinent part:

> "Section 1—General Requirements
>
> **Program Overview**
>
> Some type of fall protection shall be employed anytime an employee is performing work from elevated heights and is exposed to a potential fall of six (6) feet or more in construction and four (4) feet or more manufacturing and warehousing. Employees who are exposed to any fall hazard from an impaling hazard, energized electrical hazard, exposed moving machinery parts, window, elevator, door or any other opening shall be protected from fall exposures four (4) feet or more in all situations. In these situations, fall protection suitable to prevent injury shall be employed.

[2] Exhibit E, p. 67.

The following hierarchy shall be used when choosing methods to eliminate or control fall hazards:

1. **Elimination or substitution**--i.e. removal of the hazard

2. **Passive Fall Protection**--i.e. isolating or separating the hazard from the workers

3. **Fall Restraint**--i.e. preventing the person (CSS) from reaching fall hazard

4. **Fall Arrest**--i.e. attaching a person to system designed to stop a fall after it has started

Fall arrest systems may only be used when one of the three methods of fall prevention outlined are not feasible".[3]

10. The ALJ concluded Employer's fall protection program required methods to be employed to prevent falls when an employee worked at a height of 6 feet or higher in construction. This policy was in force at the job site where Claimant was injured.

11. Joshua Wolitsky is a division manager and testified on behalf of Employer. He oversees the day-to-day operations from production to the books. Claimant worked as part of Employer's infield production staff in Mr. Wolitsky's division. When Claimant was hired on June 12, 2017, it was for a full-time, forty hour per week position. Mr. Wolitsky testified employees could work overtime hours (depending on the project) and could put in a request for those hours.

12. Mr. Wolitsky testified Employer has safety guidelines and Claimant was responsible for following those guidelines. Claimant was advised of the safety guidelines, starting with the onboarding process. At the time of the onboarding, all types of safety related topics were discussed, including fall protection, PPE (personal protective equipment), scaffolding, ladder training, lift training and the like. Claimant would have received training on these subjects the first two days of his employment. Employer also holds weekly safety meetings. Mr. Wolitsky testified Claimant attended a safety meeting on fall protection after his initial training. As part of the training, he would have been taught not to clip while working at heights. A sign in sheet confirmed Claimant attended a meeting.

13. Mr. Wolitsky stated Claimant was required to use fall protection equipment while working on a roof. This included a full body harness, horizontal lifeline, along with a yo-yo and lanyard, which attaches to the backside of the equipment. The horizontal lifeline is tied off to the anchorage point (on the building), which then hooks into the harness. Employees are required to use fall protection any time they are operating at heights above six (6) feet. An employee is allowed to unhook from the fall protection

[3] Exhibit F, pp.97-98.

system once that employee is on the ground. If an employee is observed unhooking the harness while working at height by Mr. Wolitsky or a supervisor, that employee is taken from the job and disciplinary action would follow.

14. Mr. Wolitsky confirmed the fall protection safety plan which was in force on the Fort Lupton job where Claimant was injured.[4] Estaban Cabral was foreman on the job and was responsible for making sure the fall protection plan was implemented and the system installed. Mr. Cabral had 15 years of experience and was familiar with the system and how it was to be installed. Mr. Cabral was responsible for the job site where Claimant was working.

15. Mr. Wolitsky testified he would know if an employee would be entitled to a signing bonus and he would have to approve it as the division manager. He did not do that in this case. There was a referral bonus Mr. Garner in the amount of $450.00. Mr. Wolitsky did not know what the retention bonus was.

16. Rose Davidson testified on behalf of Employer. Her position was Senior Manager of Human Resources Information Systems. In that capacity, she oversaw Employer's HR operations, including managing HR information system and benefits. Ms. Davidson testified there was no record Claimant was entitled to a sign-on bonus and if he was eligible for a sign-on bonus, this would have been included in the offer letter. If Claimant had been eligible for a sign-on bonus, the first half would be paid after three months of employment, the second half paid after six months of employment.

17. Ms. Davidson testified Claimant was eligible for employee benefits which included health, dental and vision insurance. There was also a short term disability/long term disability ("STD/LTD") plan in which employees were automatically enrolled at the beginning of their employment. Ms. Davidson confirmed Employer's benefits package included tuition reimbursement, EAP, flexible spending accounts and life insurance.

18. Ms. Davidson said employees were eligible to enroll in health insurance benefits any time during the initial 90-day period of employment. Ms. Davidson testified employees were required to make such an election within that period of time in order to secure coverage. Employer has an electronic system (ESS) on which employees can sign up for insurance. Ms. Davidson stated if the employee enrolled for health insurance coverage, the coverage would begin on the first day of the following month. If Claimant had signed up, his health insurance coverage would have been effective on October 1, 2017.

19. The deadline for Claimant to enroll for health insurance coverage was September 10, 2017. Ms. Davidson verified Claimant did not elect health insurance within the first ninety (90) days of his employment and was not eligible for this benefit. He did not have vison or dental coverage. On cross-examination, Ms. Davidson was asked about two calls made by Claimant after midnight on September 11, 2017, which

[4] Exhibit G, p. 243.

concerned a password reset. Ms. Davidson testified that was too late to sign up for insurance as this was past the September 10, 2017 deadline.

20. Claimant was enrolled in the STD/LTD policy when he began his employment.[5] Claimant made a contribution for that coverage in the first pay period in which he was eligible. Ms. Davidson testified that because he was not working after the 90-day period, this coverage was not in force, as the policy specified you had to be an active employee. The ALJ did not find this explanation credible. Although Ms. Davidson said Employer returned premiums to Claimant, the ALJ finds it is more probable than not that Claimant was covered by Employer's STD/LTD policy at the time of his accident by virtue of Employer's acceptance of the premiums. There was no evidence in the record whether employer paid some portion of the premiums related to this policy. There was also insufficient evidence for the ALJ to determine whether STD/LTD premiums should be included in Claimant's AWW.

21. Claimant participated in safety training while working for Employer and his training record was admitted into evidence. More particularly, he attended safety training on June 19, 2017. The subject was fall protection. Claimant also completed training on August 8, 2017 and the subjects were: fall protection, PPE and scaffolding training. The ALJ inferred Employer promulgated its safety policies and rules during the trainings Claimant attended.

22. Mr. Cabral worked for Employer as a foreman, a position he has held for two years. He has worked for Employer for a total of 17 years. As a foreman, he was responsible for reporting any issues with safety cables and the retractable cable. He was also responsible for making sure employees stay tied off throughout the day. He also set up the clamps that connect to the retractable cables, which attach to the main rafters. He set up the cable system and moved it as the job progressed. Mr. Cabral testified that if an employee was 6 feet or higher, that employee had to be tied off.

23. Claimant was injured on September 22, 2017 while working for Employer. He was working on a jobsite located in Fort Lupton, Colorado. Claimant was working at a height of anywhere from 24 to 30 feet and was unclipped from his safety harness when he fell.

24. Mr. Cabral was working with Claimant on the day of the accident. Jesus Palacios and Carlos Rodriguez were also working that day. Mr. Cabral stated they got to the roof by way of a scissor lift and had to hook into the fall protection system before untying from the scissor lift. They were putting insulation on the roof, which involved stacking rolls on the second rafter and then rolling out the insulation. The insulation was installed between the purlins. The fall protection system was in place on the building and a horizontal safety line ran from one end, with the anchors were set on the main beams. Mr. Cabral testified that if an employee was more than six feet inside of

[5] The policy was not admitted into evidence at the hearing.

an edge on this type of roof, that person did not have to be tied off.[6] The ALJ inferred Mr. Cabral believed there were some circumstances when employees could unhook from the safety harness, even when working above 6 feet.

25. Mr. Cabral had moved to set up a retractable line at a different location on the roof. He saw Claimant and Mr. Palacios walking over to the other part of the roof. Neither Mr. Burd nor Mr. Palacios was hooked up.[7] Mr. Cabral did not see either unhook their harnesses. Mr. Cabral started cussing, asking them what they were doing, as they had unhooked from the retractable. He saw Claimant step on the insulation and fall.

26. Mr. Palacios testified at hearing. He has worked for Employer as an installer for eleven (11) years. At the time of the accident, he was working overtime hours and has continued to do so since then. He was helping Mr. Cabral run the rolls of insulation from one edge of the roof to the next. This took approximately hour and a half and he was clipped in while he was working. Once they were finished running the rolls, they would get on top of the roof and help everybody else run the overlays.

27. Mr. Palacios testified he unclipped his harness when he walked across with Claimant. He was the first to walk across and both of them unhooked from the horizontal line to walk along the edge of the building. Mr. Palacios stated walking across the roof and near the edge while unhooked was a violation of company policy. He was aware of the company policy. Mr. Palacios testified they were supposed to be clipped in at all times. Mr. Cabral did not tell him to stop walking across after he unclipped. They had done it many times on that job. Mr. Palacios said there were not safety lines on the roof where they were located. He saw Claimant fall backwards.

28. Mr. Palacios stated they worked to install the overlay without being clipped in before September 22, 2017. Mr. Palacios testified he was never disciplined or reprimanded for unclipping his harness while working.[8] That included discipline imposed by Mr. Cabral.

29. Mr. Wolitsky testified he was not aware that Mr. Cabral, Mr. Rodriguez, Claimant, and Mr. Palacios worked unclipped from the fall protection system. If he had received notice from the manager that they were working unclipped, these employees would have been pulled from the job site and disciplined accordingly. If an employee was unclipped at high heights, that was a terminable offense, as this was one of the most dangerous things an employee can do in there in this industry. Mr. Wolitsky testified employees were encouraged to discuss the violations they witnessed.

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[6] Hearing Transcript Volume I ("Hrg. Tr. Vol. I"), p. 209:11-16.

[7] Hrg. Tr. Vol. I, p. 196: 6-11.

[8] Hrg. Tr. Vol. I, p. 270: 24-25.

30. There was no evidence in the record that Mr. Wolitzky disciplined employee(s) for unhooking safety harness while working at heights. Mr. Cabral testified he did not discipline employees for unhooking safety harnesses. Mr. Palacio was not disciplined for unhooking his harness on the jobsite on the date Claimant was injured. The ALJ found these were examples of Employer not enforcing the fall protection safety policy.

31. Photographs of the accident site were admitted at hearing.[9] These showed the area where Claimant fell, including a section of the insulation that was open through which Claimant fell. The pictures also depicted the roof on the building, which was partially completed, as well as area where insulation had been laid between the perlins.

32. A drawing/reconstruction of the area where Claimant was also admitted at hearing. This depicted the area in which Claimant, Mr. Palacios and Mr. Cabral was working. There was an area of exposed insulation where Claimant fell.

33. There was no evidence that equipment failure, including the harness Claimant was wearing and the lanyard, was a cause of the accident.

34. On October 10, 2017, a General Admission of Liability ("GAL") was filed on behalf of Respondents, admitting for wage and medical benefits. The GAL admitted for an AWW of $813.27, which gave a TTD rate of $542.18. This GAL reduced Claimant's TTD benefits by 50% for a safety rule violation and these benefits have been paid at a rate of $271.09 per week.

35. An Employer's First Report of Injury was completed on December 5, 2017. It stated Claimant was installing insulation when he fell.

36. An expert report prepared by David Glabe, PE, dated April 16, 2018 was admitted into evidence. His areas of specialty included fall protection, scaffolding, shoring, forming and construction engineering. Mr. Glabe, who is a structural engineer, was retained by Respondents and offered several opinions related to the subject accident. First, he concluded Employer complied with the applicable OSHA regulations regarding safe workplaces, training and fall protection. Mr. Glabe also concluded Claimant did not comply with applicable OSHA regulations; this failure to do so resulted in his accident and injuries. Third, Mr. Glabe concluded Employer provided effective fall arrest systems that not only complied with applicable OSHA regulations, but also provided Claimant with fall arrest protection for the work activity he was doing at the time of his fall.

37. Mr. Glabe testified as an expert in civil engineering, as well as fall protection safety and fall protection systems. Mr. Glabe opined the accident was caused when Claimant unhooked his lanyard from the safety line and he had no protection to either arrest the fall or restrain him from a fall. This was the cause of his

[9] Exhibit 1.

injuries. Mr. Glabe concluded Employer complied with applicable OSHA regulations regarding safe workplaces, training and fall protection. This was based upon his knowledge and understanding of the OSHA standards and expectations that come out of those standards. He also reviewed Employer's training program for fall protection and stated Employer did a thorough job as far as written documentation. Employees knew they needed to use fall protection and there was training on the program.

38. Mr. Glabe testified that the fall protection system in place at the time of the Claimant's fault complied with OSHA regulations. The horizontal lifeline installed at the jobsite was the correct choice and retractable lanyards (also known as yo-yos) were also in use. These locked up to prevent any further fall. Fixed length lanyards were in use and connected directly to horizontal life line. Mr. Glabe stated the system in place would have work had it been used. He testified Claimant did not comply with section 5(b), which requires employees to comply with OSHA standards. Mr. Glabe opined it was Claimant's failure to use the system and hook into a lifeline which resulted in his non-arrested fall to the floor below.

39. David Johnson testified as an expert on behalf of Claimant. He was qualified as an expert in construction safety, OSHA compliance and general industry standards. His job duties/responsibilities over the past twenty-four years has included jobsite visits to inspect, audit and evaluate how workers are following policies/procedures and OSHA regulations. He prepared two reports, the first of which was preliminary (February 20, 2018) and detailed what records he needed to provide a more complete opinion. In the report dated May 3, 2018, Mr. Johnson concluded that this accident could have been prevented with proper planning, training and supervision at the site level. He opined no site specific fall protection plan was created for this site as required by company policy. He modified the first opinion in his report, noting that based upon the testimony of witnesses, Claimant was likely not going to use the ladder that was underneath the area where the fall occurred. He reaffirmed the second opinion, namely that the fall protection plan in place at the job site where Claimant was injured was not sufficient.

40. Mr. Johnson testified fall protection was in place at the roof structure, but opined it was not adequate. The horizontal lifeline system which was in place and installed was beneficial for the area of the roof where it was installed. However, it did not protect work being done in other areas of the building, which also needed fall protection. Mr. Johnson said that there should have been another horizontal lifeline for Claimant and Mr. Palacios to clip into once they got to the flat roof. He noted Mr. Cabral was secured by a 40-foot retractable lifeline and he was going to secure them to that, allowing the next worker to walk over using that lifeline. Mr. Johnson believed that was a reasonable plan for getting to the flat roof. However, there was no place for the workers to connect at the flat roof. Even if Claimant had been able to tie off at the purlins, there were not anchor points he could have tied into, as he was wearing an 11-foot self-retracting life line.

41. Mr. Johnson testified there was not a specific fall protection plan in place that laid out the sequence of what was to occur when workers were moved around to different positions on the roof. Specifically, there was a gap in the fall protection in terms of what steps were going to be taken once the big rolls of insulation were rolled out. Mr. Johnson testified the gap in the fall protection and was present once the workers got nearer to the finished roof section. On cross-examination, Mr. Johnson agreed that a fall protection plan did not have to be in writing. He agreed Mr. Cabral was right in not yelling at Claimant and Mr. Palacios. Mr. Johnson stated once they got to the stable portion of the roof, Mr. Cabral should have (as a competent person) stopped the work and required Claimant and Mr. Palacios go to the middle of the roof, as opposed to the edge. He should have talked with them and possibly installed an anchor point for them to tie off. Mr. Johnson opined that Mr. Cabral was not enforcing Employer's safety rules requiring fall protection. The ALJ noted this was borne out by the specific circumstances of Claimant's fall and credited this testimony.

42. Mr. Johnson was present for the testimony where Mr. Palacios related that he stayed at a particular location (Point E) for approximately five minutes. Mr. Johnson opined Mr. Cabral should have made sure that there was an adequate fall protection systems available throughout the work area. This was evidence to him of a lackadaisical attitude and complacency regarding fall protection on the project, as the employees were right near the edge of the roof and didn't tie off. Mr. Cabral was responsible for enforcing the plan. On cross-examination, Mr. Johnson agreed that if Claimant had remained at Point E and didn't unhook the harness, he would not have fallen. Mr. Johnson said Claimant would not have been able to stay hooked in while Mr. Cabral moved the horizontal lifeline system.

43. The ALJ finds the admitted AWW did not fairly compensate Claimant. Claimant proved he was entitled to a signing bonus in the amount of $600.00, which should be included in his AWW. Since Claimant worked for three months, the ALJ determined his AWW should be increased $50.00 per week, which was determined by dividing the amount of the signing bonus by 12 weeks.

44. Claimant's wages varied from week to week before his injury. In addition, the testimony of Claimant's wife led the ALJ to conclude that the weeks in July when Claimant took off to spend time with his son caused the calculation of AWW to be low. The ALJ found the calculation of Claimant's average weekly wage should include the total wages earned from July 23, 2017 through September 17, 2017, which included weeks in which Claimant worked overtime hours. Claimant's earnings during this 10 week period totaled $8,859.03. This gave an average of $885.90 earned per week.

45. Claimant failed to prove he was entitled to a higher average weekly wage based upon the value of health insurance benefits. The evidence showed that Claimant did not sign up for health insurance within the specified period and was not covered under Employer's health insurance plan.

46. The ALJ was unable to determine whether Claimant's average weekly wage should be increased by the value of the STD/LTD benefits.

47. Employer adopted a safety policy which covered its workers who worked at a height above 6 feet, including Claimant. Employer's safety policy required any employee who worked at a height of above 6 feet required that employee to utilize some type of fall protection.

48. The ALJ finds Employer trained its employees on the fall protection safety policy and communicated its terms to employees, including Claimant. Claimant attended training sessions in which the safety policy that required workers to be connected to a harness while working at height was discussed. The ALJ inferred Claimant knew of the rule which prohibited unhooking the safety harness when he was working at heights 6 feet or above.

49. The ALJ was unable to conclude Claimant willfully violated the safety rule when he unhooked the safety harness on September 22, 2017, as there was evidence that a co-worker (Mr. Palacios) also violated the safety rule at the same time. The ALJ was unable to determine Claimant's state of mind prior to the fall either directly or indirectly from the evidence.

50. Employer did not uniformly enforce the safety policy which required all employees to be hooked in while working at height.

51. Evidence and inferences inconsistent with these findings were not persuasive.

CONCLUSIONS OF LAW

Generally

The purpose of the Workers' Compensation Act of Colorado (Act), § 8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. § 8-40-102(1), C.R.S. 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. § 8-43-201(1), C.R.S.

A Workers' Compensation case is decided on its merits. § 8-43-201, C.R.S. (2016). 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).

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). In the case at bench, the credibility of Employer's witnesses, as well as experts determined whether there was a willful violation of a safety rule.

AWW

§ 8-42-102(2), C.R.S. (2016) requires the ALJ to calculate Claimant's AWW based on the earnings at the time of injury as measured by the Claimant's monthly, weekly, daily, hourly or other earnings. This section establishes the so-called "default" method for calculating Claimant's AWW.

However, if for any reason, the ALJ determines the default method will not fairly calculate the AWW, § 8-42-102(3), C.R.S. (2016) affords the ALJ discretion to determine the AWW in such other manner as will fairly determine the wage. § 8-42-102(3), C.R.S. establishes the so-called "discretionary exception". *Benchmark/Elite, Inc. v. Simpson,* 232 P.3d 777 (Colo. 2010); *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993). The overall objective in calculating the AWW is to arrive at a fair approximation of Claimant's wage loss and diminished earning capacity. *Campbell v. IBM Corp., supra; Avalanche Industries v. ICAO*, 166 P.3d 147 (Colo. App. 2007)

In *Campbell*, Claimant's initial injury occurred ten years before her deteriorating condition caused her to cease working. Her employer argued that her AWW should be based on the wages she earned at the time of her initial injury, rather than the higher wages she had earned through salary increases and promotions during the intervening years. The Colorado Court of Appeals determined that it would be "manifestly unjust to base Claimant's disability benefits in 1986 and 1989 on her substantially lower earnings in 1979", and determined that her AWW should be based upon the higher salary earned at the time her deteriorating condition caused her to stop working. *Campbell v. IBM Corp., supra,* 867 P.2d at 82. The rationale for the Court's decision was one of fairness and Justice Plank stated:

"The entire objective of wage calculation [under the Act] is to arrive at a fair approximation of the claimant's wage loss and diminished earning capacity. Although [AWW] generally is determined from the employee's wage at the time of injury, if for any reason this general method will not render a fair computation of wages, the administrative tribunal has long been vested with discretionary authority to use an alternative method in determining a fair wage". *Campbell v. IBM Corp., supra,* 867 P.2d at 82.

Likewise, in *Pizza Hut v. ICAO*, 18 P.3d 867, (Colo. App. 2001), Claimant was injured while working as a delivery driver. He then obtained a second job at a hospital. Claimant concurrently held two jobs for a short period, then quit the delivery job. The Colorado Court of Appeals affirmed the increase in Claimant's average weekly wage and reinforced the principle that the ALJ had discretion to calculate Claimant's wages

based on earnings from a subsequent employer and not upon wages earned at the time of injury, as the former represented a fairer calculation of Claimant's AWW.

In the case at bench, there was a dispute whether Claimant was entitled to a signing bonus while working for Employer. Claimant argued his AWW should be increased by the amount related to the signing bonus. Respondents, relying on the testimony of Ms. Davidson and Mr. Wolitzky asserted there was no evidence Claimant was entitled to a signing bonus, as it was not referenced in the offer letter. (Findings of Fact 15-16). As found, Claimant was entitled to a higher AWW, as it was more probable than not he was to receive a signing bonus. (Finding of Fact 38). The ALJ credited the testimony of Ms. Burd, as well as Mr. Garner on this subject. (Findings of Fact 4-5). The ALJ determined Claimant was entitled to a signing bonus and prorated the amount of that bonus over the first three months of his employment, thereby increasing the average wage by $50.00 per week.

Claimant further argued that his average weekly wage should be increased to include the value of fringe benefits to which he was entitled (health, dental, and STD/LTD). Including signing bonus with all other benefits he expected to receive, Claimant asserted his AWW should be increased to $1,422.23, the maximum benefit rate for 2017. Respondents averred Claimant's admitted average weekly wage was correct and fair reflection of what Claimant was earning at the time of his injury. Respondents noted the admitted AWW calculation was based on Claimant's total earnings during his time of employment, $11,395.83 earned in 14 weeks from June 12, 2017 to September 17, 2017, equals $813.27 per week. Respondents contended Claimant failed to prove an entitlement to a higher AWW based upon a signing bonus and various fringe benefits.

As found, Claimant did not enroll in Employer's health insurance plan within the time period for enrollment and therefore that cannot be included in the AWW. (Finding of Fact 45). Likewise, there was insufficient evidence which would allow the ALJ to determine whether the STD/LTD policy should be included in the AWW. (Findings of Fact 20, 46).

The ALJ determined the fairest assessment of Claimant's AWW was to consider his wages from July 23, 2017 through September 17, 2017. This accounted for weeks when Claimant took time off in July. This also included weeks when he worked less than 40 hours, along with those when he qualified for overtime. Claimant earned a total of $8,859.03 over those 10 weeks, which gives an AWW of $885.90 per week. When the sign-on bonus is included, Claimant's average weekly wage should be increased to $935.90 per week.

Willful Violation of a Safety Rule

Section 8-42-112(1)(b), C.R.S. governs the imposition of a penalty for a violation of a safety rule. That section provides for a 50 percent reduction in Claimant's compensation when Respondents prove "the injury is caused by the employee's willful failure to obey any reasonable rule adopted by the employer for the safety of the

employee". The question of whether the Respondents met their burden and proved a willful safety rule violation by a preponderance of the evidence is generally one of fact for determination by the ALJ. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office,* 907 P.2d 715, 719 (Colo. App. 1995).

In *Lori's Family Dining*, Claimant was engaged in horseplay with co-employees, which escalated to an altercation. Claimant was injured when he fell and broke his arm. The employer prohibited horseplay and had warned employees against such conduct. Employer's policies required three written warnings before termination. The ALJ declined to impose a 50% penalty for a safety rule violation on the grounds that employer had not enforced safety rule, which was affirmed by the Industrial Claim Appeals Office. The Colorado Court of Appeals considered whether the denial of the penalty was appropriate under those circumstances. Justice Hume noted the most frequent ground for rejecting a penalty for violation of a safety rule was the "lack of enforcement of the rule or policy by an employer with knowledge of and acquiescence in its violation". The Court affirmed the ALJ's denial of the safety rule violation. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office,* 907 P.2d at 719.

As a starting point, the ALJ concluded Employer adopted a written safety policy which was in force at the time Claimant was injured. (Finding of Fact 9). This policy was expressed in Employer's Fall Protection Program. The specific policy at issue was the Safety and Hazard Communication Program, which required employees to wear a harness when working at heights above six feet. (Findings of Fact 10, 47).

As determined in Findings of Fact 7-10, Employer took steps to insure its employees were informed of the policies and the safety rules were reinforced throughout their employment. The testimony of Mr. Garner and Mr. Wolitsky established Claimant receive training, specifically Employer's fall protection rules. (Findings of Fact 6, 12). The ALJ concluded that Employer communicated the safety policies to Claimant, who underwent training on fall protection. (Finding of Fact 10). Claimant's completion of the safety training was established by Employer. The ALJ concluded (by both direct evidence and inferences) that Claimant was aware of the safety policy. (Finding of Fact 48). Therefore, Respondents proved there was a safety rule which was communicated to employees, including Claimant. That does not end the inquiry, however. The ALJ next considered whether Employer enforced the subject safety policy.

The ALJ concluded Employer had not enforced the safety rule. First, there was direct evidence in the form of witness testimony which established employees worked on the subject jobsite and unhooked the safety harnesses in violation of the policy. Mr. Cabral, who was the supervisor of the job site confirmed he witnessed Claimant and Mr. Palacios unhook their safety harnesses. (Finding of Fact 25). Mr. Palacios testified he unhooked the safety harness and was not subject to discipline. (Finding of Fact 27.) Mr. Palacios testified he had unhooked several occasions at this job site. This evidence was apposite to the ALJ's determination that Employer did not enforce the safety rule at all times.

As determined in Findings of Fact 13, 29-30, Employer witnesses testified that violations of the rule against unhooking a safety harness subjected employees to discipline, up to and including termination. The written terms of the fall protection policy also described the failure to follow it as a disciplinable offense. (Finding of Fact 9). However, the evidence showed Employer did not discipline employees who violated the rule against unhooking safety harnesses. No contrary evidence was introduced to refute this. There was no evidence any employee was disciplined for what occurred on the date when the Claimant was injured. (Findings of Fact 29-30). Thus, while the evidence before the ALJ proved Employer had an established policy, which was communicated to employees, the Employer acquiesced in the violations of the policy. This fits within *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office, supra*, and its progeny. Where an Employer does not enforce a safety rule it adopted, this denudes the safety rule of its force and effect. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office,* 907 P.2d at 719. Under these circumstances, Respondents were not entitled to reduce Claimant's benefits for violation of the safety rule.

Second, there was dissonance between the written text of Employer's safety rule governing fall protection and its employees' understanding of the rule. As found, Employer's fall protection policy required any employee who worked at the height of 6 feet or above was required to wear protection at all times. (Findings of Fact 9-10). Employer management witnesses, Mr. Garner and Mr. Wolinsky testified that wearing fall protection was required at all times when employees worked above 6 feet. (Findings of Fact 6, 13). These Employer witnesses uniformly testified it was a violation of the safety rule to unhook from the harness plan for working higher than 6 feet off the ground.

However, Mr. Cabral, who supervised the jobsite where Claimant was injured, testified an employee could unhook the harness working on the roof, as long as the employee was more than 6 feet from any edge.[10] The ALJ noted Employer's written policy did not make such a distinction, but the fact that the supervisor at the jobsite thought there was such a distinction led the ALJ to find there was a divergence between the written policy and Mr. Cabral's understanding of the policy.

Third and finally, the ALJ was unable to conclude that Claimant's willful violation of the safety rule was the cause of the fall. Respondents were required to show Claimant's conduct was willful, that is; he knew the rule, then intentionally did what the rule prohibited. *Bennett Props. Co. v. Indus. Comm'n*, 165 Colo. 135, 140, 437 P.2d 548, 551 (1968). On this element, Respondents failed to meet their burden. As used in this statute, the word "willful" means "with deliberate intent", *City of Las Animas v. Maupin*, 804 P.2d 285, 286 (Colo. App. 1990) [citation omitted], or "the intentional doing of something either with the knowledge that it is likely to result in serious injury, or with a wanton and reckless disregard of its probable consequences". *Johnson v. Denver*

[10] Respondents' expert Glabe testified OSHA regulations refer to a warning line which is installed within 6 feet of the edge of the roof. A warning line has flags on it and is installed to inform workers some sort of fall protection system must be used. [Hrg. Tr. Vol. II, p. 73: 24-74:15].

Tramway Corp., 115 Colo. 214, 222, 171 P.2d 410, 414 (1946) (emphasis omitted) [quoting 1 William R. Schneider, *The Law of Workmen's Compensation* § 282, at 876 (2d ed. 1932)].

Respondents argued, relying on the testimony of Messrs. Wolinsky, Garner and Glade, that Claimant intended to unhook the safety harness because two physical actions were required to unhook the harness. Because Claimant attended training on the safety policy, Respondents asserted this knowledge, coupled with the physical action required to unhook the harness, led to the conclusion this was a willful violation of a safety rule. *Bennett Props. Co. v. Indus. Comm'n*, *supra,*165 Colo. 135; *Scott Triplett, v. Evergreen Builders, Inc. and St. Paul Fire and Marine Ins. Co.,* W. C. No. 4-576-463. (ICAO May 11, 2004). However, Respondents were required to show that Claimant's conduct in violating the safety rule was intentional, which required a deliberate decision on the part of Claimant. *Scott Triplett v. Evergreen Builders, Inc, and St. Paul Fire and Marine Ins. Co., supra.*

The ALJ found that while Claimant had knowledge of the safety rule, this did not necessarily prove his conduct was entirely volitional. (Finding of Fact 49). Given the fact that Mr. Palacios also concurrently violated the safety rule and there were no repercussions, Claimant may have thought unhooking the safety harness was allowed in limited circumstances. Under the facts present in this case, the ALJ was unable to determine Claimant's violation of the safety rule was willful. (Finding of Fact 29).

For these reasons, the ALJ determined Respondents failed to meet their burden of proof. Claimant did not willfully violate Respondent-Employer's fall protection safety rule and Respondents are required to pay the full amount of Claimant's TTD benefits.

ORDER

IT IS ORDERED:

1. Respondents failed to prove Claimant willfully violated a safety rule. Claimant is entitled to receive 100% of his indemnity benefits.

2. Respondents shall pay 100% of Claimant's indemnity benefits.

3. Claimant's AWW is increased to $935.90 per week. Claimant TTD benefits shall be paid at the rate of $623.93 per week

4. Respondents shall file an Amended GAL reflecting Claimant's higher AWW and for the full amount of TTD benefits.

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

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

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, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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. 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: January 8, 2019

Digital signature

_____

Timothy L. Nemechek
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, C 80203

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 5-050-078-02 and 5-056-383-01

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER ON REMAND

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

Claimant,

v.

Employer,

and

NEW HAMPSHIRE INSURANCE COMPANY &
TRAVELERS INDEMNITY COMPANY,

Insurers / Respondents.

No further hearings have been held in the above-captioned matter. On June 18, 2018, the Administrative Law Judge's (ALJ's) issued Full Findings of Fact, Conclusions of Law and Order, was mailed to the parties after a perceived completion of the post-hearing briefing schedule. The hearing was held on April 10, 2018, and Respondent Travelers' post-hearing brief was due on April 25, 2018. The certificate of mailing thereon is April 25, 2018. Due to an oversight, Respondent Travelers' brief was not brought to the ALJ's attention as of the issuance of the June 19 Full Findings. On June 19, 2018, Respondent Travelers filed a Motion to Reconsider and Reopen to Consider Travelers' Brief. This Motion was not brought to the ALJ's attention until August 10, 2018. In the interim, on July 2, 2018, Respondent Travelers filed a Petition to Review.

On December 18, 2018, the Industrial Claim Appeals Office (ICAO), issued a Remand Order, providing that the ALJ review the matter *de novo*, after considering Respondent Travelers' post-hearing brief.

In its post-hearing brief, Respondent Travelers essentially argues that there were insufficient factual findings concerning a permanent aggravation of the Claimant's carpal tunnel condition while he was employed under the insurance coverage of Travelers, the second and last employer herein. In support of this argument, Respondent Travelers

cites *Chaco, Inc. v. Indus. Claim Appeals Office* (09CA2135) [an unpublished Court of Appeals opinion, wherein the Court noted that the ALJ properly concluded that the second employer was not on the risk because there were no factual findings linking the causation, aggravation, or acceleration of claimant's occupational disease to the period of the the second employer's coverage]. In contrast to the facts in *Chaco*, there are facts and factual findings are made linking the permanent aggravation of Claimant's carpal tunnel condition to the period when he was employed under Travelers' coverage, and his work was heavier (*See* Finding of fact No. 13 herein below). Travelers essentially argues for a re-weighing of the evidence and a different exercise of discretion, thus, eliminating Travelers from the risk and placing the risk on New Hampshire, the first carrier. After carefully considering Travelers' arguments in its post-hearing brief, the ALJ determines that they are not squarely on point to the facts in the present case.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on April 10, 2018, in Denver, Colorado. The hearing was digitally recorded (reference: 4/10/18, Courtroom 1, beginning at 8:30 AM, and ending at 12:00 PM).

W.C. No. 5-050-078-02 is an occupational disease claim for bilateral carpal tunnel syndrome alleging a date of injury of April 4, 2017 wherein New Hampshire was the insurance carrier until April 13, 201-based on a stipulation of the parties and finding of the ALJ. W.C. No. 6-056-383 is an occupational disease claim for bilateral carpal tunnel syndrome, alleging a date of injury of May 16, 2017 wherein travelers was the insurance carrier. On January 21, 2018, Prehearing ALJ (PALJ) Michael J. Barbo ordered a consolidation of both cases for hearing.

Claimant's Exhibits 1 through 6 were admitted into evidence, without objection. Respondents New Hampshire's Exhibits A through M were admitted into evidence, without objection. Respondent Travelers; Exhibits A through J and L through N were admitted into evidence without objection. Claimant objected to Travelers' Exhibit K, and it was withdrawn.

At the conclusion of the hearing, the ALJ ordered post-hearing briefs. Claimant's opening brief was filed on or about April 16, 2018. Respondent New Hampshire's answer brief was filed on or about April 20, 2018. Respondent Travelers' post-hearing brief was filed on April 25, 2018. On or about April 27, 2018, Claimant advised that he would **not** be filing a reply brief. On June 1, 2018, the ALJ granted Respondent New Hampshire's "Motion to Correct New Hampshire's Response Brief." **The matter was deemed submitted for decision on remand on December 19, 2018.**

ISSUES

The issues to be determined by this decision concern two fully contested occupational disease claims for alleged bilateral carpal tunnel syndrome. Depending on which insurance carrier is liable, additional issues concern medical benefits, average weekly wage (AWW) and temporary total disability (TTD) benefits from approximately June 15, 2017 (the last date the Claimant worked). The paramount issue is which carrier was on the risk when the Claimant substantially and permanently aggravated his bilateral carpal tunnel syndrome.

FINDINGS OF FACT ON REMAND

Based on the evidence presented at hearing and a review of the post-hearing briefs including Travelers' post-hearing brief, the ALJ makes the following Findings of Fact on Remand:

Preliminary Findings

1. At the commencement of the hearing, the parties stipulated, and the ALJ finds, that workers' compensation insurance coverage changed from New Hampshire to Travelers. The ALJ finds that the change in carriers occurred on or about April 13, 2017. The Claimant last worked on June 15, 2017.

2. The Claimant began work for the Employer on February 6, 2017 as a crew chief on oil and gas drilling rigs. He was required to sign Rig Tickets showing the job title that he performed for the Employer. The Rig Tickets in evidence show from the date the Claimant began his employment until April 6, 2017 he was a crew chief. (Respondent New Hampshire's Exhibit G pp. 29 through 47). The ALJ infers and finds that Claimant's pre-April 6, 2017 duties were significantly **lighter** than his post-April 6, 2017 job duties (while Travelers was the carrier). His job duties changed to relief operator, meaning he would do the work of a derrick worker or crewman as needed, on April 7, 2017(Respondent New Hampshire's Exhibit G, p. 47).

3. Beginning on April 7, 2017, the Claimant first worked as a derrick worker, and again on April 12, 2017 during New Hampshire's coverage (Respondent New Hampshire's Exhibit G, pp.47 and 50). He then worked on the day the coverage changed to Travelers as a derrick worker which was April 13, 2017 (Respondent New Hampshire's Exhibit G p.51).

4. After the change of coverage to Travelers, the Claimant worked one time as a derrick worker and 39 times as a crewman until which time he was taken off of

work on June 16, 2017 (Respondent New Hampshire's Exhibit G, pp. 52 through 108). The ALJ finds this work, under the coverage of Travelers, was heavier than the previous work under the coverage of New Hampshire.

5. The Claimant originally filed a workers' compensation claim in the State of Wyoming. In completing the required form, he was asked to describe his symptoms. He stated" first noted tingling and numbness in early April. Progressed to constant throbbing pain and numbness and loss of grip strength by May" (Respondent New Hampshire's Exhibit D p. 8).

6. The Claimant's last date worked was June 15, 2017. A Worker's Claim for Compensation was completed and filed on June 23, 2017. The Employer's First Report was filed August 16, 2017.

7. New Hampshire filed a Notice of Contest on July 28, 2017. Travelers filed a Notice of Contest on September 29, 2017.

Compensability/Last Injurious Exposure

8. The Claimant testified at hearing that by the time he needed a physician in May of 2017, his grip strength was bad enough that he could not hold a toothbrush.

9. In early April 2017, the Claimant's job duties prior to April 7, 2017 did not cause symptoms of carpal tunnel syndrome (while New Hampshire was the carrier).

10. The ALJ finds that the Claimant developed bilateral carpal tunnel syndrome as a result of his employment with the Employer. The parties stipulated, and the ALJ found, that Respondent New Hampshire's coverage ended on April 13, 2017 and Respondent Travelers insurance coverage began on the same day.

11. Based on the testimony and records, if the Claimant's symptoms as of the date of the coverage change were primarily tingling and possibly some pain, Claimant's condition was not severe enough for him to seek medical care. After the date of the coverage change (to Travelers), however, according to the Claimant, his condition progressed to constant throbbing, pain, numbness, and loss of grip strength to include not being able to hold a toothbrush. By the end of May 2017, the Claimant's condition had progressed to the point where he believed he needed medical care and treatment.

12. The Rig Tickets from the Employer show that prior to the change in coverage the Claimant worked 2 times as a derrick worker and his third time as a derrick worker was on the date of coverage change. After the date of the coverage change, the Claimant worked one time as a derrick worker and 39 times as a crewman. The job duties prior to and after the coverage change were not the same, the duties were heavier after Travelers came on the risk. The job duties with the Employer caused

the Claimant's carpal tunnel syndrome, and the heavier duties after Travelers came on the risk aggravated and accelerated the carpal tunnel syndrome. The Claimant's last injurious exposure occurred on June 15, 2017, when the Employer was insured by Travelers.

13. The ALJ finds, based upon a consideration of the totality of facts concerning job duties, that there was a substantial and permanent aggravation of the Claimant's bilateral carpal tunnel syndrome as of his last day on the job, June 15, 2017. The determinative factor is not how long the employment lasted but focuses on both the harmful nature of the concentration of the exposure and the magnitude of the effect of such exposure. In this case, after the coverage change the Claimant was subjected to the job duties that caused the original condition much more often and for an extended period of time. The fact that the Claimant's subjective complaints indicated that his condition progressed to include additional symptoms that were not present prior to the coverage change is a factor. The Claimant's symptoms were not severe enough to create the need for him to seek medical care until after the change of coverage. These factors lead to the factual conclusion that there was a substantial and permanent aggravation of the occupational disease of bilateral carpal tunnel syndrome after the change of coverage to Travelers.

Medical

14. The ALJ finds that there was no persuasive evidence presented concerning medical referrals or lack thereof by the Employer or either New Hampshire or Travelers. Therefore, the issues concerning carrier liability for medical care and treatment remains unresolved.

15. After seeking initial medical care on May 26, 2017, the Claimant had a medical appointment on June 19, 2017 with Nextcare. The medical report for that date of examination took the Claimant off of work stating that continuation of his work could worsen his condition. He has not worked after that date.

16. John Raschbacher, M.D., a Level-II accredited physician [by the Division of Workers' Compensation (DOWC)], examined the Claimant on December 15, 2017, in an Independent Medical Examination (IME). Dr. Raschbacher also consulted the DOWC Medical Treatment Guidelines (MTG) for carpal tunnel syndrome. He reviewed the Claimant's medical history, job duties, and medical records. In his report, Dr. Raschbacher wrote that the Claimant's bilateral carpal tunnel syndrome was work-related and was caused by the change in the work performed to relief operator in April 2017. Dr. Raschbacher stated: "My recommendation is to see a hand surgeon and have surgery (carpal tunnel release, bilaterally)." The ALJ finds that Dr. Raschbacher's opinion supports a permanent aggravation/acceleration of the Claimant's bilateral carpal; tunnel syndrome while the Employer was insured by Travelers.

17. At hearing, Dr. Raschbacher testified consistently with his report. He had since reviewed the original and amended jobsite analyses prepared by Dawn Leskinen, M.A., CRS, CVE, CEAS I, finding neither jobsite analysis changed his medical opinions and conclusion about work-relatedness.

.18. Dr. Raschbacher considered all of the available vocational information (both job site assessments and the Claimant's explanation of the errors in same), the EMG/NCV testing, as well as the 6-step causation analysis for cumulative trauma conditions - carpal tunnel syndrome set forth in the MTG.

19 Although the Claimant's burden of proof is never lessened, the ALJ can find no reasonable alternate mechanism as probably causing the Claimant's carpal tunnel syndrome. To be clear, neither Respondent Carrier is obliged to identify a plausible, alternative exposure.

20. As Dr. Raschbacher also notes, the way the Claimant specifically performed his tasks and the degree of force and duration of the work performed by the Claimant were enough to make it likely that he suffered the industrial disease due to what Claimant was doing, starting in March, 2017 for the Employer. According to the Claimant, he worked longer and was exposed to more weight, twisting, and vibrations than indicated in the jobsite analyses, and the jobsite analyses did not properly evaluate the work he was doing. The ALJ does not have to resolve who is correct on this point, because there is no dispute. Suffice it to say, the Claimant was doing repetitive work at the time his symptoms occurred, and this repetitive work was at or near the primary and secondary risk factors set forth in the MTG.

Average Weekly Wage

21. The Claimant's AWW as of the date of his last injurious exposure, June 15, 2017, was $1,243.69, which was less than the State AWW for Fiscal Year (FY) 2016/2017, thus the Claimant's TTD rate is $829.13 per week, or $118.45 per day.

Temporary Total Disability

22. After seeking initial medical care on May 26, 2017, the Claimant had a medical appointment on June 19, 2017 with Nextcare. The medical report for that date of examination took the Claimant off of work stating that continuation of his work could worsen his condition. He has not worked after that date. There is **no** persuasive evidence that this total restriction has been lifted. The Employer has **not** offered the Claimant any modified work. The Claimant has not returned to any work nor has he earned any wages since June 16, 2017. No physician has declared him to be at maximum medical improvement (MMI). He has been sustaining a 100% temporary wage loss since June 15, 2017. Therefore, he has been temporarily and totally disabled since June 16, 2017 and continuing.

Ultimate Findings

23. Other than Dr. Raschbacher's IME opinions attributing the Claimant's last injurious exposure to his work after April 13, 2017, the date that coverage changed to Travelers, there are no other persuasive medical opinions contradicting Dr. Raschbacher's opinions. The ALJ finds Dr. Raschbacher's opinions highly persuasive and credible. Also, the ALJ finds the Claimant's testimony credible and undisputed.

24. The ALJ makes a rational choice to accept Dr. Raschbacher's opinions and the Claimant's testimony; and, to reject any opinions and evidence to the contrary.

25. The ALJ finds that the Claimant has sustained an occupational disease, bilateral carpal tunnel syndrome, which resulted directly from his employment or the conditions under which his work was performed, and 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 Claimant's employment, and which can be fairly traced to the employment as a proximate cause and which did not come from a hazard to which the Claimant would have been equally exposed outside of the employment. As found, the Claimant has proven an occupational disease with an onset date of March 2017 and a last injurious exposure date of June 15, 2017, when Travelers was on the risk.

26. No persuasive evidence was presenting concerning the authorization of medical care and treatment for the Claimant's bilateral carpal tunnel syndrome was presented, however, the Claimant's first medical care was in May 2017, when New Hampshire was on the risk. Therefore, the issue of authorization must be reserved for future decision.

27. All of the Claimant's medical care and treatment for his bilateral carpal tunnel syndrome is and was causally related to his last injurious exposure of June 16, 2017, when Travelers was on the risk, and reasonably necessary to cure and relieve the effects thereof.

28. The Claimant's AWW as of the date of his last injurious exposure, June 15, 2017, was $1,243.69, which was less than the State AWW for Fiscal Year (FY) 2016/2017, thus the Claimant's TTD rate is $829.13 per week, or $118,45 per day.

29. The Claimant has been temporarily and totally disabled from June 16, 2017 through April 10, 2018, the hearing date, both dates inclusive, a total of 299 days; and, from April 11, 2018 and continuing until termination or modification of benefits is warranted.

30. The Claimant has proven, by a preponderance of the evidence that he sustained the occupational disease of bilateral carpal tunnel syndrome with a date of

last injurious exposure of June 15, 2017, when Travelers was on the risk; that his medical care and treatment for the occupational disease was and is causally related to the last injurious exposure and reasonably necessary to cure and relieve the effects thereof; that his AWW is$1,243.69, thus, yielding a TTD rate of $829.13 per week, or $118.45 per day; and that he has been temporarily and totally disabled since June 16, 2017 and continuing.

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 Bodensleck v. Indus. Claim Appeals Office,* 183 P.3d 684 (Colo. App. 2008);*Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Rockwell International v. Turnbull,* 802 P.2d 1182, 1183 (Colo. App. 1990); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The ALJ determines the credibility of the witnesses. A*renas v. Indus. Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000). The weight and credibility to be assigned evidence is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Youngs v. Indus. Claim Appeals Office,* 297 P.3d 964, **2012 COA 85.** The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913); *also see Heinicke v. Indus. Claim Appeals Office,* 197 P.3d 220 (Colo. App. 2008). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential Ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). The ALJ has broad discretion to determine the admissibility and/or weight of evidence based on an expert's knowledge, skill, experience, training and education. *See* S 8-43-210, C.R.S; *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P.2d 501 (Colo. App. 1995). As found, *See, Annotation, Comment: Credibility of Witness Giving Un-contradicted Testimony as Matter for Court or Jury,* 62 ALR 2d 1179, maintaining that the fact finder is not free to disregard un-contradicted testimony. As found, other than Dr. Raschbacher's IME

opinions attributing the Claimant's last injurious exposure to his work after April 13, 2017, the date that coverage changed to Travelers, there are no other persuasive medical opinions contradicting Dr. Raschbacher's opinions. The ALJ finds Dr. Raschbacher's opinions highly persuasive and credible. Also, the ALJ finds the Claimant's testimony credible and undisputed.

Substantial Evidence

b. An ALJ's factual findings must be supported by substantial evidence in the record. *Paint Connection Plus v. Indus. Claim Appeals Office,* 240 P.3d 429 (Colo. App. 2010); *Leewaye v. Indus. Claim Appeals Office,* 178 P.3d 1254 (Colo. App. 2007); *Brownson-Rausin v. Indus. Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005). *Also see Martinez v. Indus. Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007). Substantial evidence is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co.v. Gussert,* 914 P.2d 411 (Colo. App. 1995). Reasonable probability exists if a proposition is supported by **substantial evidence** which would warrant a reasonable belief in the existence of facts supporting a particular finding. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985). It is the sole province of the fact finder to weigh the evidence and resolve contradictions in the evidence. See *Pacesetter Corp. v. Collett,* 33 P. 3d 1230 (Colo. App. 2001). An ALJ's resolution on questions of fact must be upheld if supported by substantial evidence and plausible inferences drawn from the record. *Eller v. Indus. Claim Appeals Office,* 224 P.3d 397, 399-400 (Colo. App. 2009). As found, the ALJ made a rational choice to accept Dr. Raschbacher's opinions and the Claimant's testimony; and, to reject any opinions and evidence to the contrary.

Compensability of Occupational Disease/Bilateral Carpal Tunnel Syndrome

c. An "occupational disease" means 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. § 8-40-201 (14), C.R.S. *See City of Colorado Springs v. Indus. Claim Appeals Office,* 89 P. 3d 504 (Colo. App. 2004). As found, the Claimant has proven an occupational disease of bilateral carpal tunnel syndrome, with an onset date of March 2017, and a last injurious exposure of June 15, 2017.

d. Section 8-41-304 (1), C.R.S., assesses sole and full liability for workers' compensation benefits on the employer in whose employment the claimant sustains the last injurious exposure. There has only been one employer herein. Consequently, the **substantial permanent aggravation** of the Claimant's carpal tunnel syndrome

occurred when the Employer was insured by Travelers. As found, Respondent Travelers is solely and fully liable for all workers' compensation benefits, including medical benefits after Travelers was on the risk (no medical costs were incurred before Travelers was on the risk).

Medical Benefits

e. To be a compensable benefit, medical care and treatment must be causally related to an industrial injury or occupational disease. *Dependable Cleaners v. Vasquez,* 883 P. 2d 583 (Colo. App. 1994). As found, Claimant's medical treatment is causally related to his occupational disease of bilateral carpal tunnel syndrome, with an onset in March 2017 (no medical costs were incurred until May 2017). And a date of last injurious exposure of June 15, 2017. Also, medical treatment must be reasonably necessary to cure and relieve the effects of the industrial occupational disease. § 8-42-101 (1) (a), C.R.S. *Morey Mercantile v. Flynt,* 97 Colo. 163, 47 P. 2d 864 (1935); *Sims v. Indus. Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). As found, the Claimant's medical care and treatment was and is causally related and reasonably necessary to cure and relieve the effects of his occupational disease..

Average Weekly Wage (AWW)

f. An AWW calculation is designed to compensate for **total** temporary wage loss. *Pizza Hut v. Indus. Claim Appeals Office,* 18 P. 3d 867 (Colo. App. 2001). *See* § 8-42-102, C.R.S. As found, Claimant has been losing 100% of his wages since June 15, 2017. *See also Avalanche Industries, Inc. v. Clark,* 198 P.3d 589 (Colo. 2008). As found, the Claimant's AWW is $1,243.69.

Temporary Total Disability

g. To establish entitlement to temporary disability benefits, a claimant must prove that the industrial injury has caused a "disability," and that he has suffered a wage loss that, "to some degree," is the result of the industrial disability. § 8-42-103(1), C.R.S; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). When a temporarily disabled employee loses his employment for other reasons which are not his responsibility, the causal relationship between the industrial injury and the wage loss necessarily continues. Disability from employment is established when the injured employee is unable to perform the usual job effectively or properly. *Jefferson Co. Schools v. Headrick*, 734 P.2d 659 (Colo. App.1986). This is true because the employee's restrictions presumably impair his opportunity to obtain employment at pre-

injury wage levels. *Kiernan v. Roadway Package System*, W.C. No. 4-443-973 [Indus. Claim Appeals Office (ICAO), December 18, 2000)]. As found, after seeking initial medical care on May 26, 2017, the Claimant had a medical appointment on June 19, 2017 with Nextcare. The medical report for that date of examination took the Claimant off of work stating that continuation of his work could worsen his condition. He has not worked after that date. There is **no** persuasive evidence that this total restriction has been lifted. The Employer has **not** offered the Claimant any modified work. The Claimant has not returned to any work nor has he earned any wages since June 16, 2017. No physician has declared him to be at maximum medical improvement (MMI).

h. Once the prerequisites for TTD are met (*e.g.,* no release to return to full duty, MMI has not been reached, a temporary wage loss is occurring, modified employment is not made available, and there is no actual return to work), TTD benefits are designed to compensate for a 100% temporary wage loss. *See Eastman Kodak Co. v. Industrial Commission,* 725 P. 2d 107 (Colo. App. 1986); *City of Aurora v. Dortch,* 799 P. 2d 461 (Colo. App. 1990). As found, the Claimant has been sustaining a 100% temporary wage loss since June 16, 2017. Therefore, he has been temporarily and totally disabled since June 16, 2017 and continuing.

<u>Burden of Proof</u>

i. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an occupational disease, the date of last injurious exposure, and entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Indus. Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Indus. Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000). *Kieckhafer v. Indus. Claim Appeals.Office*, 284 P.3d 202, 205 (Colo. App. 2012).. 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 [Indus. Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). “Preponderance” means “the existence of a contested fact is more probable than its nonexistence.” *Indus. Claim Appeals Office v. Jones*, 688 P.2d 1116 (Colo. 1984). As found, the Claimant has sustained his burden on compensability; last injurious exposure on June 15, 2017; causal relatedness and reasonable necessity of medical care and treatment for the bilateral carpal tunnel syndrome; AWW of $1,243.60; and, TTD from June 16, 2017 and continuing.

ORDER UPON REMAND

IT IS, THEREFORE, ORDERED THAT:

A. Any and all claims against Respondent New Hampshire Insurance Company are hereby denied and dismissed.

B. The Claimant's medical care and treatment for the occupational disease of bilateral carpal tunnel syndrome was and is causally related to the last injurious exposure of June 15, 2017; and, it was and is reasonably necessary to cure and relieve the effects thereof; and Respondent Travelers is liable for all medical care after it came on the risk.

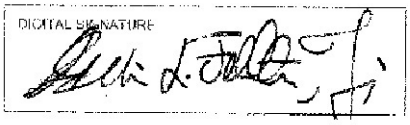
C. Respondent Travelers Indemnity Company shall pay the Claimant temporary total disability benefits $829.13 per week, or $118.45 per day, from June 16, 2017 through April 10, 2018, both dates inclusive, a total of 299 days, in the aggregate amount of $35, 415.55, which is payable retroactively and forthwith.

D. From April 11, 2018 and continuing as provided by law, Respondent Travelers Indemnity Company shall pay the Claimant $829.13 per week in temporary total disability benefits.

E. Respondent Travelers Indemnity Company shall pay the Claimant statutory interest of eight percent (8%) per annum on all amounts due and not paid when due.

F. Any and all issues not determined herein, including authorization of medical providers and treatment, are reserved for future decision,

DATED this 11th day of January 2019.



_____
EDWIN L. FELTER, JR.
Administrative Law Judge

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts,**1525 Sherman Street, 4th Floor, Denver, CO 80203.** You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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* § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, *see* Rule 26, OACRP. You may access a form for a petition to review at** *http://www.colorado.gov/dpa/oac/forms-WC.htm*.

CERTIFICATE OF SERVICE

I hereby certify that I have sent true and correct copies of the foregoing **Full Findings of Fact, Conclusions of Law and Order On Remand** on this_____day of January 2019, electronically in PDF format, addressed to:

Division of Workers' Compensation
cdle_wcoac_orders@state.co.us

_____
Court Clerk

Wc.ord .rm

STATE OF COLORADO
OFFICE OF ADMINISTRATIVE COURTS
Workers' Compensation No. 5-078-773

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

In the Matter of the Workers' Compensation Claim of:

Claimant,

vs.

Employer,

and

,

Carrier No. 004257-020963-WC-01,
Insurer,
Respondents.

Hearing in the above-captioned matter was held before Kimberly Turnbow, Administrative Law Judge, on November 1, 2018, in Denver, Colorado. The hearing was digitally recorded in courtroom 3, beginning at 8:30 a.m., and ending at 9:15 a.m.

, Esq. represented who was present in person. , Esq. represented y.

Hereinafter, the judge refers to shall be referred to as "Claimant," to as "Employer," to as "Insurer," and to Insurer and Employer collectively as "Respondents."

Also, in this proposed order, "ALJ" refers to the Administrative Law Judge; "C.R.S." refers to the Colorado Revised Statutes; "TTD" refers to temporary total disability; and "ATP" refers to authorized treating provider.

ISSUE

- Whether Claimant has proven, by a preponderance of the evidence, that he sustained both an "accident" and a resulting compensable "injury" to his left shoulder on April 26, 2018?

PROCEDURAL MATTERS

Respondents' and Claimant jointly submitted exhibits A-H without objection.

FINDINGS OF FACT

Claimant Alleges Incident at Work on April 26, 2018

1. Claimant testified that he worked as a water technician for Employer at a jobsite in Wyoming. He testified that at the time of the alleged injury Employer assigned him to stay at the jobsite in Wyoming for a period of two weeks.

2. Claimant testified that he sustained an injury to his left shoulder on April 26, 2018 when wind blew shut a heavy steel door of a diesel container. He testified that the door hit his left upper arm.

3. Claimant testified that the impact of the door against his shoulder caused his alleged work injury. Specifically, Claimant alleges that he sustained an acute rotator cuff tear because of this impact incident.

4. Claimant did not provide an adequate explanation of either (1) how a gust of wind would push a heavy steel door hard enough into his shoulder to cause an actual injury; or (2) how a simple impact incident to the shoulder could cause a rotator cuff tear.

5. Dr. Timothy O'Brien, a board certified orthopedic surgeon, performed an IME in this case. He testified by deposition that the mechanism of injury as described by Claimant would not result in an acute rotator cuff tear. Rather, the mechanism of injury more likely and at the most would cause a contusion/bruise to the outside/lateral aspect of the left arm. Dr. O'Brien explained that rotator cuff tears occur when the arm is positioned overhead, which was not the case here.

6. Dr. O'Brien further explained that with the mechanism of injury as described – a blow to the outside of the left arm – force would dissipate into the deltoid muscle rather than the rotator cuff. As a result, he testified that, even if Claimant had a pre-existing cuff tear, it would be very unlikely for the mechanism of injury as described to aggravate the tear.

Although Admittedly Trained To Report Injuries Immediately, Claimant Did Not Report the Alleged Injury for a Week

7. Claimant conceded that Employer provided instructions and bout how to report work injuries. Specifically, Employer requires that an employee timely report a potential work injury.

8. Despite his training, Claimant conceded he did not report a work injury to his employer until May 3, 2018, after returning to Denver from the Wyoming job site. As a result, he delayed reporting the alleged incident to Employer for a week.

Claimant Continues Heavy Lifting and Full Duties after Alleged Injury

9. Claimant continued to work at full duty after his alleged injury for a total of between three and six days. During this time, he conceded that he was able to perform his normal job duties and that he did not have help from other employees during this time.

10. Claimant explained that his job required heavy lifting of more than fifty pounds several times a day. Specifically, Claimant testified that he lifted chemical bags weighing at least fifty pounds three to four times a day after his alleged injury. He explained that he lifted the chemical bags from the ground to a height of approximately five feet to pour them into water containers.

11. Claimant also testified that he lifted and connected hoses two or three times per day, and that the hoses weighed in excess of fifty pounds.

12. Dr. O'Brien testified that Claimant's testimony was completely inconsistent with sustaining an acute work injury to his left. Dr. O'Brien testified that both acute rotator cuff tears and aggravations of rotator cuff tears are some of the "most disabling injuries we see" and that they are associated with "substantial weakness" and inability to lift the affected arm.

13. Dr. O'Brien specifically and persuasively testified that the likelihood Claimant would be able perform his full duties after an acute new tear, or an acute new-on-chronic tear, was almost zero percent. And that it would be almost impossible for Claimant to be able to continue to lift 50-pound objects and pull hoses with that injured extremity.

14. The ALJ finds and determines that Claimant's testimony that he was able to perform his full job duties, including heavy lifting of 50 pounds to a five foot height, is inconsistent with sustaining either an acute rotator cuff tear or an aggravation of a pre-existing tear. In so finding, the ALJ credits both Claimant's testimony regarding his job duties and Dr. O'Brien's testimony regarding Claimant's level of function.

Claimant Has Intervening Incident at Home Prior to Reporting the Injury or Seeking Medical Treatment for the First Time

15. After working three to six days after the alleged work injury, Claimant returned to his Denver home. Claimant still did not report a work injury or seek medical care. Claimant did not provide a persuasive explanation of why he did not timely report the alleged work injury.

16. Claimant testified that after he returned to Denver (but prior to his hospital visit on May 2, 2018), he bumped his left shoulder when going down the stairs in his home. He testified that prior to this incident, he had pain that "bothered" him, but it was not so bad. After the incident in his home where his shoulder hit a wall, he had more pain.

17. After hitting his shoulder against the wall at home, Claimant sought medical care at the emergency room the next day, May 2. Claimant admittedly never reported a work injury or sought medical care before his home incident.

18. The hospital record from May 2, 2018 documents that, at admission, Claimant reported new pain in his left shoulder occurring the night prior. Specifically, he reported hitting a wall after walking down stairs and missing a step.

Claimant Reported a Work Incident Which Occurred a "Few Months Ago" at the Hospital

19. At the hospital, Claimant reported that he hit his arm on a steel door at work *a few months ago*. As a result, the initial medical record was inconsistent with an injury occurring a week prior at work as Claimant alleged.

20. Dr. O'Brien testified that the need for medical attention on May 2, 2018 appeared to be due to the incident occurring in Claimant's home. He based this opinion on the fact that the home incident required Claimant to obtain treatment within twenty-four hours of its occurrence. However, based on the hospital's triage history, the reported work injury occurred months earlier.

21. The ALJ finds and determines that the incident that occurred in Claimant's home motivated him to seek medical treatment on May 2, 2018.

22. As noted above, Claimant conceded that prior to the home incident, he was able to perform his regular job duties.

23. The ALJ finds and determines that this history further proves that Claimant's need for disability and lost wages is related to the home incident rather than the alleged work incident.

Initial Medical Record Inconsistent with an April 26, 2018 Injury

24. As noted above, Claimant went to St. Anthony's emergency room on May 2, 2018 after the incident in his home. The record documents that immediately prior to admission, Claimant sustained an injury to his left shoulder on his staircase at his house.

25. The history of illness taken by the hospital's triage nurse documents that a few months prior to admission Claimant hurt his left shoulder.

26. The ALJ infers that the history of present illness is inconsistent with the assertion of the need for medical treatment due to an alleged injury occurring on April 26, 2018. Specifically, the ALJ finds and determines that Claimant's report that he sustained

an injury two months prior to admission would render the date of injury in early March 2018 rather than a week prior on April 26, 2018.

Claimant Finally Reports the Alleged Work Injury to the Employer after the Incident at Home and the ER Visit

27. Claimant eventually reported the alleged work injury to Employer after the incident at home and the hospital visit. Specifically, Claimant reported the alleged work injury on May 3, 2018 after having the incident at home and seeking medical care. Thus, Claimant did not report the alleged work injury for a week.

Claimant Fails to Disclose the Incident that Occurred at Home to His Treating Providers for the Work Injury

28. The ALJ finds that the medical record establishes that none of Claimant's medical providers documented the incident at Claimant's home and prompted him to seek medical treatment. Claimant failed to tell the workers' compensation providers about the home incident.

29. Claimant disclosed the home incident during litigation after it was clear that Respondents would obtain the emergency room records.

No Acute Findings on MRI Performed Less than Month after Alleged Injury

30. Claimant underwent a left shoulder MRI on May 21, 2018. The study established an irregular 2.5 cm full-thickness tear of the rotator cuff with retraction and edema, subscapularis tendinopathy without tear, partial tear/tendinopathy in the biceps with degenerative SLAP lesion, and an os acromiale with synchondrosis.

31. Dr. O'Brien reviewed the MRI scan and opined the radiographic findings were not acute. Rather, he testified that the findings were chronic and long-standing with greater than 99 percent assurance.

32. Specifically, Dr. O'Brien testified that the MRI's findings were chronic and long-standing due to the following:

- A complete absence of an accumulation of blood or fluid which is anticipated in any acute tear of muscle or tendon;
- The size of the tear – 2.5 centimeters – without bleeding suggests that the muscle has been malfunctioning for a long period of time;
- The AC joint had arthritis in it suggesting a long-standing problem; and
- The presence of retraction at the tear suggests a chronic pull of a muscle over time rather than an acute tear.

33. Dr. O'Brien additionally testified that the MRI is such a sensitive test that it would be able to pick up even a very minor tear (i.e. an acute aggravation of a pre-existing tear). He testified that the MRI did not show that such a minor tear occurred, because there was still no accumulation of blood or posttraumatic fluid that you would anticipate even with a minor tear.

34. The ALJ finds and determines that the MRI does not support a finding that Claimant sustained an acute rotator cuff tear or an acute aggravation of a pre-existing tear.

Claimant Failed to Establish a Compensable Injury on April 26, 2018

36. The ALJ finds and determines Claimant failed to meet his burden to establish he sustained an acute compensable injury on April 26, 2018. The ALJ finds and determines there is insufficient objective evidence to support a finding that the need for medical treatment or disability after the alleged incident causally related to an incident occurring on April 26, 2018. In so finding, the ALJ finds the initial emergency room record documenting an intervening home incident and the testimony of Dr. O'Brien regarding the emergency room record and MRI to be persuasive and credible.

37. The ALJ additionally finds and determines that Claimant presented insufficient evidence that any incident occurring on April 26, 2018 aggravated, accelerated, or combined with a pre-existing condition to cause the need for medical care or disability. In so finding, the ALJ finds the testimony of Dr. O'Brien regarding Claimant's MRI to be persuasive and credible.

CONCLUSIONS OF LAW

General Legal Principles

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. § 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. § 8-43-201, 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*, 592 P.2d 792 (Colo. 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. § 8-43-201, C.R.S. A workers' compensation case is decided on the merits. *Id.*

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. Indus. 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 Ins. Co. v. Cline*, 57 P.2d 1205 (Colo. 1936).

When determining credibility, the ALJ should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co.*, 57 P.2d at 1205.

The ALJ has found Claimant's testimony is not credible or consistent with the totality of the evidence. The ALJ weighs Claimant's testimony accordingly.

Claimant Failed to Prove a Work-Related Accident on April 26, 2018 that Resulted in a Compensable Injury

A compensable industrial accident is one that results in an injury requiring formal medical treatment or causing disability. As a result, there needs to be both an "accident" and compensable "injury" which requires the need for formal medical care. *Wherry v. City and Cty. of Denver*, W.C. No. 4-475-818 (I.C.A.O., March 7, 2002). 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); *Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990).

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*, 805 P.2d 1167; *see also Subsequent Injury Fund*, 793 P.2d 576. 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,* 805 P.2d at 1167.

As found, Claimant did not persuasively explain how wind could blow a heavy steel door into his shoulder to cause an injury. Claimant did not persuasively explain how an impact to the outside of his upper left arm could cause a rotator cuff tear.

The claimant's behavior immediately after the alleged incident including, but not limited to, not reporting the incident and continuing his full job tasks requiring heavy lifting to shoulder level, is inconsistent with the claimant sustaining a compensable injury on April 26, 2018. Although an "accident" may have potentially occurred, there was no resulting compensable "injury" requiring the need for medical treatment. Instead, the need for medical care only arose after the incident that claimant had at home.

The ALJ also finds significant the initial medical record of the emergency room where Claimant described the subsequent home injury and the alleged work incident was noted as taking place well before the reported injury date.

The ALJ specifically credits the opinions of Dr. O'Brien that the MRI revealed no acute radiographic abnormalities and that all of the radiographic findings where chronic

and long-standing. Consequently, per the credible and persuasive report of Dr. O'Brien, there is insufficient evidence in the totality of the record that Claimant sustained an injury on April 26, 2018, that required medical treatment or disability. *Wherry*, W.C. No. 4-475-818. Claimant's claim for benefits related to an alleged April 26, 2018 incident is denied and dismissed.

Also as found, there is insufficient evidence in the medical records that any incident occurring on April 26, 2018 aggravated, accelerated, or combined with a pre-existing condition to cause the need for medical care or disability. *Merriman v. Indus. Comm'n*, 210 P.2d 448 (Colo. 1949). In so finding, the ALJ specifically credits the testimony of Dr. O'Brien that no radiographic findings on the MRI would suggest a new-on-chronic injury to the shoulder. Claimant's claim for benefits related to an alleged April 26, 2018 aggravation is denied and dismissed.

ORDER

1. Claimant failed to prove by a preponderance of the evidence that he sustained either an acute compensable injury or a compensable aggravation of a pre-existing condition during the course and scope of his employment with employer on April 26, 2018. Claimant's claim for medical treatment and Workers' Compensation benefits is denied and dismissed with prejudice.

Dated January 9, 2019

/s/ Kimberly Turnbow
Administrative Law Judge
Office of Administrative COurts
1525 Sherman Street #400
Denver, CO 80203

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, 1525 Sherman Street, 4th Floor, Denver, Colorado, 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the Order, as indicated on the 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 § 8-43- 301(2), C.R.S. (as amended, SB 09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a Petition to Review at http://www.colorado.gov/dpa/oac/forms-WC.htm.

ISSUES

The issue raised at hearing involves Claimant's entitlement to additional medical benefits. The questions answered by this decision are:

I. Whether Claimant's claim is closed by virtue of his failure to object to a December 10, 2014 final admission of liability (FAL).

II. If the claim is closed, whether Claimant established, by a preponderance of the evidence, that he is entitled to reopen it based on an alleged worsening of condition or whether Claimant is barred from reopening the claim pursuant to the two-year statute of limitations enumerated at C.R.S. § 8-43-303(2)(b).

III. Whether Claimant's need for L3-4 epidural injections as recommended by Dr. Vikas Patel is reasonable, necessary and related to this 2010 industrial injury.

Because the ALJ is convinced, based upon the evidence presented, that Claimant's need for injections at L3-4 is probably unrelated to his May 4, 2010 industrial injury, this order does not address Respondents' assertions that his claim is closed (for failure to object to a final admission of liability) or that Claimant is prevented from seeking additional medical benefits because the pertinent statute of limitations enumerated at C.R.S. § 8-43-303(2)(b) has run.

FINDINGS OF FACT

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

Issue and Background

1. The threshold issue in this case is whether Claimant's need for epidural injections at L3-4 are causally related to his May 5, 2010 industrial injury based upon the assertion that a prior work-related surgical fusion at L4-5 caused adjacent segment disease or alternatively that that fusion accelerated Claimant's pre-existing spinal/disc degeneration sufficient to cause the L3-4 level to become symptomatic and require treatment in the form of said injections.

2. Based upon the complexity of the issue presented, the passage of time, and an intervening and complex medical history, the following additional background is necessary to completely appreciate the nature of the parties' dispute:

- Claimant injured his low back in a work related incident on May 4,

2010. At that time, Claimant "bent down to lift and maneuver a heavy a light pole to change ballast. After manipulating the pole, Claimant stood up to turn and walk away at which time he experienced severe pain in his back causing him to fall to the ground.

- Claimant was subsequently evaluated by Dr. Rakesch Khosla on May 17, 2010. At that time, Claimant reported a bit of vacillating back pain over the last couple weeks. After additional work-up, including urinalysis to exclude the presence of kidney stones, Claimant was diagnosed with mechanical back pain and degenerative disk disease.

- X-rays of the lumbar spine obtained May 21, 2010 revealed degenerative changes in the thoracic and lumbar spine, including "some lateral bridging osteophytes, particularly at the superior endplate of L4 in addition to a 1-2 mm anterior subluxation of L4 on L5.

- An MRI of the lumbar spine was done on June 7, 2010, a few weeks after Claimant first sought treatment for his back from his primary care physician (PCP). This MRI included in its findings, disc desiccation from L2-S1, a bilobed disk bulge or mild protrusion with intraforaminal extension on the right at L3-4 causing "mild compromise of the neural foramen without definite L3 entrapment" along with a broad-based central disc bulge or mild protrusion and bilateral facet and ligamentum flavum hypertrophy at L4-5. This study also demonstrated the presence of bone edema in the posterior laminar arch on the left at L4 and the right L5 pedicle suggestive of advanced stress reaction at L4-5. Finally, the MRI revealed mild dextroscoliosis in upper mid lumbar region, which Dr. Patel explained is a rotational curvature of the spine.

- A First Report of Injury was filed and Respondent's admitted liability for Claimant's injury by way of a General Admission of Liability (GAL) filed August 31, 2010.

- Claimant would subsequently undertake substantial conservative treatment to cure and relieve him from the effects of his low back injury.

- An MRI of the lumbar spine was repeated on April 18, 2011. Findings from that MRI were similar to those revealed in the study dated June 7, 2010 with the interpreting radiologist noting that when technical differences were accounted for, he did not suspect significant change at L4-5. The L3-4 level according to this MRI

demonstrated minor disc desiccation.

- Claimant was placed at maximum medical improvement (MMI) on March 5, 2012 by Dr. Richard Nanes with 20% whole person impairment. Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Nanes opinions concerning MMI and impairment on March 19, 2012. This admission admitted liability for reasonable, necessary and related medical treatment and/or medications after MMI.

- The claim was then voluntarily reopened by way of a GAL on June 12, 2012. Following the reopening, Claimant underwent an MRI of the lumbar spine which demonstrated a 1-2 mm increase in the subtle spondylolisthesis first noted on Claimant's April 18, 2011 MRI. Minor disc desiccation as previously noted by MRI dated April 18, 2011 was "unchanged". Claimant subsequently underwent an L4-5 fusion procedure with Dr. Stephen Shogan on November 28, 2012. Dr. Shogan performed the aforementioned procedure using an "Aspen Device".

- On January 11, 2013, x-ray imaging demonstrated a 6 mm anterolisthesis of L4 on L5 along with facet arthropathy and disc space narrowing.

- Repeat MRI of the lumbar spine with contrast enhancement performed March 25, 2013 revealed no detectable spondylolisthesis at L4-5; however, the was lateral disc bulging into the foramina greater on the left than right side without significant change on the left. The L3-4-disc level demonstrated "mild enhancement of the facet joints with minor disc bulging without stenosis or interval change.

- On June 20, 2013, flexion and extension x-rays were obtained demonstrating an "anterospondylolisthesis of L4 in relation to L5 measuring 7 mm. In extension anterospondylolisthesis measures 5 mm and during flexion anterospondylolisthesis measures 9 mm."

- On September 9, 2013 a CT myelogram of the lumbar spine was performed which revealed [m]oderate-severe central spinal stenosis and moderate bilateral foraminal narrowing at L4-5 secondary to a combination of degenerative disc disease, facet arthropathy, and degenerative listhesis". When this study was compared with an MRI performed November 14, 2012, it was felt that Claimant's central stenosis at this spinal level had progressed. At the L3-4 segment, the CT demonstrated degenerative changes including "mild concentric disc bulging and facet arthropathy

causing mild central spinal stenosis with AP dimension of the thecal sac measuring 9 mm".

- Claimant also underwent an electrodiagnostic (EMG) study on September 9, 2013, during which it was documented that he underwent low back surgery for severe pain and that while he initially appeared to recover "quite well", in the last few months before the EMG he had a recurrence of progressive and low back pain radiating down into the buttocks and posterior thighs. Claimant's EMG was interpreted as mildly abnormal with findings of chronic denervation.

- It was determined that Claimant's November 28, 2012 fusion procedure, as performed by Dr. Shogan, had failed and that a second, i.e. revision surgery would be necessary to correct a likely pseudoarthritis and achieve stability at the L4-5 spinal segment. Therefore, on March 3, 2014. Dr. Patel performed an L4-5 revision surgery utilizing a interbody cage device and pedicle screws and rods to correct Claimant's nonunion. Correct positioning of the pedicle screws and alignment of the remaining hardware placed during surgery was confirmed by x-ray imaging.

- On April 21, 2014, post-surgical x-rays demonstrated no evidence of hardware failure along with "moderate disc space narrowing and proliferative endplate degenerative changes . . . at the thoracolumbar junction".

- At his six-month postop appointment on September 2, 2014, Claimant reported being pleased with resolution of his leg pain. Nonetheless, he reported residual back pain. Consequently, x-rays were obtained which demonstrated that Claimant's L4-5 bone graft had not yet incorporated.

- Following post-surgical care Claimant was again placed at MMI with 19% permanent impairment by Dr. Nanes on November 26, 2014. Claimant returned to full unrestricted work duty.

- Respondents filed a FAL consistent with Dr. Nanes' opinions on December 10, 2014. The FAL also admitted to reasonable and necessary and related post MMI medical treatment and/or medications.

- On March 3, 2015, Claimant returned to Dr. Patel for a one-year postop follow-up. During this appointment, Claimant reported having pain with "strenuous activity" associated with work, twisting and cold weather but otherwise was doing well. X-rays were

obtained. The imaging revealed no acute abnormality, postsurgical changes at L4-5 with progressive incorporation of the bone graft and "[m]ultilevel degenerative disc disease in the lower thoracic spine and upper lumbar spine . . . without significant change".

- Due to persistent complaints of back pain, Claimant was referred by Dr. Nanes for yet another MRI. This MRI was completed August 12, 2015. Imaging addressed the entire lumbar spine segments from T-11 through S1. Regarding the L3-4 spinal segment, the MRI revealed a "mild broad based disc bulge and small posterior osteophytes which appear new, accompanied by bilateral facet joint degeneration producing mild central canal stenosis, moderate left neural foraminal stenosis, and mild right neural foraminal stenosis". Comparison was made with the MRI dated March 25, 2013. No comparison to the September 9, 2013 appears to have been done. As noted by report, the September 9, 2013 CT scan demonstrated degenerative changes including "mild concentric disc bulging and facet arthropathy causing mild central spinal stenosis with AP dimension of the thecal sac measuring 9 mm". Comparison of the reports from the September 9, 2013 CT scan and the August 12, 2015 MRI reveal the following consistencies: mild disc bulging and mild central canal stenosis.

- Claimant returned to Dr. Patel on August 18, 2015. During this appointment, Claimant reported increasing pain, similar to that he had pre-operatively. The August 12, 2015 MRI was reviewed and interpreted as demonstrating degeneration and disc herniation at L3-4. Aggressive conservative care, including core strengthening and PT was suggested along with a "bilateral transforaminal epidural steroid injection to assist with diagnosis and treatment of Claimant's L3-4-disc herniation.

- On September 15, 2015, Dr. Patel administered bilateral transforaminal epidural steroid injections at L3-4.

- On September 29, 2015, Claimant suffered an injury to his left knee after tripping over 4 by 4 blocks.

- On September 30, 2015, Claimant returned to Dr. Nanes for follow-up for his low back during which appointment he reported no benefit from the injections administered approximately two weeks prior.

- On February 5, 2016, Claimant underwent a left arthroscopic arthroplasty and loose body removal of the left knee with Dr. David Weinstein. Post-surgical care focused on the left knee without

much attention paid to Claimant's low back throughout the balance of 2016.

- On March 20, 2017, Claimant underwent additional MRI of the lumbar spine on the referral of his PCP. Comparison of the results of this MRI to the MRI dated August 12, 2015 were done. The L3-4 segment demonstrated broad based disc bulging, moderate-severe central canal narrowing and hypertrophic change causing moderate to severe bilateral neural foraminal stenosis. The impression provided was documented as "[p]rogressive disc and hypertrophic degenerative disc disease throughout the lumbar spine with varying degree of canal and foraminal narrowing.

- On May 9, 2017, Claimant returned to the medical offices of Dr. Patel for a follow-up visit. Claimant was evaluated by Nurse Practitioner (NP)Susan Estes. According to NP Estes, Claimant's fusion appeared to be healed but he had "adjacent level disc degeneration and stenosis at L3-4 and some facet arthritis below the fusion at L5-S1". She opined that disc degeneration and stenosis at L3-4 was "likely caused from the increased pressure that the L4-5 fusion has put on the L3-4 region". Dr. Patel felt that Claimant's symptoms were likely emanating from the L3-4 segment due to the stenosis present at this level. He recommended an epidural steroid injection to help "verify" this. Plans were made to have Claimant schedule bilateral injections through Kaiser to "keep his out of pocket cost down".

- The recommended injection was submitted to Insurer for authorization. The request was denied leading Claimant to file an Application for Hearing along with a Petition to Reopen based upon an alleged change of condition.

Claimant's Hearing Testimony

3. Claimant testified that he did not believe that he was at MMI on November 26, 2014 as opined by Dr. Nanes. This testimony is supported by Claimant's pain diagram completed November 26, 2014 at his MMI appointment whereon he noted that he had 2/10 pain in his low back 100% of the time. Claimant also testified that after MMI and his surgeries he "gradually started having more problems with his back".

Dr. Patel's Deposition Testimony

4. Dr. Patel by deposition on October 1, 2018. Dr. Patel is a fellowship trained orthopedic surgeon. He is currently Chief of Orthopedic Spine Surgery at Colorado University (CU) Medical Center. Dr. Patel has not seen Claimant since May 9, 2017. As noted, the evaluation on this date was performed by NP Estes.

5. Dr. Patel testified that it is not uncommon for patients who have undergone fusion procedures to develop adjacent level problems above or below the fusion.

6. As set forth above, it is Claimant's assertion that he suffers from adjacent segment disease. He argues that treatment, i.e. the epidural steroid injection is now needed at L3-4, adjacent (above) the L4-5 fusion because wear and tear caused by the fusion has degenerated and made symptomatic the L3-4 segmental level.

7. Dr. Patel testified that he believed that claimant required an transforaminal injection at L3-4 to assist in determining whether Claimant's pain was emanating from that level. Simply put, Dr. Patel noted that an L3-4 injection would help for diagnostic purposes.

8. Dr. Patel did not recall reviewing Claimant's June 7, 2010 MRI report. After reviewing the June 7, 2010 MRI report at deposition, Dr. Patel conceded that it demonstrated disc desiccation and a bilobed disc bulge, meaning that the disc at this spinal segment was bulging to two different directions prior to the L4-5 fusion.

9. Dr. Patel testified that it is difficult to predict when symptoms associated with adjacent level disease may manifest themselves. He noted that it can vary with some patients manifesting symptoms as early as six months while in others cases it could be as long as 20 years. He also testified that there is no easy way to know if the extra forces placed on an adjacent level by a fusion is "pushing something over the edge as opposed to the natural progression of [degenerative] disease." He said, "it's hard to know whether that was going to happen anyway or whether it was going to happen because of the increased stress that you put on that level because of the fusion surgery."

10. When asked if the findings noted on Claimant's 2010 MRI could produce symptoms emanating from L3-4 level by 2017, in the absence of the L4-5 fusion, Dr. Patel responded: ". . . yes, it is possible that he would have had symptoms at L3-4 without having had a fusion at L4-5". He also testified that he could not, simply by looking at the multiple imaging reports, opine that the findings noted on the 2017 MRI report represented the natural progression of degenerative change over time. However, Dr. Patel did agree with the general concept that over the course of eight years, it would be expected that a degenerative condition would worsen, testifying "[t]hat is the natural history of degenerative conditions, that they do slowly progress and slowly worsen."

11. Dr. Kathleen D'Angelo performed an independent medical examination (IME) at the request of respondents. As part of her IME Dr. D'Angelo completed an extensive review/summary of the existing medical records in addition to completing an interview and examination. Thereafter, Dr. D'Angelo authored a lengthy report dated January 6, 2018, in which she concludes that Claimant's current low back symptoms are not consistent with adjacent level disease and that his current need for treatment at

L3-4 is not related to Claimant's L4-5 fusion and therefore, his May 4, 2010 industrial injury.

12. Dr. D'Angelo testified in support of her opinions by deposition on October 24, 2018. Dr. D'Angelo is board certified in internal medicine and has been Level II Accredited through the Division of Workers' Compensation since 2001. Her medical practice is currently limited to occupational medicine.

13. As part of her Level II certification, Dr. D'Angelo testified that she studied and taught concepts for assessing causality in the field of workers' compensation.

14. Dr. D'Angelo reviewed a substantial number of the imaging reports associated with this case opining that, overtime, the reports demonstrate a "very clear progression of disc desiccation, bulging, and other degenerative changes, including facet joint abnormalities at L3-L4, as well as progressive disc desiccations at other levels". She testified further that is what would be expected with degenerative spine disease.

15. Dr. D'Angelo reiterated her opinion that Claimant's pattern of persistent and unremitting symptoms following his fusion surgery is not consistent with adjacent segment disease. Dr. D'Angelo cited studies of long term follow up after fusion surgery which showed that adjacent segment disease requires many years to develop, not months, as is the case here based upon the record supporting that Claimant's recurrence of pain occurred 6 months or less after his lumbar fusion at L4-5. Dr. D'Angelo noted that the natural history of osteoarthritis is for progression of findings on radiological studies and intermittent flares of pain. She opined that claimant's current complaints are related to the natural progression of the underlying degenerative condition of his spine. As stated Dr. Dr. D'Angelo: "[H]ere you have a gentleman with a preexisting disc protrusion with evidence of preexisting facet joint arthropathy at that level who now is presenting with diffuse disc desiccations, multiple profuse – protrusions…multiple levels at which you have ligamentous hypertrophy and facet joint arthropathy. I am not sure why we are saying, Oh, L3-L4 is different just because that is adjacent to the surgical site".

16. In her deposition, Dr. D'Angelo also addressed the proposed treatment at L3-4. She testified that Claimant's diffuse low back pain and leg pain rendered it difficult to determine what level or levels were causing his pain. She questioned whether the proposed injection would be diagnostic in this case leading her to opine that the Claimant "would be where he is right now with or without those surgeries, with or without that injury". The ALJ interprets this testimony to indicate that Dr. D'Angelo believes that Claimant's current symptoms are all related to the ongoing degenerative process present in Claimant's thoracic and lumbar spine.

17. Based upon careful review of Dr. Patel's deposition testimony, the ALJ finds a lack of evidence to support Claimant's suggestion that Dr. Patel espouses the opinion that Claimant's ongoing symptoms/need for treatment are related to adjacent

level disease at L3-4 caused by the L4-5 fusion. Rather, the ALJ finds from the deposition transcript that Dr. Patel agrees generally that adjacent level disease can develop in some patients who have undergone fusion after an indeterminate period of time. Moreover, while Claimant could have adjacent level disease, Dr. Patel was careful to note that there is "no easy" way to tell whether failure of an adjacent level is due to the forces applied on it from an adjacent fusion versus the natural progression of a pre-existing degenerative process. The content of his deposition also fails to persuade the ALJ that Dr. Patel addressed the question of whether Claimant's L4-5 fusion likely accelerated Claimant's pre-existing degenerative spine disease to cause the symptoms he suspects are emanating from L3-4.

18. In this case, Dr. Patel testified that if a patient gets good relief from an injection, then it can be implied that the area where the medication was administered is the probable source of the pain. Consequently, injections can be diagnostic in nature. As noted above, Claimant underwent bilateral transforaminal epidural injections at the L3-4 level on September 15, 2015 for symptoms similar to both which he was experiencing prior to his revision surgery and what he is currently reporting. The injection failed to result in any benefit and it was documented by Dr. Nanes on September 30, 2015 that Claimant was "still in about the same amount of low back pain as compared to [his] last visit". While a second injection was supported by Dr. Nanes, Claimant never followed-up for receipt of the same. Given Claimant's response to prior injections, the ALJ finds Dr. D'Angelo's skepticism about the efficacy of trying more, as well as her suspicion that Claimant's current pain may not be emanating from the L3-4 level persuasive. Indeed, Claimant reports diffuse pain and the imaging studies conclusively establish that he has degenerative disease at multiple levels of the thoracic and lumbar spines, any of which are probably contributing to his present symptoms. Moreover, even if Claimant's pain is emanating from the L3-4 level, Claimant failed to establish that his need for an epidural injection at L3-4 is causally related to his May 4, 2010 industrial injury. Consequently, his claim for additional medical treatment, in the form of repeat injections, must be denied and dismissed.

CONCLUSIONS OF LAW

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

Generally

A. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S. 2007, *et seq*., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. 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.

B. In accordance with §8-43-215 C.R.S., this decision contains specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision, the ALJ

has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. *See Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). This decision does not specifically address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

C. Assessing weight, credibility and sufficiency of evidence in Workers' Compensation proceeding is the exclusive domain of the ALJ. *University Park Care Center v. Industrial Claim Appeals Office*, 43, P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. 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); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002). While the ALJ is convinced that Claimant's reports of persistent low back pain are credible and the recommended treatment is reasonable and necessary, the medical evidence persuades the ALJ that the need for such treatment is not causally related to his May 4, 2010 industrial injury.

D. The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913); *see also Heinicke v. ICAO*, 197 P.3d 220 (Colo.App. 2008). To the extent, expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting all, part or none of the testimony of a medical expert. *Colorado Springs Motors, Ltd. v. Industrial Commission,* 441 P.2d 21 (Colo. 1968); see also, *Dow Chemical Co. v. Industrial Claim Appeals Office*, 843 P.2d 122 (Colo.App. 1992) (ALJ may credit one medical opinion to the exclusion of a contrary opinion). When considered in its totality, the ALJ concludes that the evidence in this case supports a reasonable inference/conclusion that Claimant suffers from progressive degenerative disc and spine disease, the natural progression of which has probably resulted in his current symptoms and need for treatment at L3-4. While it is true that Claimant underwent fusion at L4-5, the evidence that this fusion applied additional force and strain on the L3-4 level to cause adjacent level disease is not as persuasive as the evidence presented, primarily through Dr. D'Angelo, establishing that Claimant's pre-existing degenerative condition progressed naturally to cause symptoms at this level. Similarly, there is a dearth of evidence to suggest that the L-4-5 fusion accelerated Claimant's degenerative process to cause the L3-4 level to fail and require treatment.

Dr. Patel's recommended L3-4 Transforaminal Epidural Steroid Injections

E. The claimant in a workers' compensation claim bears the burden of establishing entitlement to medical treatment. *See Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997); *Sims v. Industrial Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). Once a claimant has established a compensable work injury, he/she is entitled to a general award of medical benefits and respondents are liable to provide all reasonable and necessary medical care to cure and relieve the effects of the work injury. *Section 8-42-101, C.R.S.*; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo.App. 1990). However, a claimant is only entitled to such benefits as long as the industrial injury is the proximate cause of the his/her need for medical treatment. *Merriman v. Indus. Comm'n*, 210 P.2d 448 (Colo. 1949). Ongoing benefits may be denied if the current and ongoing need for medical treatment or disability is not proximately caused by an injury arising out of and in the course of the employment. *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. App. 1997). In other words, the mere occurrence of a compensable injury does not require an ALJ to find that all subsequent medical treatment and physical disability was caused by the industrial injury. To the contrary, the range of compensable consequences of an industrial injury is limited to those which flow proximately and naturally from the injury. *Standard Metals Corp. v. Ball*, 172 Colo. 510, 474 P.2d 622 (1970). As found here, Claimant has failed to establish, by a preponderance of the evidence, that his L4-5 fusion acted upon the L3-4 level to cause adjacent level disease or that this fusion aggravated/acceleration Claimant's degenerative disc/spine disease and that this aggravation/acceleration caused his need for medical treatment, including the recommended injections.

F. A pre-existing condition "does not disqualify a claimant from receiving workers' compensation benefits." *Duncan v. Indus. Claims Appeals Office*, 107 P.3d 999, 1001 (Colo. App. 2004). However, an employer is not liable for the natural progression of pre-existing conditions if a claimant's employment duties, or as in this case, a prior work-related injury does not aggravate, accelerate or combine with the pre-existing infirmity or disease to produce disability and/or the need for treatment. *See generally, H & H Warehouse v. Vicory*, 805 P.2d 1167, 1169 (Colo. App. 1990); Roberts v. Industrial Commission, 509 P.2d 1285 (Colo.App. 1973). Even temporary aggravations of pre-existing conditions may be compensable. *Eisnack v. Industrial Commission*, 633 P.2d 502 (Colo.App. 1981). Pain is a typical symptom from the aggravation of a pre-existing condition. Thus, a claimant is entitled to medical benefits for treatment of pain, so long as the pain is proximately caused by the employment–related activities or in this case by the side effects of treatment for a compensable injury and not the underlying pre-existing condition. *See Merriman v. Industrial Commission*, 120 Colo. 400, 210 P.2d 488 (1940).

G. As found in this case, the totality of the evidence presented persuades the ALJ that Claimant's current symptoms and need for treatment, specifically a L3-4 transforaminal epidural steroid injection is probably related to age, genetic predisposition and his long standing pre-existing progressive disc/spinal disease. While the ALJ is convinced that Claimant's need for the aforementioned injection is reasonable and necessary, the ALJ credits Dr. D'Angelo's opinions to conclude that

Claimant's current need for L3-4 treatment is, more probably than not, related to the natural progression of his pre-existing degenerative spinal disc disease rather than an industrial cause, including his prior L4-5 fusion surgery. Consequently, the ALJ concludes that Claimant has failed to prove that there is a causal connection between his May 4, 2010 industrial injury and the resulting condition for which he seeks medical treatment benefits. §8-43-201, C.R.S.; *Ramsdell v. Horn*, 781 P.2d 150 (Colo. App. 1989); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000). Accordingly, his request for treatment under this claim must be denied and dismissed.

ORDER

It is therefore ordered that:

1. Claimants claim for medical benefits, in the form of additional L3-4 injections is denied and dismissed.

2. The stay concerning Claimant's obligation to reimburse Respondents' out of pocket expenses associated with the untimely cancellation of Dr. D'Angelo's anticipated hearing testimony is hereby lifted. Claimant shall reimburse Pinnacol Assurance in accordance with the Colorado Workers' Compensation fee schedule for a total of eight (8) units of expert witness time as set aside by Dr. D'Angelo for hearing preparation and anticipated testimony.

3. 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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. 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: January 11, 2019

/s/ Richard M. Lamphere

Richard M. Lamphere
Administrative Law Judge
Office of Administrative Courts
2864 S. Circle Drive, Suite 810
Colorado Springs, CO 80906

ISSUES

- Whether the claimant has demonstrated by a preponderance of the evidence that permanent placement of a spinal cord stimulator, as recommended by Dr. Edward Maurin, is reasonable medical treatment necessary to maintain the claimant at maximum medical improvement (MMI).

The parties agreed that the issue of reopening the claimant's claim would be held in abeyance, without prejudice.

FINDINGS OF FACT

1. The claimant was injured on October 16, 2012. At that time, the claimant was working for the employer as a driller. The injury occurred when the claimant stepped on some grease, which caused him to slip and fall onto his back. The claimant testified his knees, shoulders, and back were injured in the October 16, 2012 fall.

2. The claimant has had extensive medical treatment since the 2012 work injury. This treatment has included physical therapy; spinal injections; magnetic resonance imaging (MRI) of his left shoulder, cervical spine, lumbar spine, and left knee; surgeries to the claimant's left knee and left shoulder; a L5-S1 spinal fusion; and various pain medications, including opioids. During this claim the claimant's authorized treating physician (ATP) has been Dr. Randal Jernigan.

3. On March 3, 2014, Dr. Jernigan placed the claimant at maximum medical improvement (MMI). At that time, Dr. Jernigan assessed a whole person impairment of 36% and imposed permanent restrictions of no lifting over 40 pounds.

4. The claimant testified that since being placed at MMI, he has had increasing low back symptoms that include pain that radiates into his left leg. On April 6, 2015, Dr. Jernigan noted that the claimant was still experiencing back pain. On January 11 2016, Dr. Jernigan noted that the claimant was experiencing left leg sciatica that was impacting the claimant's ability to sleep.

5. On May 24, 2016, the claimant was seen at Spine Colorado by Dr. Douglas Orndorff to discuss whether additional spinal surgery would be warranted given the claimant's continued left sided radiculopathy. At that time, Dr. Orndorff assured the claimant that there was union of the spinal fusion. Dr. Orndorff did not recommend additional surgery for the claimant.

6. On June 14, 2016, Dr. Jernigan noted that the claimant continued to have very severe low back pain that was radiating into both legs with numbness and tingling. Subsequently, Dr. Jernigan referred the claimant for an additional neurology consultation at San Juan Regional Neurology. On August 23, 2016 and August 30,

2016, the claimant was seen at San Juan Regional Neurology by Dr. Karen LeComte. It was at these appointments that Dr. LeComte noted that the claimant's asymmetrical symptoms were not typical of lumbar sacral radiculopathy or spinal stenosis. Dr. LeComte recommended the claimant undergo a brain MRI to address the possibility of demyelinating disease (multiple sclerosis).

7. On August 31, 2016 the claimant sought treatment with Dr. Jernigan. However, Dr. Jernigan sent the claimant to the emergency department because the claimant was experiencing symptoms of facial droop and an inability to speak. On that same date, the claimant was treated at Mercy Regional Medical Center for these symptoms. The claimant was diagnosed with transient aphasia, likely related to anxiety. A brain MRI performed on that date was normal.

8. On February 8, 2018, Dr. Jernigan referred the claimant to Dr. Tashof Bernton for testing and evaluation for complex regional pain syndrome (CRPS). The claimant was seen by Dr. Bernton on February 26, 2018. After testing, Dr. Bernton noted in his report that the evaluation was negative for CRPS. Dr. Bernton noted a differential diagnosis of lumbar radiculopathy.

9. The claimant continued to complain of low back pain that radiated in to both legs. Subsequently, Dr. Jernigan referred the claimant to Dr. Edward Maurin for a neurology consultation. On May 8, 2018, the claimant was seen by Dr. Maurin and reported three years of low back pain and left leg symptoms. Dr. Maurin opined that the claimant has chronic pain syndrome and recommended a spinal cord stimulator (SCS) trial.

10. The recommended SCS trial began on July 12, 2018. Following the SCS trial, the claimant reported to Emily Godfrey, PA-C that during the trial his pain symptoms were improved by 50%. Following the success of the trial, Dr. Maurin recommended permanent placement of a SCS device.

11. The claimant testified that during the SCS trial he had a reduction in his pain symptoms. With that reduction is his pain, the claimant was more active, was able to be on his feet more, and walk further when compared to his function prior to the SCS trial. The claimant also testified that he slept better during the SCS trial and was able to reduce his use of pain medications. The claimant testified that he took only half of his normal dosage of pain medication, Nucynta, during the SCS trial.

12. The claimant testified that he would like to undergo the recommended permanent SCS placement because he believes that it will improve his pain management and allow him to wean off his pain medications.

13. Dr. Jernigan testified that he agrees with Dr. Maurin's recommendation for permanent placement of an SCS. Dr. Jernigan noted in his testimony that the claimant experienced a 50% improvement in his back pain and had better use of his legs. Dr. Jernigan also testified that a permanent SCS device would increase the claimant's function and reduce, or even eliminate, the claimant's need for pain medication.

14. On July 27, 2018, Dr. John Douthit performed a review of the claimant's medical records related to the recommended permanent placement of an SCS device. In his report, Dr. Douthit opined that the claimant's SCS trial was not a valid trial under the Colorado Medical Treatment Guidelines (the guidelines), which require a functional assessment both before and after the trial. Dr. Douthit noted that the claimant's reports of improved function were subjective. Therefore, Dr. Douthit recommended an additional SCS trial before consideration of permanent SCS placement. Following Dr. Douthit's report, the respondents denied authorization of permanent placement of an SCS device.

15. The ALJ credits the medical records and the testimony of the claimant regarding the claimant's symptoms and the results of the SCS trial. The ALJ also credits the opinions of Drs. Maurin and Jernigan over the contrary opinion of Dr. Douthit. The ALJ finds that the claimant experienced functional improvement during the SCS trial. The ALJ finds that the claimant has demonstrated that it is more likely than not that permanent placement of a SCS device is reasonable medical treatment necessary to maintain claimant at MMI.

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 8-43-201, C.R.S., 2008. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 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, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and 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 (2012).

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).

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

5. 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, C.R.S., thus authorizes the ALJ to enter an order for future treatment if supported by substantial evidence of the need for such treatment. *Grover v. Industrial Commission*, *supra.*

6. The Colorado Workers' Compensation Medical Treatment Guidelines (the guidelines) are regarded as accepted professional standards for care under the Workers' Compensation Act. *Rook v. Industrial Claim Appeals Office*, 111 P.3d 549 (Colo. App. 2005). The statement of purpose of the guidelines is as follows: "In an effort to comply with its legislative charge to assure appropriate medical care at a reasonable cost, the director of the Division has promulgated these 'Medical Treatment Guidelines.' This rule provides a system of evaluation and treatment guidelines for high cost or high frequency categories of occupational injury or disease to assure appropriate medical care at a reasonable cost." W.C.R.P. 17-1(A). W.C.R.P. 17-5(C) provides: "The treatment guidelines set forth care that is generally considered reasonable for most injured workers. However, the Division recognizes that reasonable medical practice may include deviations from these guidelines, as individual cases dictate."

7. While it is appropriate for an ALJ to consider the guidelines while weighing evidence, the Medical Treatment Guidelines are not definitive. *See Jones v. T.T.C. Illinois*, Inc., W.C. No. 4-503-150 (May 5, 2006); *aff'd Jones v. Industrial Claim Appeals Office* No. 06CA1053 (Colo. App. March 1, 2007) (not selected for publication) (it is appropriate for the ALJ to consider the guidelines on questions such as diagnosis, but the guidelines are not definitive); *see also Burchard v. Preferred Machining*, W.C. No. 4-652-824 (July 23, 2008) (declining to require application of medical treatment guidelines for carpal tunnel syndrome in determining issue of PTD); *see also Stamey v. C2 Utility Contractors et al*, W.C. No. 4-503-974 (August 21, 2008) (even if specific indications for a cervical surgery under the medical treatment guidelines were not shown to be present, ICAO was not persuaded that such a determination would be definitive)

8. As found, the claimant has demonstrated by a preponderance of the evidence that permanent placement of a spinal cord stimulator recommended by Dr. Maurin is reasonable medical treatment necessary to maintain claimant at MMI. As found, the medical records, the testimony of the claimant, and the opinions of Drs. Maurin and Jernigan are credible and persuasive.

ORDER

It is therefore ordered:

1. The respondents shall pay for permanent placement of a spinal cord stimulator, pursuant to the Colorado Medical Fee Schedule.

2. The issue of reopening the claimant's claim is held in abeyance, without prejudice.

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

Dated January 14, 2019

Cassandra M. Sidanycz
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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 ALJ'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 ALJ; 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. 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. **In addition, it is recommended that you send a copy of your Petition to Review to the Grand Junction OAC via email at oac-gjt@state.co.us.**

STATE OF COLORADO
OFFICE OF ADMINISTRATIVE COURTS

W.C. No. 5-061-258-002

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Claimant, ,

vs.

Employer, ,

and

SELF-INSURED, c/o CCMSI,
Insurer/Respondents.

A hearing in this matter was held on November 29, 2018 before Administrative Law Judge Kimberly Turnbow. represented Claimant who was present in person. represented Respondents, and was present on behalf of the . The hearing was held in Courtroom 3 and digitally recorded beginning at 8:30 a.m. and ending at 9:30 a.m. The Judge admitted into evidence Claimant's exhibits 1-8 and Respondents exhibits A-E. The Judge additionally entered the post-hearing deposition testimony of Respondents' expert witness Carlos Cebrian, M.D.

Also in this order, the following words or acronyms may be used: "Judge" or "ALJ" refers to the Administrative Law Judge; "C.R.S." refers to Colorado Revised Statutes (2018); "the Act" refers to the Workers' Compensation Act of Colorado, Sections 8-40-101, et seq., C.R.S.; "OAC" refers to the Office of Administrative Courts; "OACRP" refers to the Office of Administrative Courts Rules of Procedure, 1 CCR 104- 1; "WCRP" refers to the Workers' Compensation Rules of Procedure, 7 Code Colo. Reg. 1101-3.

ISSUE

- Whether Claimant met his burden of proving by a preponderance of the evidence that his right shoulder labrum tear caused by the July 26, 2007 incident that injured his elbow?

FINDINGS OF FACT

1. Claimant suffered an injury to his right upper extremity on July 26, 2007.

2. On July 27, 2007, Claimant described the injury as occurring "when loading patient into the medic unit I felt a pop in my elbow and significant pain in my right elbow bicep area." Claimant testified at hearing that he personally entered this description into the Littleton Accident/Injury/Incident Report, and that it was true and accurate.

3. Claimant did not immediately seek treatment for his right upper extremity injury. Almost two weeks later on August 9, 2017, while attending a medical appointment for a left upper extremity injury, Claimant described to Sharon Walker, M.D., that while lifting a pram "he felt 2 pops in the right antecubital fossa [anterior elbow]. He got immediate bad pain in this area." There is no mention of a right shoulder injury or pain in Dr. Walker's report, and Claimant testified at hearing that he did not complain of right shoulder problems to Dr. Walker during the August 9, 2017 examination. Nor is there any indication in the medical record of any pain or injury proximal to the elbow. Consistent with the absence of any right shoulder injury, or even an injury proximal to the elbow, Claimant waived any physical examination of the right shoulder.

4. Claimant continued to work his regular job duties without complaints or restriction on the use of his right shoulder. According to Claimant's testimony, this included the active and strenuous use of his right shoulder.

5. Claimant returned for treatment of his right elbow only with Dr. Walker on October 16, 2017. Dr. Walker noted that the chief complaint was to his right elbow.

6. On December 29, 2017, Respondents filed a General Admission of Liability for the July 26, 2017 incident and authorized medical treatment to cure and relieve Claimant from the effects of the right elbow injury.

7. Dr. Walker did not diagnose a right shoulder injury until April 6, 2018, assessing a right shoulder strain, and ordering an MRI. The MRI report showed a labrum tear, "age unknown," and chronic arthrosis. After the MRI, Dr. Walker referred Claimant to Dr. Hatzidakis for "labral tear & arthritis." Respondents authorized this initial evaluation, including the MRI. Respondents then sought a record review completed by Carlos Cebrian, M.D. on July 5, 2018, to address the causation of newly alleged shoulder injury. Thereafter, Respondents challenged the compensability of the shoulder injury.

8. Renne M. Charest, PA-C at Western Orthopedics evaluated Claimant on May 1, 2018. At that time, Claimant inaccurately, and inconsistent with the

contemporaneous record, provided a history of experiencing "pain into his shoulder" on July 26, 2017. This inaccurate history repeats throughout Claimant's treatment at Western Orthopedics, including evaluations on June 28, 2018, noting "continuing right shoulder pain," August 23, 2018, describing "right shoulder pain since a work-related injury on July 26, 2017." This inaccurate history culminates in the operative report inaccurately assuming "an injury to his shoulder on July 26, 2017." To the extent any of the reports by medical professionals at Western Orthopedics express an opinion that the shoulder surgery related to the alleged July 26, 2017 incident, those opinions are unreliable because of the inaccurate history provided by Claimant.

9. Dr. Walker attempted to explain the absence of contemporaneous shoulder complaints by suggesting that Claimant had a high pain threshold. This explanation is lacking because Claimant complained of pain in the elbow immediately per his report to Littleton, and to Dr. Walker on August 9, 2017, without mentioning shoulder problem.

10. More compelling is Dr. Carlos Cebrian's opinion that the mechanism of the injury described by Claimant "would not have injured the shoulder labral at the same time as a distal biceps tendon rupture." Dr. Cebrian elaborated, noting that because the maximum force was at the elbow causing a tendon tear, there "would not have been simultaneous force of a significant level to the labrum to cause a SLAP tear in the shoulder." As Dr. Cebrian explained at his deposition:

> There would not have been sufficient force simultaneously at two opposite ends of the humerus at the distal end to tear the biceps and at the upper end to cause a labral tear. The biceps was probably torn with some extension when Mr. Goorman was dealing with a combative patient, which is how distal biceps typically tear, when there is a forceful extension at that joint. So, if the force is primarily at the elbow, there wouldn't have been the same level of significant force at the shoulder which would have caused the humeral head to pull out of the socket to cause a labral tear of an acute nature.

11. Dr. Cebrian additionally explained that the mechanism of injury Claimant described is not typically associated with labrum tears, stating that Claimant may have "had a mild traction pull on his arm, but not to the significant extent that would have caused a labral tear at the same time as a distal biceps tendon rupture."

12. Unlike Dr. Walker's opinion, Dr. Cebrian's opinion is consistent with the contemporaneous record indicating pain in the elbow, not the shoulder.

CONCLUSIONS OF LAW

The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. The Claimant 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,* 592 P.2d 792, 800 (Colo. 1979). The facts in a worker's compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. A worker's compensation case is decided on its merits. Section 8-43-201, C.R.S. (2018).

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 Engn'g, Inc. v. Indus. Claim Apps. Office*, 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' 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 Ins. Co. v. Cline*, 57 P.2d 1205, 1209 (Colo. 1936) overruled in part on other grounds by *Lockwood v. Travelers Ins. Co*., 498 P.2d 947 (Colo. 1972).

The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 441 P.2d 21 (Colo. 1968).

The Claimant must prove a causal nexus between the claimed need for treatment and the work-related occupational disease or injury. *Singleton v. Kenya Corp.*, 961 P.2d 571 (Colo. App. 1998). Here, Claimant has failed to meet his burden of proof that the labrum tear is causally related to the July 26, 2017 incident. The contemporaneous report of the injury mentions only an elbow injury and elbow pain, without any mention of a shoulder injury or pain. This is shortly followed by Claimant's detailed description of an elbow injury and elbow pain to the Dr. Walker on August 9, 2017, again without any reference to a right shoulder injury or pain. These contemporaneous records recorded at the time of the injury and shortly thereafter are a reliable indication that the extent of the injury suffered by Claimant was limited to the elbow.

Moreover, in the context of Claimant's obligation to meet the burden of proof, the evidence fails to sufficiently explain the absence of shoulder complaints at the time of the injury. The MRI revealed a labrum tear of uncertain age. Dr. Walker's surmise that Claimant has a high pain threshold does not adequately explain the repeated contemporaneous and detailed descriptions of an injury to, and pain in, the elbow but no reports of pain in the shoulder. The fact that Claimant continued to work full duty after July 26, 2017 using his shoulder for strenuous activities, and reported an elbow injury and pain, but did not report or complain of a shoulder injury is further undisputed evidence not refuted by Claimant by a preponderance of the evidence.

The medical opinions of Dr. Cebrian that (1) the contemporaneous medical record does not support a labrum tear, and (2) the mechanism of the injury would not cause the elbow injury and at the same time generate enough force (or traction) to tear the labrum are found credible and persuasive.

Overall, the medical opinion and factual evidence presented by Respondents outweigh the evidence supplied by Claimant. Claimant has failed to prove by a preponderance of the evidence that he suffered a shoulder labrum tear caused by the injury on July 26, 2017. Because Claimant has failed to establish a causal nexus between the incident and his shoulder complaints, the issue raised about medical payments is moot.

ORDER

Based on the foregoing findings of fact and conclusions of law, it is Ordered that the claim for benefits related to the alleged right shoulder condition are denied and dismissed.

Dated this 11th day of January 2019.

/s/ Kimberly Turnbow
Administrative Law Judge
Office of Administrative Courts
1525 Sherman, #400
Denver, CO 80203

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, 1525 Sherman Street, 4th Floor, Denver, Colorado, 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the Order, as indicated on the 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 § 8-43- 301(2), C.R.S. (as amended, SB 09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a Petition to Review at http://www.colorado.gov/dpa/oac/forms-WC.htm.

CERTIFICATE OF MAILING OR SERVICE

I hereby certify that I have served true and correct copies of the foregoing FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER by U.S. Mail, or by e-mail addressed as follows:

Division of Workers' Compensation
cdle_wcoac_orders@state.co.us

Date: 1/11/2019

/s/ Jenna Thompson
Court Clerk

ISSUES

- Did Claimant prove he suffered a compensable injury to his right knee on December 8, 2017?
- Did Claimant prove entitlement to reasonably necessary medical treatment to cure and relieve the effects of his injury?
- What is Claimant's average weekly wage?

STIPULATIONS

The parties agreed if the claim is compensable, Claimant is entitled to temporary partial disability (TPD) from December 9, 2017 through May 11, 2018, and temporary total disability (TTD) from May 12, 2018 through May 14, 2018, based on the AWW determined by the ALJ.

FINDINGS OF FACT

1. Claimant worked for Employer on the I-25 ILEX construction project in Pueblo. Although his formal job title was heavy equipment operator, he worked approximately 85% to 90% of the time as a laborer. The work was physically demanding and required heavy lifting, bending, squatting, and walking on uneven surfaces.

2. On December 8, 2017, Claimant was prepping an area between two bridges for asphalt. He was carrying an 8-foot long L-shaped metal cage estimated to weigh approximately 20 pounds. The work area was somewhat sloped. When he was ready to put the cage down, he stepped forward onto his right leg and the knee "popped" and "buckled." Claimant felt immediate pain in the knee after the incident.

3. Claimant's co-worker, Richard Padilla, was working nearby and heard Claimant exclaim "Ow, my knee!" Claimant was limping and in obvious pain. Mr. Padilla helped Claimant walk to their boss's truck to rest.

4. Claimant has a significant history of prior problems with his right knee. He suffered a work-related knee injury in January 2014 when he stepped on a rock. Claimant underwent a right knee arthroscopy with patellar chondroplasty and plica excision on February 6, 2015. The operative note indicates grade 3 chondral fissuring of the patellar apex, grade 1 chondromalacia of the lateral tibial plateau and grade 1-2 chondromalacia of the medial tibial plateau.

5. Claimant's knee remained symptomatic after MMI. He underwent viscosupplementation injections in 2015 with limited benefit. He was eventually put at MMI in May 2016 with a 24% scheduled lower extremity rating. On the advice of his ATP,

he went to the gym regularly to aggressively strengthen his quadriceps muscles and lose weight. Claimant's knee problems slowly improved, and after several months of working out his symptoms resolved. Claimant's testimony regarding the resolution of his prior knee symptoms is corroborated by Mr. Padilla's testimony and the lack of any medical records relating to his knee between July 2016 and December 2017. Additionally, Claimant worked a physically demanding job for eight months between April 2017 and December 2017 without limitation or difficulty. Mr. Padilla worked closely with Claimant on a daily basis for approximately two months before the accident and observed no knee problems or limitations before December 8, 2017. The records also show Claimant lost 30 pounds between May 11, 2016 and December 11, 2017.

6. Claimant's right knee caused no disability and required no medical treatment immediately before December 8, 2017.

7. After the December 8 accident, Employer referred Claimant to CCOM. Claimant saw Brendan Madrid, NP at the initial appointment on December 11, 2017. He described the mechanism of injury consistent with his testimony at hearing. Mr. Madrid diagnosed a right knee "sprain" and ordered an MRI. Mr. Madrid imposed restrictions of carrying no over 20 pounds, no kneeling, squatting, or walking on uneven surfaces, and frequent breaks to allow for icing and to elevate the knee. Mr. Madrid opined the objective findings were consistent with a work-related injury.

8. Claimant saw Dr. Centi at his next CCOM appointment on December 19, 2017. He was having "constant" right knee pain and still waiting for the MRI. Physical examination showed moderate edema and effusion, medial joint line tenderness, equivocal Lachman's and anterior drawer test, and an antalgic gait. Dr. Centi changed Claimant's restrictions to sedentary work "sitting 95% of the time." He also opined, "the cause of this problem is related to work activities."

9. Claimant had a right knee MRI on January 19, 2018. It showed a small joint effusion and no evidence of torn ligaments. Dr. Centi referred Claimant to Dr. Ronald Royce for an orthopedic evaluation.

10. Claimant saw Dr. Royce on February 7, 2018. Dr. Royce recommended physical therapy and gave Claimant a cortisone injection for the pain and swelling.

11. The cortisone injection was minimally helpful, so Dr. Centi referred Claimant to Dr. Derek Purcell for a second orthopedic opinion.

12. Claimant saw Dr. Purcell on March 22, 2018. Dr. Purcell diagnosed "right knee early patellofemoral osteoarthritis, exacerbated by a work-related injury versus caused by a work-related injury." Dr. Purcell opined, "I would recommend that he exhaust conservative measures. A reasonable approach at this point would be viscosupplementation."

13. Claimant saw Dr. Timothy Hall for an IME at his counsel's request on May 23, 2018. Claimant told Dr. Hall his knee symptoms were "totally different" from the pain he had from the previous injury. Dr. Hall diagnosed chondromalacia patella exacerbated

by the work injury. Dr. Hall opined Claimant's ongoing knee symptoms were most likely related to the December 8, 2017 event. He further opined Claimant's previous knee condition made him more susceptible to injury. Dr. Hall agreed Claimant should try viscosupplementation injections.

14. Dr. William Ciccone performed an IME for Respondents on August 7, 2018. Dr. Ciccone diagnosed right knee pain with chondromalacia. Dr. Ciccone noted Claimant did not fall or twist his knee, and opined the mechanism Claimant described would not have aggravated or accelerated any degenerative process already occurring in his knee. Dr. Ciccone concluded Claimant sustained no new injury and his symptoms were due to degenerative arthritis without contribution from his work.

15. Dr. Ciccone testified in deposition for Respondents on October 31, 2018. He reiterated his opinion the mechanism Claimant described was not one he would associate with injury to a joint. He indicated there was no evidence of any new pathology because of the December 8, 2017 incident. Dr. Ciccone testified chondromalacia tends to worsen over time, and symptoms can wax and wane from day to day. He further noted viscosupplementation is generally used for arthritis and other degenerative conditions.

16. Claimant and Mr. Padilla are credible.

17. Dr. Hall, Dr. Centi, and Dr. Purcell's causation opinions are more persuasive than the contrary opinions offered by Dr. Ciccone.

18. Claimant proved he suffered a compensable aggravation of his pre-existing right knee condition as a direct result of his work activities on December 8, 2017.

19. The evaluations and treatment Claimant received by and through CCOM were reasonably necessary to diagnose and treat the compensable injury.

20. Claimant proved viscosupplementation injections are reasonably necessary to cure and relieve the effects of the compensable injury and try to bring Claimant back to baseline.

21. Claimant's wages from Employer were relatively stable, without significant seasonal fluctuations. The ALJ finds the 12 weeks before the injury provide the best approximation of Claimant's typical preinjury wages and the wage loss caused by the injury. Claimant earned $19,517.51 during the 12 weeks before his injury, [1] which equates to an average weekly wage of $1,626.46.

[1] The 12-week window actually ends on December 9, 2017. Although the final pay period included the date of injury, the final paystub shows Claimant's wages for that period were not impacted by the injury, as Claimant had worked 40 hours plus 17.5 hours overtime.

CONCLUSIONS OF LAW

A. Claimant proved a compensable injury

To receive compensation or medical benefits, a claimant must prove he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *Pacesetter Corp. v. Collett*, *33 P.3d 1230* (Colo. App. 2001). The claimant must prove that an injury directly and proximately caused the condition for which she seeks benefits. *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).

If an industrial injury aggravates, accelerates, or combines with a pre-existing condition to produce disability or a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Compensable medical treatment includes evaluations or diagnostic procedures to investigate the existence, nature, or extent of an industrial injury. *Garcia v. Express Personnel*, W.C. No. 4-587-458 (August 24, 2000). Pain is a typical symptom from the aggravation of a pre-existing condition, and if the pain triggers the claimant's need for medical treatment, the claimant has suffered a compensable injury. *Merriman v. Industrial Commission*, 210 P.2d 448 (Colo. 1949); *Dietrich v. Estes Express Lines*, W.C. No. 4-921-616-03 (September 9, 2016). But the mere fact that a claimant experiences symptoms at work does not necessarily mean the employment aggravated or accelerated the pre-existing condition. *Finn v. Industrial Commission*, 437 P.2d 542 (Colo. 1968); *Cotts v. Exempla*, W.C. No. 4-606-563 (August 18, 2005). Rather, the ALJ must determine whether the need for treatment was the proximate result of an industrial aggravation or is merely the direct and natural consequence of the pre-existing condition. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985); *Carlson v. Joslins Dry Goods Company*, W.C. No. 4-177-843 (March 31, 2000).

To prove an aggravation, a claimant need not show an injury objectively caused any identifiable structural change to their underlying anatomy. Rather, a purely symptomatic aggravation is a sufficient basis for an award of medical benefits if it caused the claimant to need treatment he would not otherwise have required but for the accident. *Merriman v. Industrial Commission*, 210 P.2d 448 (Colo. 1949); *Dietrich v. Estes Express Lines*, W.C. No. 4-921-616-03 (September 9, 2016).

In *City of Brighton v. Rodriguez*, 318 P.2d 496 (Colo. 2014), the Supreme Court addressed whether an unexplained fall at work satisfies the "arising out of" test. The court identified three categories of risks that cause injuries to employees: (1) employment risk directly tied to the work itself; (2) personal risks, which are inherently personal; and (3) neutral risks, which are neither employment -related more personal. The first category of risks encompasses risks inherent to the work environment and are compensable, whereas the second category of risks is not compensable, unless an exception applies. The court further defined the category of personal risks to encompass so-called idiopathic injuries, which are considered "self-originated" injuries that spring from a personal risk of the claimant, such as heart disease, epilepsy, or similar conditions. The third category —

"neutral risks" — are compensable if the application of a "but for" test shows any employee would have been injured simply by virtue of being at work. The court was careful to point out that the "but for" test does not relieve the claimant the burden of proving causation, nor does it suggest that all injuries occurring at work are compensable.

When a claimant's injury is "precipitated" by a pre-existing condition, the injury is not compensable unless a "special hazard" of employment increased the probability or severity of the injury. *National Health Laboratories v. Industrial Claim Appeals Office*, 844 P.2d 1259 (Colo. App. 1992); *Gates Rubber Co. v. Industrial Commission*, 705 P.2d 6 (Colo. App. 1985). The classic case is the employee who suffers an epileptic seizure at work that causes him to fall from a scaffold or ladder. *E.g., Ramsdell v. Horn*, 781 P.2d 150 (Colo. App. 1989).

As found, Claimant proved he suffered a compensable injury to his right knee on December 8, 2017. The testimony of Claimant and his coworker, Mr. Padilla, was credible and persuasive. Although Claimant had a prior right knee injury that resulted in a permanent impairment rating, his condition subsequently improved and was not causing any significant problems immediately before December 8, 2017. Claimant was working a physically demanding job without limitation or difficulty and had pursued no formal treatment for his right knee for more than a year.

Claimant's injury arose out of an employment risk and was precipitated by the act of placing weight on his right leg and bending down while carrying a metal cage. The injury was not precipitated by his pre-existing condition or any other purely personal risk. The ALJ infers the additional weight of the cage subjected Claimant's knee to a greater force than would otherwise be associated with taking a normal step. The ALJ also credits Dr. Hall's opinion that Claimant's prior injury rendered the knee more susceptible to injury from forces that might not otherwise be injurious to a healthy knee. The causation opinions of Dr. Centi, Dr. Purcell, and Dr. Hall are more persuasive than the contrary opinions offered by Dr. Ciccone. The persuasive evidence shows the work accident aggravated Claimant's pre-existing condition, proximately causing disability and at least a need for diagnostic testing and conservative care.

Respondents cite *Alexander v. Emergency Courier Services*, W.C. No. 4-917-156-01 (October 14, 2014) to support their position that Claimant's injury is not compensable. The ALJ finds *Alexander* factually distinguishable. In that case, the claimant's knee spontaneously popped while he was extending his leg to take a step. No weight or other force was being applied to the claimant's knee at the moment of injury. By contrast, Claimant's injury occurred when he stepped onto his right leg while carrying a twenty-pound metal cage. Moreover, the Panel in *Alexander* did not hold the claimant's injury was noncompensable as a matter of law but merely upheld the ALJ's factual finding under the substantial evidence rule.

B. Viscosupplementation injections are reasonably necessary.

The respondents are liable for medical treatment reasonably necessary to cure and relieve the effects of an industrial injury. Section 8-42-101(1)(a); *Snyder v. Industrial*

Claim Appeals Office, 942 P .2d 1337 (Colo. App. 1997). Compensable medical treatment includes evaluations or diagnostic procedures to investigate the existence, nature, or extent of an industrial injury. *Garcia v. Express Personnel*, W.C. No. 4-587-458 (August 24, 2000). Where the respondents dispute the claimant's entitlement to medical benefits, the claimant must prove that an injury directly and proximately caused the condition for which he seeks benefits. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999).

As found, the viscosupplementation injections recommended by Dr. Purcell are reasonably necessary to treat the compensable injury. Dr. Ciccone explained it is reasonable to try viscosupplementation if, as here, cortisone injections are not effective. His primary disagreement was based on his opinion Claimant suffered no compensable injury. Since the ALJ has found Claimant symptomatically aggravated his pre-existing condition, it is reasonable to use viscosupplementation to try to bring Claimant back to baseline.

Claimant's request for PRP injections recommended by Dr. Ciccone must be denied. The ALJ can only award treatment recommended by an ATP and lacks jurisdiction to order treatment recommended solely by an IME. *Torres v. City and County of Denver*, W.C. No. 4-937-329-03 (May 15, 2018); *Short v. Property Management of Telluride*, W.C. No. 3-100-726 (May 4, 1995).

C. Claimant's average weekly wage is $1,626.46

Section 8-42-102(2), C.R.S. provides that compensation is payable based on the employee's average weekly earnings "at the time of the injury." The statute sets forth several computational methods for workers paid on an hourly, salary, per diem basis, etc. But § 8-42-102(3) gives the ALJ wide discretion to "fairly" calculate the employee's AWW in any manner that seems most appropriate under the circumstances. The entire objective of AWW calculation is to arrive at a "fair approximation" of the claimant's actual wage loss and diminished earning capacity because of the industrial injury. *Campbell v. IBM Corp*., 867 P.2d 77 (Colo. App. 1993).

As found, Claimant's AWW is $1,626.46. The ALJ agrees with Claimant's argument that the most reasonable method to calculate his AWW is to average the 12 weeks leading up to Claimant's injury.

ORDER

It is therefore ordered that:

1. Claimant's claim for a right knee injury on December 8, 2017 is compensable.

2. Insurer shall cover medical treatment from authorized providers reasonably necessary to cure and relieve the effects of Claimant's injury, including treatment from CCOM, Dr. Royce, and a trial of viscosupplementation as recommended by Dr. Purcell.

3. Claimant's request for PRP injections based on Dr. Ciccone's recommendation is denied and dismissed.[2]

4. Insurer shall pay Claimant TPD benefits from December 9, 2017 through May 11, 2018, and TTD benefits from May 12, 2018 through May 14, 2018, based on an AWW of $1,626.46, subject to the maximum compensation rate in effect on Claimant's date of injury.

5. Insurer shall pay statutory interest of 8% per annum on all benefits not paid when due.

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

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DATED: January 15, 2019

s/Patrick C.H. Spencer II
Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

[2] This order is not intended to limit Claimant's right to pursue PRP injections if later recommended by an ATP, nor Respondents' right to contest same.

ISSUES

The issue set for determination included:

(1) Did Respondents prove Claimant received an overpayment of benefits?

(2) If Respondents proved there was an overpayment, by what terms is Claimant required to repay the overpayment to Respondents?

FINDINGS OF FACT

1. On May 18, 2015, Claimant suffered an admitted industrial injury while working for Employer. Claimant injured his lumbar spine.

2. A General Admission of Liability ("GAL") was filed on behalf of Respondents on March 30, 2016. The GAL admitted for medical benefits only.

3. On October 4, 2016, Claimant was placed at MMI by Kathy McCranie, M.D., who was an ATP. Dr. McCranie assigned a 13% whole person medical impairment rating. This included 5% for a spinal disorder and 8% based on a loss of range of motion ("ROM") under the *AMA Guides*.

4. Respondents filed a Final Admission of Liability ("FAL") based upon Dr. McCranie's 13% whole person rating. The PPD award for that 13% rating to $30,397.64.

5. Claimant underwent a DOWC Independent Medical Examination, which was performed by Linda Mitchell, M.D. Dr. Mitchell determined Claimant was not at MMI.

6. On April 27, 2017, a GAL was filed on behalf of Respondents for medical benefits, based upon the DIME physician's determination.

7. Claimant received further treatment, including an injection to the lumbar spine, as well as undergoing an MRI.

8. Claimant returned to Dr. Mitchell on March 29, 2018 for a follow-up DIME. Dr. Mitchell determined Claimant was at MMI as of December 12, 2017. Dr. Mitchell assigned a 5% whole person medical impairment rating, pursuant to the *AMA Guides*. Because Claimant's ROM measurements were not considered valid, no impairment was assigned due to loss of range of motion in the lumbar spine.

9. On May 21, 2018, Respondents filed a FAL based upon Dr. Mitchell's rating. The 5% rating entitled Claimant to a PPD award in the amount of $11,691.40. The FAL specified that an overpayment of PPD benefits existed in the amount of $18,706.24. Marchelle Robinson filed the FAL on behalf of Respondent-Insurer.

10. Ms. Robinson testified at hearing. She has been a claim professional for 19 years. In that capacity, she oversees and manages workers' compensation claims. This includes payment of medical bills, as well as indemnity payments. She is the claims professional to whom this case has been assigned.

11. Ms. Robinson testified she is familiar with the case, including the pleadings filed. She confirmed that the PPD benefits admitted to in the November 29, 2016 FAL were paid out completely. The PPD totaled $30,397.64. Ms. Robinson testified there were two lump sum payments in the amount of $10,000 taken on the PPD award and the lump sum discount was applied.

12. Ms. Robinson confirmed there was no objection or Application for Hearing filed in response to the May 21, 2018 FAL.

13. Claimant testified that he did not dispute an overpayment existed by virtue of the FAL filed in May 2018.

14. Respondents established an overpayment occurred because Claimant received more in PPD benefits than he was entitled to, based upon the DIME physician's rating.

15. Claimant testified that he is not working and intends to repay Insurer. Claimant stated he continues to experience pain in his low back due to his injury, which limits his activities. The ALJ inferred Claimant is suffering from financial exigencies due to his lack of income.

16. The ALJ determined that a payment in the amount of $65.00 per month will avoid undue hardship to Claimant, while requiring repayment of the overpaid PPD benefits to Respondents. The amount is roughly equivalent to dividing the amount of the total overpayment $18,706.24 (at the time of the FAL) by Claimant's life expectancy of 21.8 years.[1]

17. Evidence and inferences inconsistent with these findings were not persuasive.

CONCLUSIONS OF LAW

General

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

[1] The Colorado life expectancy table is found in WCRP 7-3 [7CCR 1103-01].

benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. § 8-40-102(1), C.R.S. The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of Respondents. § 8-43-201(1), C.R.S.

A Workers' Compensation case is decided on its merits. § 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 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).

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).

Overpayment

In the case at bench, Respondents bore the burden of proof to establish Claimant received an overpayment of benefits. The Colorado Workers' Compensation Act defines an overpayment as "money received by a Claimant that exceed the amount that should have been paid, or which Claimant was not entitled to receive… For an overpayment to result, it is not necessary for the overpayment exist at the time the claimant received disability or death benefits under said articles". § 8-40-201(15.5) C.R.S. (2017).

An overpayment in the amount of $18,706.24 occurred in this case by virtue of the fact that Respondents originally admitted for a higher medical impairment rating, as issued by the ATP. (Finding of Fact 3). PPD benefits based upon that rating were paid in full. (Finding of Fact 11). This was confirmed by Ms. Robinson, the claims professional for Respondents-Insurer who testified at hearing. (Finding of Fact 11). After Claimant requested a DIME, that physician (Dr. Mitchell) concluded Claimant's permanent medical impairment was lower, which resulted in the overpayment. (Finding of Fact 9). As found, Claimant did not contest that such an overpayment of benefits existed. (Finding of Fact 13).

§ 8-42-113.5(1)(c), C.R.S. (2017) provides authority for Insurer in the instant case to seek an order for repayment of an overpayment of benefits. § 8-43-207(q) C.R.S. (2017) grants express authority to an ALJ to conduct a hearing to require repayment of overpayment of benefits. The ALJ has discretion to determine the terms required of Claimant for the repayment. *Louisiana Pacific Corp. v. Smith*, 881 P.2d 456 (Colo. App.1994). See also *Leah Turner v. Chipotle Mexican Grill*, W.C. No.4-893-631-07 (ICAO February 8, 2018). Neither the Colorado Workers' Compensation Act, nor the WCRP requires or prescribes a certain method for such reimbursement.

Appellate courts which have considered this issue and evaluated the terms of repayment have upheld the discretion of the trial court, beginning with *Johnson v. Industrial Commission,* 761 P.2d 1140 (Colo.1988). In *Johnson*, the Colorado Supreme Court approved an offset of the amount overpaid by an insurer against future workers' compensation disability benefits that might be awarded to the Claimant. Justice Quinn's opinion did not determine what method of recoupment was proper, nor did it provide specific guidance as to how Claimant was to repay the overpayment.

In *Louisiana Pacific Corp. v. Smith*, 881 P.2d 456, *supra,* Claimant received Social Security disability benefits and was overpaid permanent total disability benefits. The ALJ ordered a reduction of Claimant's permanent disability benefits over Claimant's life expectancy until the overpayment was fully recouped. The ALJ reasoned this would avoid undue hardship to Claimant. The Industrial Claims Appeals Office affirmed the decision, as did the Colorado Court of Appeals, which reasoned there was not an abuse of discretion. *Id; Simpson v. Industrial Claim Appeals Office,* 219 P.3d 354, 360-361 (Colo. App. 2009).

As found, Claimant's economic circumstances because he was not working led the ALJ to balance the potential of undue hardship with Insurer's right to recoup the overpayment. (Finding of Fact 16). Accordingly, the ALJ determined that payment in the amount of $65.00 per month was warranted under the circumstances of this case.

ORDER

It is therefore ordered:

1. Respondents met their burden of proof and established Claimant was overpaid in the amount of $18,706.24.

2. Claimant shall repay Respondents at the rate of $65.00 per month.

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

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petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

DATED: January 14, 2019

Digital signature

Timothy L. Nemechek
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, CO 80203

ISSUES

I. Has Claimant shown, by a preponderance of the evidence, that he suffered a compensable injury while working for Employer on August 7, 2018?

II. Has Claimant shown, by a preponderance of the evidence, that he is entitled to all reasonable and necessary medical treatment related to a work injury?

III. Has Claimant shown, by a preponderance of the evidence, that he is entitled to Temporary Total Disability payments?

STIPULATIONS

The parties stipulated that Claimant's Average Weekly Wage is $700.60. The ALJ accepted this stipulation.

PRESERVED PROCEDURAL ISSUE

At the outset of hearing, Claimant wished to enter a stipulation that Claimant's cardiac arrest of August 7, 2018 was not work-related for purposes of the hearing, without entirely waiving the right to argue work-relatedness of the cardiac arrest at some future date, if warranted. Counsel for Respondents objected, reasoning that Claimant's theory of recovery at hearing was that he sustained a work-related injury due to a special hazard of employment. Such analysis is dependent upon a finding that Claimant sustained an initial *non-work related* event from a personal medical condition.

Therefore, Respondent asserted, that by attempting to preserve the right to argue relatedness of the cardiac arrest for some hypothetical later date, Claimant was attempting to improperly preserve a second attempt to litigate compensability for the same event under two contradictory theories of recovery. The ALJ permitted Claimant to proceed with the stipulation that the cardiac arrest was not work-related. However, the ALJ deferred any ruling on Claimant's future ability to raise the work-relatedness of his heart attack until such occasion might arise, if it ever should. The ALJ duly notes that Respondents have preserved their objection to moving forward at today's hearing, absent an express waiver by Claimant from ever litigating a possible link between his heart attack and this work incident. (The ALJ further notes that the evidence presented at hearing supports a finding that this heart attack was indeed not work-related).

FINDINGS OF FACT

Based upon the evidence received at Hearing, the ALJ makes the following Findings of Fact:

1. Claimant was employed as a drywall installer for Employer. On August 7, 2018, Claimant sustained a cardiac arrest while working in a scissor lift. He lost consciousness and collapsed, falling inside the scissor lift. Claimant is not contending that his cardiac arrest was caused by his employment.

2. Colorado Springs Fire Department (CSFD) personnel were the first responders to the incident. Bystanders reported that Claimant fell from a standing position. Those bystanders were performing CPR upon the CSFD's arrival. (Ex. D, p. 81). Claimant was inside the scissor lift at that time (which had lowered to ground level) and was then removed from the lift to continue medical treatment. Claimant was noted to have a hematoma on the left occipital portion of his head. American Medical Response arrived on site, diagnosed Claimant with a cardiac arrest, and transported Claimant to UC Health Memorial Hospital. (Ex. E).

3. Claimant was assessed at Memorial Hospital with a cardiac arrest secondary to anterior and inferior myocardial infarction, coronary artery disease, and ischemic cardiomyopathy. (Ex. F, p. 98). He was separately diagnosed with a scalp hematoma. Claimant was noted to have bruising behind his left ear from his fall, which resulted in cervical and head CTs being administered. The head CT was negative and the cervical CT only showed multilevel degenerative changes.

4. Claimant was placed in a cervical collar. *Id. at 128.* As of August 9, 2018, Claimant was noted to be awake, off of pressor medication, and appearing 'much better.' *Id. at 104.* He was evaluated by the wound/ostomy/skin team which noted he was awake and "able to turn self." *Id. at 182.* He was to be started on beta-blocker and ACE inhibitor medications. *Id. at 203.*

5. On August 10, 2018, Dr. Kanchan Kanel performed Claimant's daily medical evaluation on that day and noted Claimant "feels okay." *Id. at 213.* Claimant's neck was noted to be supple without any documented complaints of pain. *Id.*

6. Claimant was evaluated by Memorial Hospital physical therapy staff on August 11, 2018. Claimant demonstrated independence with bed mobility, transfers and ambulation for 500 feet. *Id. at 215.* Katie McCord, P.T., felt that Claimant did not require any physical therapy at that time. On August 11, 2018, Claimant was noted to have 'normal' neck range of motion. *Id. at 217.* He was discharged later that day. His discharge summary, prepared by Dr. Kanel, noted that he had no complaints and 'felt good'.

7. Claimant next sought medical treatment on August 16, 2018. He was examined at the Parkview Medical Center. (Ex. G). He complained of headaches and pain in the right side of his neck "over the past week since fall," which had been

improving but then worsened gradually the day prior. *Id.* On exam, Claimant had full range of motion in his neck, but with complaints of pain and with muscle tenderness and spasm. *Id* at *241.* He was provided trigger point injections at the right posterior upper cervical paraspinal muscles. A CT scan taken that day showed "a right sided C3-C4 facet joint *effusion*." (Ex. 2, p. 3) (emphasis added).

8. Claimant was then evaluated at CCOM in Pueblo on August 17, 2018 by Brendon Madrid, N.P. (Ex. H, p. 248). Inspection showed purplish bruising on the left side of the neck due to drainage when he [Claimant] hit his head. (Ex. 3, p. 37). Claimant reported 10/10 neck pain but he denied headaches or numbness and tingling in his upper extremities. He also denied any memory loss. On exam, Claimant had "very little range of motion in his neck." *Id.* Mr. Madrid diagnosed Claimant with a concussion, a muscular strain, and referred Claimant for physical therapy.

9. Claimant returned to CCOM on 9/4/18, and saw Dr. Olsen. Dr. Olsen noted that Claimant still had tenderness along the right posterior neck muscles. Claimant's pain diagram referenced the right neck area, with pain at 7/10. Further, it was noted by Dr. Olsen:

> Looking at his neck he does have some improved range of motion. Right rotation is still somewhat limited. He does have pain on palpation of the sternocleidomastoid and posterior neck muscles. (Ex. 3, p. 33).

Dr. Olsen set the goal for Claimant to be able to "turn his neck all the way to the right without pain in the next 3 weeks" *Id at p. 35.*

10. Claimant returned to CCOM on 9/11/18. Claimant continued to have muscle spasms in his neck. Rotating his neck causes a spasm either right or left, but particularly to the left. "Palpation does show some tightness of the cervical muscles along the lateral portion of the neck as well as his trap" (Ex. 3, pp. 28-29). A cervical MRI was requested. *Id at p. 25.*

11. Dr. Olsen again saw Claimant on 9/25/18. He noted that Claimant "continues to have limitations and neck range of motion in all directions. He has about 30° rotation both left and right. Flexion and extension are limited." Under his *diagnosis*, Dr. Olsen put: "1. Concussion with loss of consciousness of 30 minutes or less, subsequent encounter; 2. Strain of muscle, fascia and tendon at neck level, subsequent encounter" (Ex. 3, p. 24).

12. Claimant was referred to see Michael Sparr, M.D. with Accelerated Recovery Specialists. He evaluated Claimant on October 1, 2018. Claimant reported his pain as between 7-10/10. (Ex. J, Ex. 5). He described bilateral cervical pain radiating to his trapezii and with numbness in his left biceps. Claimant also complained of headaches occurring 2-3 times per week. Claimant had "profoundly" limited cervical extension and limited flexion as well. *Id. at 278.*

13. Dr. Sparr diagnosed a cervical facet dysfunction with myofasciitis, with the possibility of a cervical disc herniation, associated with headaches. He recommended a cervical MRI, since it is **"reasonable, necessary and appropriate given the severity of pain and direct trauma that the patient experienced."** (Ex. 5, p. 105). (emphasis added). He also recommended trigger point injections, massage therapy, occipital nerve blocks, and possibly facet injections. Those were never authorized.

14. Claimant returned to CCOM to see Dr. Olsen on 10/16/18. At this time, Dr. Olsen noted that Claimant's "neck range of motion showed *improvement.* He still has some limitations with left rotation. Also extension is limited" (Ex. 3, p. 21) (emphasis added). His goal was still to be able to turn his neck all the way to the right without pain. *Id at p. 22*.

15. The last entry from Dr. Olsen is from 11/13/18. Dr. Olsen noted that by this time, Claimant was negative for headache, and had regained much of his range of motion. Dr. Olsen further noted in his narrative "He is scheduled to see Dr. Sparr "tomorrow" but so far his treatment has not been authorized (Ex. 3, p. 16). Pain was down to 3/10, 30% of the time. *Id.* Claimant's most recent work restrictions were "no lifting over 30 pounds, no pushing or pulling over 40 pounds" *Id at p. 17.* Follow up with Dr. Olsen was set for one month, at which time Claimant was anticipated to be at MMI. *Id.*

16. Kathleen D'Angelo, M.D. performed an Independent Medical Exam ("IME") of Claimant on Respondents' behalf. A report was issued on November 4, 2018. (Ex. C). Claimant reported his pain was between 7-9/10. *Id at 8.* Dr. D'Angelo inquired of the events of the accident. She noted that Claimant stated he went up in the lift, "we had to come back down and that's when I think I passed out." She inquired whether Claimant fell first and then had the heart attack, or had the heart attack resulting in the fall. Claimant was not certain. He stated it "could have been" that he fell first. *Id at 16*. Claimant ultimately stated he did not remember when he fell. When pressed on why he thought he might have fallen before his cardiac arrest, Claimant stated it was because the lift was wobbly and he may have lost his balance when coming down in the lift.

17. Claimant reported to Dr. D'Angelo that he began having headaches and neck pain "about the day after I got out of the hospital." *Id. at 11.* Claimant also reported having dizziness, and Dr. D'Angelo noted discussing with him that his blood pressure medications he recently started (Metroprolol and Lisinpril) can cause dizziness. Claimant also reported tingling down his left arm 2-3 times per week. Dr. D'Angelo noted she found no evidence to corroborate his memory complaints on exam and that his recall of dates, events, and names was 'excellent.' *Id at 23-24.*

18. Dr. D'Angelo opined that Claimant had full cervical range of motion, but some complaints of muscle tenderness upon palpation. *Id at 24.* Claimant's neurological exam was normal. She opined that Claimant's cardiac conditions were all non-work related. She noted that head injuries were not a recognized cause of cardiac arrest, but the cardiac arrest was a recognized cause of loss of consciousness. She felt

that any contusion he sustained to his left occipital scalp would have been secondary to his cardiac event and did not *cause* the cardiac event.

19. Dr. D'Angelo also noted that Claimant's complaints of dizziness, confusion, depression, and impaired memory and cognition may be caused by his medications. She also opined that there was no reason to suggest Claimant's current extensive subjective symptoms, including headaches, neck pain, upper back pain, and his cognitive complaints were related to the head contusion. She later clarified she was not opining on the *legal question* of whether those conditions would be considered work-related after they arose from a non-work related cardiac arrest. *Id at 42-43.*

20. Robert Ayala testified at hearing. Mr. Ayala is Claimant's brother, and also works for Employer. He was working directly with Claimant on August 7, 2018. He testified he and his brother were using the scissor lift to raise up to 30 feet to perform their work. He described the lift as a 5' x 8' cage lift on 4 wheels, made out of metal, which went up and down like an elevator. He testified that if the lift is not level, it will sound an alert and stop moving. Photographs of a scissor lift Claimant identified at hearing as a similar model, if not the exact lift, are contained in Exhibit L. (At hearing, the parties concurred that the portion of the scissor cage marked in green highlighter is the mid-level bar which Claimant struck when he fell. Respondents argue that said bar was likely "hollow" instead of solid metal. The ALJ concurs that this bar is indeed quite likely to be boxed steel (thus 'hollow'), and not solid. The significance of this distinction, or lack thereof, will be addressed in the Conclusions of Law, *infra).*

21. Mr. Ayala testified that as they were going up in the lift, the "buzzer" went off, indicating the lift was not stable. Mr. Ayala therefore told Claimant they should go back down. He testified that after they had gone all the way down, he began stepping backwards to climb out of the lift, facing Claimant, who was still standing inside the lift. He testified it was at this time that he saw Claimant fall and hit the back of his head on the middle rail of the lift. He stated that the lift was not moving, and was stable at the time Claimant passed out. He testified the middle rail was about 2 feet off of ground level. He testified he did not see Claimant's head strike any protruding parts from the rail, corner of the rail, or control box.

22. Claimant testified at hearing. Claimant testified the scissor lift he was working on had two rails, a top rail and mid rail, with the mid rail about 2 feet high and the top rail about 4 feet high. He testified the rails had squared edges. He testified the rails and floor were made of metal. Claimant testified him and his brother had been placing plywood under the lift to keep it balanced during that day. He testified the lift would wobble the higher up it went. Claimant testified he and his brother were going up, the lift began beeping to notify that it was unstable, they began descending in the lift, "and that was when I kind of lost consciousness and hit the rail." He testified he remembered passing out, and after that his next memory is waking up in the hospital. As of the hearing, Claimant has not returned to work, but has continued, per his testimony, to see his ATP, Dr. Olsen.

23. Claimant confirmed that he remembered losing consciousness while the lift was moving downward. He testified his brother was operating the lever which moved the lift downward when he lost consciousness. Claimant testified the gear box, which his brother was operating, was on the "front" of the lift, which is the opposite side of where the gate to enter/exit the lift is located. Claimant testified he was standing closer to the gate, or the "back" side. When asked on cross-examination whether his brother was exiting the lift at the time he lost consciousness, Claimant testified he was not. Claimant testified when he lost consciousness, his brother was looking at him to see if he was ready to come down.

24. Claimant testified his brother was asking him if he was ready to come down - meaning whether he was holding onto a rail - but he also testified they were already coming down. He testified his brother was facing the gear box on the front side of the lift while turning his head to look at Claimant near the back side of the lift. Claimant agreed he had no memory of what he struck his head on.

25. Claimant initially testified that during his stay at Memorial Hospital he was in bed the whole time without performing any physical activities. He testified his neck pain gradually got worse as he began sitting up at home after he left the hospital.

26. On cross-examination, Claimant testified he woke up in the hospital on August 9th and he did not have neck pain at that time. When asked if he had neck pain when he was discharged from the hospital, he could only state his pain began as he began standing and walking, and the first time he did so was upon discharge. Claimant was asked about the physical therapy evaluation from August 11, 2018. (Ex. F, p. 215). Claimant testified he did not remember that evaluation. When asked about the notes documenting him walking up to 500 ft. in the hospital, moving out of bed, and other tasks, Claimant stated he could not remember those activities. Claimant then testified he had neck pain when he was leaving the hospital at the time of discharge.

27. At hearing, Claimant was shown Dr. D'Angelo's note, wherein he informed her his first neck pain arose the day after he was discharged. Claimant then testified his first pain was in fact on August 12, and not the day before when he was discharged. He then testified he had a hard time remembering when his pain began. Claimant testified that he could barely move his neck when he was seen on August 16 at Parkview. When presented with the Parkview records documenting he had full range of motion in his neck without restriction, he testified those records were not correct.

28. Claimant testified he thinks he reported neck pain while at Memorial Hospital, but he could not state for certain. He did not elaborate why he thought he had informed someone at Memorial Hospital that he had neck pain, if he was also alleging he first felt neck pain upon being discharged from the hospital.

29. Claimant testified he had headaches while at Memorial Hospital and was told by a cardiologist that he should take Tylenol. Claimant testified when asked if he was surprised that this was not a documented condition, he stated that his headaches

actually started when he began walking after discharge. Claimant testified he had memory issues during his stay at Memorial Hospital and that he informed his provider at CCOM on August 17, 2018 of his memory complaints. When presented with the August 17, 2018 treatment note that documented he denied memory loss issues at that time, he testified that this record was not correct. (re: Ex. H, p. 248). Claimant testified he "most likely" had upper back pain first when he was discharged, and walking out of the hospital.

30. Dr. D'Angelo testified at hearing as an expert in the fields of internal medicine and occupational medicine. She testified Claimant's fall directly resulted from his cardiac arrest. She confirmed Claimant told her at the IME that his first symptoms in his head or neck began on August 12, 2018. She testified it was not medically likely he would first feel symptoms in his head and neck on August 12 which would be related to hitting his head on August 7th. She testified trauma to the head or cervical spine is acutely symptomatic.

31. She also testified that Claimant was taken off a respirator on August 9; his sedation stopped on that day, and by August 11, he was noted to be completely asymptomatic. She also noted Claimant had not been sedated or provided any pain killers which may have masked his symptoms while in the hospital, after he had been taken off the respirator on August 9. She also noted that Claimant's treating physicians had addressed his hematoma, and evaluated Claimant for a head and neck injuries in addition to his cardiac arrest, without documentation of those symptoms.

32. Dr. D'Angelo testified that in her opinion, it was not medically likely that, after having documented full range of motion on August 16 at Parkview, any severe restrictions documented on exam on August 17 would be related to an incident which had occurred ten days prior. She noted that the notes of Dr. Keller and the triage nurse at Parkview would have likely recognized abnormalities if present. Dr. D'Angelo testified that suffering a sudden seizing event such as a cardiac arrest, then laying immobile for several days can cause myofascial (muscular) problems, including spasms as were documented at Parkview. She noted that while at Parkview, Claimant was provided a trigger point injection, which is typically used to treat cervical myofascial spasms, as opposed to disc herniation or other cervical abnormalities which could be caused by acute trauma. She testified there was no sign of traumatic injury on Claimant's cervical imaging. She testified Claimant's exam during her IME was benign, and she could not find any evidence of neurological, facet, cervical, or even myofascial injury at that time.

33. Dr. D'Angelo testified any headache complaints Claimant had at Memorial would be more likely related to Nitroglycerin-based medications that he was administered for his cardiac issues. She testified the medications Claimant was provided for his cardiac arrest can also cause mentation issues, such as the cognitive problems of which Claimant complained. She testified Claimant's complaints of intermittent left arm numbness was not consistent with a cervical radiculopathy, but was more consistent with ongoing angina from his cardiac issues. She opined that Claimant

demonstrated during her IME excellent anterograde and retrograde memory by his recollection of events immediately prior to the fall and upon regaining consciousness. She testified this was the appropriate test for memory loss related to a concussion/brain injury, and in her opinion, Claimant demonstrated no signs of a concussion.

34. Dr. D'Angelo testified Claimant had no objective findings of injury to his head, neck, or back related to the incident subsequent to his hospitalization at Memorial Hospital. Therefore, it was her opinion that Claimant sustained no disability or required medical treatment from the August 7, 2018 incident aside from his unrelated cardiac arrest issues.

CONCLUSIONS OF LAW

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

Generally

A. The purpose of the Workers' Compensation Act of Colorado is to assure 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).* 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).

B. 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. The ALJ, as the fact-finder, is charged with resolving conflicts in expert testimony. *Rockwell Int'l v. Turnbull,* 802 P.2d 1182, 1183 (Colo. App. 1990) Moreover, the ALJ may accept all, part, or none of the testimony of a medical expert. *Colorado Springs Motors, Ltd. v. Industrial Commission,* 165 Colo. 504, 441 P.2d 21 (1968); *see also Dow Chemical Co. v. Industrial Claim Appeals Office,* 843 P.2d 122 (Colo. App. 1992) (ALJ may credit one medical opinion to the exclusion of a contrary medical opinion).

C. In accordance with Section 8-43-215, C.R.S., this decision contains Specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. See *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). This decision does not address every item

contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

D. In this case, the ALJ notes that Claimant has not been entirely consistent between his testimony and what he told his providers. There are gaps in his memory- not unsurprising given his medical condition. His onset of symptoms, and reporting of same, do not follow a medically predictable trajectory - but a failure to follow said trajectory does not render it false. Indeed, the Workers Compensation system is replete with examples of injured workers setting follow-up appointments which do not yield the expected results. MMI gets postponed, more testing ordered, referrals rendered, new discoveries made, experts confounded. And persons possibly suffering post-concussive symptoms might not be the best judge of their own memory. While the ALJ would not rely exclusively upon Claimant's testimony at hearing to make a decision, that is hardly necessary. The ALJ finds that Claimant, while not an entirely reliable medical historian, has been sincere throughout the process, including to his medical providers, in an earnest attempt to simply return to health. He fell at work, woke up in the hospital, and had to start anew. He has always answered the questions asked of him to the best of his present ability. As did, the ALJ finds, Robert Ayala.

E. The ALJ finds Dr. D'Angelo to be highly credentialed and respected. While the ALJ likewise finds Dr. D'Angelo to be sincere and credible in rendering her medical opinions, it does not necessarily render her *persuasive* on the ultimate issues. It is duly noted that greater persuasiveness sometimes occurs when one does not approach that line between expert and advocate. There is simply no need.

Compensability, Generally

F. A compensable injury is one that arises out of and occurs within the course and scope of employment. § 8-41-301(1)(b), C.R.S. An injury occurs in the course of employment when it was sustained within the appropriate time, place, and circumstances of an employee's job function. *Wild West Radio v. Indus. Claim Apps. Office*, 905 P.2d 6 (Colo. App. 1995). An injury arises out of employment when there is a sufficient causal connection between the employment and the injury. *City of Brighton v. Rodriguez*, 318 P.3d 496 (Colo. 2014). Where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove, by a preponderance of the evidence, a causal relationship between the work injury and the condition for which benefits are sought. *Snyder v. Indus. Claim Apps. Office*, 942 P.2d 1337 (Colo. App. 1997).

Mechanism of Injury

G. Respondents argue that the mechanism of injury has not been shown with sufficient particularity. The ALJ cannot concur. While it is true that there are differences in Claimant's recall of events and that of his brother, such differences are of insufficient materiality. In fact, when all details match perfectly is when one should take pause. Given what he went through, Claimant can be forgiven for being fuzzy on details, as

previously noted. He did his best at all times pertinent, and combined with that of Robert Ayala, his testimony and medical records are sufficient for the ALJ to conclude that 1) Claimant was standing on the scissor lift with Robert Ayala while on the job, 2) While on the scissor lift, Claimant suffered a heart attack - said heart attack not alleged to be caused by his employment - and lost consciousness, 3) Upon losing consciousness, Claimant fell within the scissor lift platform, striking his left occipital region on the mid-level metal bar- a distance of around 3 feet. The ALJ concludes that this mechanism is sufficient to cause the injuries Claimant suffers from.

Special Hazard of Employment

H. Purely idiopathic or personal injuries are generally not compensable under the Act, unless an exception applies. *City of Brighton v. Rodriguez,* 318 P. 3d 496, 503 (Colo. 2014). When it comes to idiopathic injuries, the "special hazard" doctrine represents an exception to the general rule of non-compensability, where an injury is compensable if the most direct cause of that injury is a preexisting idiopathic disease or condition so long as a special employment hazard also *contributed to* the injury. *Mitchell v. Food Bank of the Rockies*, W.C. No. 4-860-191-01 (ICAO August 16, 2012). However, to be considered an employment hazard, the employment condition must not be a ubiquitous one; it must be a special hazard not generally encountered. *Ramsdell v. Horn*, 781 P.2d 150, 151 (Colo. App. 1989). A special hazard of employment is one which increases either the risk of injury or the severity of injury when combined with the pre-existing condition, which is the direct or precipitating cause of the injury. *Id.* Stated another way, the question is whether the claimant was exposed to an employment hazard *not generally encountered outside the workplace. National Health Laboratories v. Industrial Claim Appeals Office,* 844 P.2d 1259 (Colo. App. 1992).

I. As noted by Claimant, a line of cases has found the existence of a special hazard-thus compensability- in a variety of contexts. In *Murray v. Colorado Department of Transportation*, W.C. No. 4-921-576-02 (June 10, 2014), sufficient evidence existed for a 'special hazard' when Claimant was injured on a set of 'stairs' on a ladder to a front end loader, in contrast to an ordinary staircase. In *Briggs v. Safeway, Inc*., W.C. No. 4-950-808-01 (July 8, 2015), a 'special hazard' was found to be present when the claimant fell, for an unexplained reason, onto a metal work table, injuring her head. The ALJ in that case found the existence of this metal work table to be more than simply a ubiquitous condition found in everyday life outside the workplace. The table itself was larger, heavier, fixed and more rigid than a table one might ordinarily find in a residential kitchen. That distinction was found to be sufficient for the ICAO.

J. Respondents seek to distinguish this case from *Briggs,* since the boxed steel bars in this scissor lift might be "hollow", and thus not "solid" like the table in *Briggs.* The ALJ is prepared to conclude that whether this scissor lift's mid-level bar is of "solid" or "hollow" construction is immaterial. Either way, when a worker strikes his head on this bar, it is the worker's head, and not the bar, that will bear the full force of the damage - unless this worker's name should be 'Curly'. Even if one assumes this steel bar is no different (which the ALJ does not) from the edge of a coffee table, it can hardly

be characterized as a hazard one might encounter in ordinary life outside of work. An essential component of Claimant's job duties is to climb into the confines of this metal platform, then rise up to 30 foot in the air. Should the platform not be sufficiently level and stable, one must return to earth to 'shim' the device and try again, lest the device fall over with all occupants aboard. Should a worker fall within the 'cage' for whatever reason, striking one of these steel bars in one direction or the other in some fashion is all but inevitable.

K. The ALJ therefore concludes that the scissor lift platform that Claimant occupied when he fell does fall within the ambit of "special hazard" of employment, in that it increased the likelihood of injury and/or severity of injury combined with Claimant's admittedly preexisting condition. This was more than an ordinary obstacle one might encounter in everyday life. Additionally, the risk of enhanced injury is greater when one hovers 30 foot above ground level.

Causal Relationship of Claimant's Injuries to the Work Accident

L. An "accident" is defined under the Act as an "unforeseen event occurring without the will or design of the person whose mere act causes it; an unexpected, unusual or undersigned occurrence." Section 8-40-201(1), C.R.S. In contrast, an "injury" refers to the physical trauma caused by the accident and includes disability. *City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967); *see also*, §8-40-201(2). Consequently, a "compensable" injury is one which requires medical treatment or causes disability. *Id*.; *Aragon v. CHIMR, et al.*, W.C. No. 4-543-782 (ICAO Sept. 24, 2004). No benefits are payable unless the accident results in a compensable "injury." § 8-41-301, C.R.S.

M. As noted earlier, Claimant has not followed the expected medical trajectory in reporting his symptoms and recovering from same. It happens. This Claimant was not acutely symptomatic for a few days - then he was. It is noted that his own ATPs, including Dr. Olsen, continued to treat his head and neck issues as *work injuries*, with possible post-concussive symptoms. Work restrictions were imposed, gradually loosened, but *remain in place as of November, 2018.* While the records suggest no objective evidence of disc or facet damage from this fall, the MRI did note an *effusion* which remains unexplained.

N. Dr. Olsen suspected soft tissue damage, in the form of a strain, to the cervical region, and made referrals to Dr. Sparr, who recommended treatment options, including trigger point injections. Those never occurred. No physician in Claimant's entire medical team suspected malingering. The ALJ finds unpersuasive the suggestion that Claimant's continuing neck problems might be due to remaining stationary in bed for a few days - instead of falling and bouncing his head on a steel bar at an oblique angle from several feet up, then falling two more feet to the floor. The latter is more likely, and the ALJ so finds.

Medical Benefits

O. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. § 8-42-101, C.R.S. Nevertheless, the right to workers' compensation benefits, including medical benefits, arises only when an injured employee establishes by a preponderance of the evidence that the need for medical treatment was proximately caused by an injury arising out of and in the course of the employment. § 8-41-301(1)(c), C.R.S.; *Faulkner v. Indus. Claim Apps. Office,* 12 P.3d 844, 846 (Colo. App. 2000). Claimant must establish the causal connection with reasonable probability but need not establish it with reasonable medical certainty. *Ringsby Truck Lines, Inc. v. Indus. Comm'n*, 491 P.2d 106 (Colo. App. 1971); *Indus. Comm'n v. Royal Indemnity Co.,* 236 P.2d 2993. A causal connection may be established by circumstantial evidence and expert medical testimony is not necessarily required. *Indus. Comm'n v. Jones*, 688 P.2d 1116 (Colo. 1984); *Indus. Comm'n v. Royal Indemnity Co., supra*, 236 P.2d at 295-296. All results flowing proximately and naturally from an industrial injury are compensable. *See Standard Metals Corp. v. Ball,* 172 Colo. 510, 474 P.2d 622 (1970).

P. In this case, the ALJ finds, by a preponderance of the evidence, that Claimant is entitled to all reasonable and necessary medical treatment for this work injury. His injuries are likely myofascial, possibly post-concussive, but his ATPs are to be the judge of that for now. He is not yet at MMI. Dr. Sparr's suggested treatment regimen should be followed, assuming it is still recommended at this point.

Temporary Total Disability

Q. To prove entitlement to temporary total disability ("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). C.R.S. § 8-42-103(1)(a), requires a 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)

R. The ALJ finds, by a preponderance of the evidence, that Claimant is entitled to TTD benefits. He suffered a compensable injury, and has been placed on restrictions by his ATP which prevent him from returning to work. There is no evidence of modified duty being offered to him by employer. The work restrictions provided by

his ATP remain in effect as of this Order, although hopefully Claimant can return to work soon with the medical treatment he is duly owed.

ORDER

It is therefore Ordered that:

1. Claimant's claim is compensable.

2. Respondents shall pay for all reasonable and necessary medical treatment to treat Claimant for his work injuries.

3. Claimant's Average Weekly Wage is $700.60.

4. Respondents shall pay Claimant Temporary Total Disability payments until terminated by operation of law.

5. 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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. 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: January 15, 2019

/s/ William G. Edie

William G. Edie
Administrative Law Judge
Office of Administrative Courts
2864 South Circle Drive, Suite 810
Colorado Springs, Colorado 80906

ISSUES

- Did Claimant prove he suffered a compensable low back injury?
- If Claimant suffered a compensable injury, are Respondents entitled to apportionment of medical benefits?
- Is Claimant entitled to TTD benefits from April 16, 2017 through August 14, 2017?

FINDINGS OF FACT

1. This claim involves an alleged low back injury with an injury date of May 1, 2016. Claimant has alleged both an occupational disease and an accidental injury.

2. Claimant has a long history of low back problems, including two surgeries. In 1986, he herniated disc after an episode of severe coughing. He tried conservative treatment for approximately a year-and-a-half and eventually had a discectomy in 1988. He did well until 2010 when his "sciatic" pain recurred with no specific injury or identifiable cause. In April 2011, he had an L4 laminectomy and L3 laminotomy for severe stenosis. The surgery was successful and Claimant returned to his regular work.

3. Claimant has worked as an automobile mechanic since approximately 1980. He worked at Employer's Honda dealership from April 2013 through December 7, 2017. Claimant's job is physically demanding, requiring frequent lifting, bending, stooping, twisting, and working in awkward postures.

4. In early May 2016, Claimant was removing a wheel from a vehicle when he felt "kind of a funny twinge in my back."[1] Claimant took some Advil he had in his toolbox and continued working. Claimant did not report the incident to Employer or seek medical treatment.

5. Claimant saw his PCP, Dr. Patrick Shahan, on June 15, 2016, but said nothing about any back or leg symptoms. The documented musculoskeletal examination shows no abnormalities of the thoracic or lumbar spine.

6. Claimant next saw Dr. Shahan on January 11, 2016. His immediate problem was an infected right great toe that had been painful for five days. Claimant also reported two months of "spasmodic type" central low back pain, "intermittent" radiating pain down both legs, and "occasional" numbness in the back of both legs. Claimant did not attribute the symptoms to any specific incident and denied any trauma to his back. Dr. Shahan noted Claimant was "overweight and does a fair amount of lifting at work as a mechanic."

[1] Claimant testified he was not sure the exact injury date, and used May 1, 2016 as his best approximation. He testified the incident happened "in May."

Physical examination showed no neurological deficits, no lumbar tenderness, and only "mild" pain with flexion and extension. Dr. Shahan diagnosed mechanical back pain and opined Claimant "could have" re-herniated a disc or it "could be muscular." He thought an MRI was not warranted because there were no neurological findings. Claimant declined physical therapy and no specific treatment was recommended. Dr. Shahan advised Claimant to "minimize" lifting at work, and completed a form clearing Claimant to drive for Uber.

7. On August 29, 2016, Claimant saw a chiropractor, Dr. Kevin Miller. He reported symptoms from his neck to his right sacroiliac area. His most significant complaints were "constant" 9/10 pain in the upper back, and "constant" 7/10 tightness/discomfort in the mid-chest. Dr. Miller palpated "mild" muscle spasms in the right sacroiliac, lower thoracic, and upper thoracic areas. Lumbar extension and flexion were "mildly reduced" with pain. The report contains no indication of any neurologic symptoms or deficits.

8. Claimant saw a massage therapist roughly every month in 2016. He started the massages on June 14, 2015, and reported pain in neck and trapezius muscles, low back, and the back of both thighs. In December 2015, February 2016, and March 2016 he received massage for low back pain. On April 25, 2016 (before the alleged date of injury), Claimant reported pain in his low back into the right leg.[2] The low back pain appears to have improved after that, because the June 2016 report does not mention Claimant's low back, and records from July and August only refer to low back "tightness."

9. Claimant worked regular duties with no limitation throughout the summer and into the fall of 2016.

10. On September 29, 2016, Claimant started feeling dizzy while repairing an airbag. His friend and co-worker, Jeff Buckham, drove Claimant to Walgreens to check his blood pressure. The reading was dangerously high, so they went to Claimant's cardiologist, who directed Claimant to the Penrose Hospital emergency room.

11. Claimant told the ER physician he felt "fine" until earlier that morning when he "developed abrupt onset of chest pain with associated chills, diaphoresis, and lightheadedness." The medical history section of the report notes "chronic" low back pain radiating to the right leg, but the review of systems indicates no current back pain. Claimant said nothing about any injury, received no workup for back pain or radicular symptoms, and received no diagnosis related to his back. Cardiac workup was negative, and Claimant was sent home.

12. Within a few days of the emergency room visit, Claimant developed severe low back pain. On October 3, 2016, Claimant reported the symptoms to Employer and completed an accident report. Claimant described "spasms" in his low back and stated

[2] As noted previously, Claimant's alleged date of injury is an approximation of when symptoms began, and Claimant's counsel argues the symptoms described in this note may be related to the incident at work. But the report contains no mention of Claimant's work and gives no suggestion the symptoms were work-related.

they were from “heavy lifting, crawling under dashes of vehicles.” Claimant listed the injury date as “May 2016.” Employer referred Claimant to its designated provider, CCOM.

13. Claimant saw Dr. Kathryn Murray at CCOM on October 3. Claimant reported back spasms and pain in both legs. She noted his prior back surgeries and that “he has had some level of back pain ever since.” Regarding the current symptoms, Dr. Murray documented,

> He states approximately 5/1/2016 his back pain worsened. He denies any one injury on that particular day or around that time and May 2016. He denies any trauma. He denies anything out of the ordinary such as longer working hours, heavier lifting, unusual positions, or increased workload.

Dr. Murray concluded,

> [T]his is not a work-related injury. Patient did not have one incident, anyone trauma, or anything out of the ordinary other than his normal day-to-day job. He has a pre-existing history of a herniated disc that required surgery in 1988 followed by laminectomy of his lumbar region and 2010. He has had some degree of ongoing back pain since that time. Would recommend for him to work with his PCP for further evaluation and treatment of his back pain.

14. Dr. Murray released Claimant at MMI with no restrictions.

15. Claimant also had a massage therapy appointment on October 3, 2016. He reported low back pain going down the right leg.

16. Employer completed a First Report of Injury on October 5, 2016, listing May 1, 2016 as the date of injury. The report indicates Claimant “said it is from heavy lifting and crawling in the course of his job.” There was no mention of a specific incident.

17. Claimant identified Mr. Buckham as a witness to the injury. Mr. Buckham testified at the hearing for Respondents. Mr. Buckham worked with Claimant daily in the adjoining service bay since June 2015. He and Claimant became friends outside of work. Mr. Buckham denied witnessing any accident involving Claimant’s low back. Mr. Buckham further testified exhibited no outward signs of back pain or any limitations before October 2016. Claimant said nothing about any back pain or leg symptoms on September 29 while Mr. Buckham was driving him around town and taking him to the ER. He spoke with Claimant at work on October 3, 2016, and Claimant said he had injured his back “a couple of months prior.” That was the first time Claimant mentioned any back injury to Mr. Buckham. The ALJ finds Mr. Buckham’s testimony credible.

18. Respondents filed a Notice of Contest on October 18, 2016.

19. On October 27, 2016, Claimant saw Dr. Kenneth Finn, a physical medicine and rehabilitation specialist. Claimant told Dr. Finn he recovered well after his last back surgery “with no pain until about May 2016 noticed a gradual increase of back pain with

radiation to the groin and both legs, right more than left." Dr. Finn noted, "his work is very physical and may be a contributing factor." Dr. Finn prescribed Norco and ordered a lumbar MRI.

20. The MRI was done on November 15, 2016. As compared to Claimant's prior March 2011 MRI, the radiologist noted a new L3-L4 disc extrusion or sequestration with caudal migration resulting in severe canal stenosis and moderate to severe left lateral recess stenosis. There was also mild to moderate caudal stenosis and moderate to severe bilateral foraminal stenosis at L4-L5.

21. Dr. Finn administered a lumbar epidural steroid injection, which gave Claimant 80% relief for one day. Dr. Finn upon further ESIs were not appropriate given the short duration of relief and recommended a surgical evaluation.

22. Claimant saw Dr. Paul Stanton, a spine surgeon, on January 24, 2017. Claimant told Dr. Stanton his pain started "mid-May of 2016" and worsened in October 2016. Claimant described the September 2016 hypertension episode and stated, "approximately one day after this he was having severe low back pain as well as right lower extremity weakness." The history portion of the report contains no discussion of any possible work-related etiology. Dr. Stanton ordered x-rays and reviewed the MRI images, which he interpreted as showing "severe central stenosis due to ligamentum flavum facet hypertrophy with a superimposed disc herniation" and disc space collapse with severe foraminal stenosis at L3-4 and L4-5 bilaterally. Dr. Stanton opined the only reasonable surgical option was an L3-L5 fusion.

23. Dr. Stanton subsequently issued an "addendum" to his report and stated, "based on a reasonable degree of medical certainty, at least 51% of probability [Claimant's] occupation as an automobile mechanic had a role in causing or aggravating and making him symptomatic of his lumbar spine."

24. Dr. Stanton performed a L3-4 and L4-5 decompression fusion on April 17, 2017 under Claimant's private health insurance. Dr. Stanton described the "operative indications" as "history of previous lumbar laminectomy with continued degeneration and progressive stenosis." Intraoperatively, Dr. Stanton observed significant scar tissue "due to the previous laminectomy" at L4-5 compressing the L5 nerve root. He also noted osteophytes and partial segmental ankyloses requiring facet osteotomy. Findings were similar at L3-4.

25. Dr. Kathy McCranie performed an IME for Respondents on December 28, 2017. Claimant attributed the back injury to the May 2016 incident lifting a wheel. He told Dr. McCranie his symptoms "escalated" in October 2016 after the ER visit. Claimant was recovering well from the April 2017 fusion and had returned to work in August 2017. Dr. McCranie opined Claimant's assertion that his back problems were triggered by lifting a wheel in May 2016 was not supported by the medical records. She noted work activities such as heavy lifting or combined lifting and twisting *can* contribute to low back pain and cause a disc herniation, but she did not believe they caused Claimant's back pain. Rather, Dr. McCranie concluded, "considering the degree of degenerative disc disease in the

patient's lumbar spine, it is medically probable that the symptoms would have developed regardless of his work activities." Dr. McCranie did not have Claimant's PCP records, so she remained open to changing her opinion "if there were additional medical records [that] supported [Claimant's] assertion that he had a specific work injury involving heavy lifting and twisting with the immediate onset of pain."

26. Dr. McCranie testified via deposition on January 30, 2018. She reviewed Dr. Shahan's records before the deposition and saw no reference to lifting a wheel in May 2016, or any other specific incident. The additional records reinforced Dr. McCranie's conclusion that claimant's back problems are not work-related. Dr. McCranie reiterated her opinion Claimant's symptoms and resulting surgery reflected the natural progression of his underlying pre-existing degenerative spine pathology. If (contrary to her opinion) the claim was ultimately deemed compensable, Dr. McCranie would apportion only 30% to 40% to the work injury.

27. The causation opinions of Dr. McCranie and Dr. Murray are credible and more persuasive than the contrary opinions in the record.

28. Claimant failed to prove he suffered a compensable accidental injury or occupational disease.

CONCLUSIONS OF LAW

To receive compensation or medical benefits, a claimant must prove he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *Pacesetter Corp. v. Collett*, *33 P.3d 1230* (Colo. App. 2001). The claimant must prove that an injury directly and proximately caused the condition for which he seeks benefits. *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).

The Workers' Compensation Act recognizes a distinction between an "accident" and an "injury." The term "accident" refers to an "unexpected, unusual, or undesigned occurrence," whereas an "injury" is the physical trauma caused by the accident. Section 8-40-201(1). In other words, an "accident" is the cause, and an "injury" is the result. *City of Boulder v. Payne*, 426 P.2d 194 (Colo. 1967). Workers' compensation benefits are only payable if an accident results in a compensable "injury." The mere fact that an incident occurred at work and caused symptoms does not establish a compensable injury. Rather, a compensable injury is one that requires medical treatment or causes disability. *E.g., Montgomery v. HSS, Inc*., W.C. No. 4-989-682-01 (August 17, 2016).

The mere existence of a pre-existing condition does not disqualify a claim for compensation or medical benefits. If an industrial injury aggravates, accelerates, or combines with a pre-existing condition to produce disability or a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). In evaluating whether a claimant suffered a compensable aggravation, the ALJ must determine if the need for treatment was the proximate result of the claimant's work or is

merely the direct and natural consequence of the pre-existing condition. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985); *Carlson v. Joslins Dry Goods Company*, W.C. No. 4-177-843 (March 31, 2000).

The Act imposes additional requirements for liability of an occupational disease beyond the "arising out of" and "course and scope" requirements. A compensable occupational disease must meet each element of the four-part test mandated by § 8-40-201(14), which defines an occupational disease as:

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

The equal exposure element effectuates the "peculiar risk" test and requires that the injurious hazards associated with the employment be more prevalent in the workplace than in everyday life or other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The claimant "must be exposed by his or her employment to the risk causing the disease in a measurably greater degree and in a substantially different manner than are persons in employment generally." *Id.* at 824. The hazard of employment need not be the sole cause of the disease, but must cause, intensify, or aggravate the condition "to some reasonable degree." *Id*.

As found, Claimant failed to prove a compensable accidental injury or occupational disease. The ALJ does not doubt the incident with the tire occurred as Claimant described around May 1, 2016. The problem is the lack of persuasive evidence linking that incident to the significant escalation of symptoms in October 2016 and eventual surgery. When Claimant saw his PCP on June 15, 2016, he said nothing about any back or leg symptoms. On July 11, 2016, Claimant reported back spasms and pain radiating down both legs "intermittently," but did not attribute the symptoms to any specific incident or activity. Physical examination at that visit showed no neurological deficits, no lumbar tenderness, and only "mild" pain with flexion and extension. An MRI was not warranted because there were no neurological findings. Claimant declined PT, and no specific treatment was recommended. In August 2016, Claimant's chiropractor documented nonspecific pain in multiple areas of his back, but there was no mention of any leg symptoms. Nor is there any suggestion the symptoms were related to Claimant's work. Massage records from June through August 2016 document no specific complaints and only "tightness" of Claimant's entire back. Claimant continued working without limitation through at least September 2016. The September 29, 2016 emergency room report noted a history of chronic low back and right leg pain, but mentions no current back or radicular symptoms. He had no workup for back pain and received no diagnosis related to his back. Claimant later told Dr. Stanton his back and leg symptoms became severe "approximately one day" after being treated at the emergency room. That coincides with the massage

therapy records, which consistently showed ongoing low back pain radiating to the right leg beginning on October 3, 2016, but not before.

The opinion evidence also points away from a compensable injury. Dr. Finn opined Claimant's work "may" have played a causal role in the development of his symptoms, but did not say a causal connection was probable. Although Dr. Stanton opined the symptoms are probably work-related, his opinion was conclusory and not accompanied by any detailed analysis. The ALJ finds the analysis and conclusions of Dr. McCranie and Dr. Murray more credible and persuasive than those offered by Dr. Finn and Dr. Stanton.

Except for the disc extrusion, the pathology shown on the MRI and observed intraoperatively was long-standing and degenerative in nature. Given the available medical records and other persuasive evidence regarding Claimant's condition before October 2016, the ALJ finds it implausible the disc extrusion occurred in May while lifting the wheel. Claimant may have suffered a minor back strain in May 2016, but it did not result in a compensable "injury" because it required no treatment and caused no disability. Although Claimant's job was physically demanding and could cause or aggravate a back condition over time, there is no persuasive evidence it did so in this case. The spontaneous worsening of Claimant's condition in October 2016 was probably due to the natural progression of his underlying degenerative pathology, without contribution from his work.

ORDER

It is therefore ordered that:

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

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, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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. 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: January 17, 2019

s/Patrick C.H. Spencer II
Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

ISSUES

- Did Claimant prove by a preponderance of the evidence that 12 occupational therapy sessions recommended by her treating surgeon, Dr. Cassidy, are reasonably necessary to cure and relieve the effects of her compensable injury?

FINDINGS OF FACT

1. Claimant worked for Employer as a stockbroker. She suffered an admitted injury to her right hand and thumb on July 19, 2015. The injury was initially diagnosed and treated as a CMC joint sprain. Over time, Claimant developed ligamentous instability in her MP joint and her ATP recommended an MP joint fusion.

2. Respondents denied the surgery and the case went to hearing before ALJ Edie on April 18, 2018. ALJ Edie approved the surgery in an order dated May 24, 2018. ALJ Edie's order contains detailed findings of fact regarding the claim history leading up to the hearing, which need not be repeated here. Neither party appealed ALJ Edie's order.

3. Surgery is now scheduled for May 31, 2019. The delay in proceeding with surgery was caused by two factors. The primary issue relates to Claimant's job. Her job with Employer was terminated in late March 2018. Claimant found new employment in May 2018, but she must be employed there for at least one year to qualify for FMLA leave.

4. The second factor was the retirement of Claimant's treating surgeon, Dr. Idler, in June 2018. Claimant was directed to Dr. Dale Cassidy, Dr. Idler's replacement at the Colorado Springs Orthopedic Group. Due to scheduling difficulties, Claimant did not see Dr. Cassidy until August 13, 2018.

5. Dr. Cassidy agreed with the recommendation for an MP joint fusion. He noted Claimant wears a thumb splint "full time" to prevent movement of the thumb. Dr. Cassidy occupational therapy while Claimant waits for surgery. Specifically, Dr. Cassidy stated, "we are going to get her working some with therapy on her range of motion and strengthening to help protect [the] area [as] she awaits surgical intervention."

6. On August 20, 2019, Dr. Cassidy submitted a request for 12 sessions of occupational therapy. The recommended modalities included paraffin, ultrasound, iontophoresis, and electrical stimulation.

7. Dr. Wallace Larson, an orthopedic surgeon, performed a records review regarding the therapy request on August 21, 2018. Dr. Larson opined therapy was not reasonably necessary because it would not help the ligamentous instability. He opined Claimant could do home exercises and strengthening, but formal physical therapy was not warranted.

8. Dr. Cassidy's opinions are more persuasive than the contrary opinions offered by Dr. Larson.

9. Claimant proved the 12 occupational therapy sessions recommended by Dr. Cassidy are reasonably necessary treatment for her admitted injury.

CONCLUSIONS OF LAW

The respondents are liable for medical treatment reasonably necessary to cure and relieve the effects of an industrial injury. Section 8-42-101(1)(a); *Snyder v. Industrial Claim Appeals Office*, 942 P .2d 1337 (Colo. App. 1997). Even if the respondents admit liability, they retain the right to dispute the relatedness of any particular treatment, and the mere occurrence of a compensable injury does not compel the ALJ to find that all subsequent medical treatment was caused by the industrial injury. *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. App. 1997); *McIntyre v. KI, LLC*, W.C. No. 4-805-040 (July 2, 2010). Where the respondents dispute the claimant's entitlement to medical benefits, the claimant must prove that an injury directly and proximately caused the condition for which he seeks benefits. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999). The claimant must prove entitlement to medical benefits by a preponderance of the evidence. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (1979). The facts in a workers' compensation case are not interpreted liberally, for either claimant or respondents. Section 8-43-201.

As found, Claimant proved the 12 occupational therapy sessions recommended by Dr. Cassidy are reasonable and necessary. Dr. Larson's rationale that therapy is unnecessary because it will not improve ligamentous instability is unpersuasive because Dr. Cassidy ordered therapy primarily as a prophylactic and preparatory measure pending surgery. Strengthening the thumb and hand is certainly reasonable given the long period of relative disuse. It is also reasonable to have the guidance of a therapist and other modalities not available at Claimant's home. Claimant has been through a protracted process of treatment and delay, culminating in the surgery scheduled for May 31, 2019, and it is both parties interest that she have a good result from surgery. The best way to improve her odds is to follow the recommendations of her surgeon.

ORDER

It is therefore ordered that:

1. Insurer shall cover the 12 occupational therapy sessions recommended by Dr. Cassidy.

2. All issues 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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. 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: January 18, 2019

s/Patrick C.H. Spencer II
Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

ISSUES

I. Whether Claimant proved by a preponderance of the evidence that medical treatment she received from North Suburban Medical Center Emergency Department and Diversified Radiology of Colorado on May 11, 2018, Montgomery Eye Care on May 17, 2018 and May 23, 2018, Dr. Chen on May 31, 2018, and Dr. Hamman on August 30, 2018 and November 8, 2018 was causally related to her May 9, 2018 industrial injury.

II. Whether Claimant proved by a preponderance of the evidence she is entitled to temporary indemnity benefits from May 9, 2018 through August 10, 2018.

STIPULATIONS

I. The parties stipulated to an average weekly wage ("AWW") of $776.98.

FINDINGS OF FACT

1. Claimant is a 51 year old woman who works for Employer as a head clerk.

2. On May 9, 2018, Claimant sustained an admitted industrial injury to her upper and lower extremities when she tripped on a shopping cart and fell.

3. The ALJ observed security footage of the incident. Claimant is observed taking a few steps then falling forward onto her knees and elbows. One camera angle clearly shows Claimant did not strike her head nor experience any whiplash-type motion from the fall. Claimant is observed immediately getting up, adjusting her clothes, checking her elbows and knees, smiling, laughing and talking to co-workers. Claimant does not appear to be confused or to have any issue walking and talking.

4. Claimant completed an Associate Work Related Injury/Illness Report approximately two hours after the fall. Claimant submitted a detailed handwritten three-page report regarding the incident. Under "Injury/Illness Type" Claimant wrote, "Both elbows both knees – wrist right hard time with filling out paper wrist (*sic*)." In describing the incident, Claimant wrote, in relevant part,

> I fell flat on floor landing on elbows & knees. Doug asked if I was ok I said not sure. I felt the pain from fall – I looked at elbows and knees after getting up. Doug left with buggy. I stayed back talking to RoseMarie and Emily. We looked at my elbows they started to have a knot and bruise. Looked at both knees they had bruises on both.

5. Claimant was wearing a wrist brace on her right wrist at the time of the fall. Claimant's written statement contains no mention of any alleged head injury or associated symptoms.

6. Claimant's supervisor, Doug Anton, was present during the fall and completed an In-Store Investigation Report. Mr. Anton documented that Claimant "tripped on buggie near time clocks and fell onto knees, elbow (right) and right wrist." Other co-workers also submitted written statements regarding Claimant's fall. None of the statements include any reference to any mechanism of injury to Claimant's head. Claimant was provided a designated providers list on May 9, 2018.

7. Claimant finished her shift on May 9, 2018 and worked her regular shift on May 10, 2018. She alleges she "got lost" on her way home from work on both May 9, 2018 and May 10, 2018 and had to call her mother for directions. There is no evidence Claimant reported these alleged incidents to Employer, experienced any cognitive issues affecting her ability to perform her regular job duties on these days, or sought medical attention on these days.

8. Claimant testified she was slurring her words by the morning of May 11, 2018 and sought treatment at authorized treating provider Concentra. Claimant presented to Darla Draper, M.D. on May 11, 2018 with complaints of bilateral knee pain, bilateral elbow pain and right hand soreness. Dr. Draper noted,

> While walking the pt tripped on a buggy and fell forward onto the elbows & knees onto tiled floor. She thinks she hit her head and had LOC for a couple seconds. R sided HA since injury + dyseqilibrium. She can't focus or think as well and writing penmanship is not as good as usual. Pt describes that she took wrong turns and was going in circles, trying to get to clinic. + nausea. Denies vomiting. Has a little numbness of R elbow. Bilateral hip and knee pain.

9. On physical examination Dr. Draper noted Claimant's judgment and insight were normal, her speech, mood and affect were appropriate, and her recent and remote memory was intact. She diagnosed Claimant with bilateral elbow and knee contusions and a concussion with loss of consciousness < 30 min. Due to Claimant's reports of a head injury and subjective complaints of associated symptoms, Dr. Draper instructed Claimant to have a friend or family member drive her to the emergency room. She also removed Claimant from work.

10. Claimant presented to the emergency department at North Suburban Medical Center at 3:14 p.m. on May 11, 2018 and was evaluated by the triage nurse at 3:22 p.m. It is noted that Claimant's chief complaint was head pain/injury. Meaghan M. Mercer, D.O. evaluated Claimant at 3:33 p.m. Claimant reported hitting her elbows and knees during a fall at work two days prior. Dr. Mercer noted, "Her next memory is looking up and seeing customers heading towards her. Pt reports unknown LOC, but positive head trauma. She went back to work for a couple hours immediately after the fall. She has felt confused since." Claimant complained of nausea, dizziness,

generalized pain, headache, fogginess and issues with memory. Dr. Mercer noted an atraumatic head, eyes, ears, nose, and throat exam, a normal neurological exam with normal mental status and normal cognition, and a GCS (Glasgow Coma Score) of 15. When reevaluated at 4:39 p.m., Claimant's pain had improved after receiving Toradol, and lab results were normal. However, at 5:01 p.m., it was noted "Pt is now c/o slurred speech and new onset left sided weakness in the past 20 minutes. On re-exam, pt had normal finger-nose, no pronator drift, no BLE drift but obvious weakness on left, subjective decreased sensation on left face and LUE." X-rays and CT scans were negative for acute abnormalities. A stroke evaluation and brain MRI were conducted. The MRI did not evidence any acute intracranial abnormality. Dr. Mercer's primary impression was post-concussive syndrome. Claimant was discharged with instructions to follow up with her physician.

11. Dr. Draper reevaluated Claimant on May 15, 2018. Claimant complained of right-sided headache, dysequilibrium, and issues with focusing and penmanship. Claimant also complained of changes in vision, forgetting what she was talking about mid-sentence, difficulty with word-finding, repeating things, and going off on tangents. On physical exam, Dr. Draper noted that Claimant's judgment, insight, speech, memory, mood and affect were normal. Her assessment included concussion with loss of consciousness, knee and elbow contusions, blurry vision and vertigo. She prescribed Claimant butalbital and meclizine for vertigo, physical therapy for the left knee, vestibular rehabilitation, and cognitive therapy. She referred Claimant for an ophthalmology evaluation and to Crosby and Chen, PLLC for a neurological evaluation for Claimant's "head/face." Dr. Draper released Claimant to modified duty on May 16, 2018 with the following restrictions: working two hours per day performing sedentary seated office duties, only in quiet darkened room, no work requiring high cognitive ability, and no driving to work.

12. Claimant also provided a 47-minute recorded statement to the claims adjuster on May 15, 2018. The ALJ listened to the entire recording in which Claimant coherently recalls and describes the May 9, 2018 work incident and subsequent events in great detail. Claimant's presentation on the recording is inconsistent with her reported symptoms of cognitive difficulties to her providers.

13. On May 17, 2018, Claimant saw Gary Mannheimer, O.D. at Montgomery Eye Care per the referral of Dr. Draper. Claimant reported hitting her head during a fall at work. She complained of decreased, cloudy, and foggy vision, as well as light sensitivity, pressure, floaters, flashes of light, and headaches. Claimant was assessed with unspecified visual field defects and prescribed eye drops for dry eye syndrome. Claimant attended a follow-up appointment at Montgomery Eye Care with James Montgomery, O.D. on May 23, 2018.

14. Dr. Draper reevaluated Claimant on May 18, 2018. Dr. Draper noted that referrals for a neurological evaluation, cognitive therapy, physical therapy and vestibular rehab were denied. Her assessment continued to include concussion with loss of consciousness. She continued Claimant's same work restrictions.

15. Claimant was seen by Debra J. Smith, M.D. at Concentra on May 23, 2018 and May 30, 2018 with continued complaints of headaches, dizziness, sensitivity to light and sound, and cognitive and memory problems. Dr. Smith's assessment included concussion with loss of consciousness, knee contusions, vertigo, and blurry vision. Claimant's work restrictions were as follows: working two hours a day performing simple, sedentary office tasks in a quiet setting, no climbing ladders, no driving to work, no working in safety sensitive positions, and no working at heights.

16. On May 31, 2018, Claimant saw Hua Judy Chen, M.D. at Crosby and Chen, PLLC for a neurological evaluation per the referral of Dr. Draper. Claimant reported thinking she hit her face and head when she fell during the work incident. On examination, Dr. Chen noted Claimant had an awake and alert mental status with no aphasia or dysarthia. Dr. Chen opined Claimant was likely suffering from a tension headache from a mild concussion and possible post-concussion syndrome with symptoms of cognitive difficulty.

17. Dr. Smith continued Claimant's same work restrictions on June 6, 2018 and June 18, 2016.

18. On July 2, 2018, Dr. Smith changed Claimant's restrictions to the following: working four hours a day in a quiet area performing simple tasks, no walking on uneven terrain, no climbing ladders, and no working is safety sensitive positions. Her assessment at the time was left knee contusion, right shoulder contusion and acute post-traumatic headache. She referred Claimant to Daniel R. Hamman, M.D. for evaluation and treatment of Claimant's left knee contusion. Dr. Hamman performed a prior knee replacement on Claimant in 2014.

19. On July 16, 2018, Dr. Smith's assessment was acute post-traumatic headache, left knee contusion, concussion with loss of consciousness, cognitive deficits, and right shoulder contusion. She again referred Claimant to Dr. Hamman, this time for both the left knee and right shoulder. Dr. Smith continued Claimant's same work restrictions.

20. On July 19, 2018, Dr. Hamman evaluated Claimant for left knee pain and performed a knee injection.

21. Dr. Smith reevaluated Claimant on July 26, 2018, noting Claimant received a shoulder injection and that physical therapy for Claimant's shoulder had been approved. Dr. Smith's assessment was acute post-traumatic headache, left knee contusion and right shoulder contusion. Dr. Smith assigned the following work restrictions: working six hours a day, lifting/pushing/pulling up to 10 pounds, taking a break every two hours to rest the knee, no reaching above shoulder with affected extremities, no repetitive motion with the right upper extremity, no climbing ladders, and no walking on uneven terrain.

22. On August 10, 2018, Dr. Smith released Claimant to work her entire shift with the same restrictions as assigned on July 26, 2018.

23. Claimant returned to Dr. Hamman for a follow-up evaluation on August 30, 2018. Dr. Hamman gave an assessment of acute right shoulder pain, right shoulder impingement, and left knee stiffness. He performed a right shoulder injection.

24. Claimant was referred to Kathy McCranie, M.D. for a psychiatric evaluation and impairment rating. Dr. McCranie reviewed Claimant's medical records and physically examined Claimant on October 26, 2018. Regarding the mechanism of injury, Claimant reported falling straight forward and striking her arms, left knee and head. Claimant denied any loss of consciousness. Dr. McCranie opined Claimant's work-related injury involved a left knee contusion, right shoulder sprain and posttraumatic headache. She assigned permanent impairment ratings for Claimant's right shoulder, left knee, and posttraumatic headaches.

25. On November 5, 2018 John Burris, M.D. performed an Independent Medical Evaluation ("IME") at the request of Respondent. Dr. Burris performed a medical record review, physically examined Claimant, and reviewed security footage of the May 9, 2018 work incident. He noted Claimant fell to the ground on her legs and elbows, did not strike her head, and was able to get up immediately. Dr. Burris noted no objective findings on his examination. He opined Claimant did not meet the criteria for a concussion or mild traumatic brain injury resulting from the May 9, 2018 work incident. He explained,

> Most importantly, she did not strike her head when she fell (which is clearly documented on the video footage of the event). Furthermore, there was no sign of head trauma at her medical evaluations (with GCS 15), no documented loss of conscious, no retrograde amnesia, repeated normal neurologic examinations, and a negative diagnostic workup (head CT and MRI). Throughout her care, [Claimant's] work restrictions assigned by her primary providers were focused on a presumed head injury. Because there was no head injury, these restrictions were not consistent with the nature of her injury, which was isolated soft tissue contusions. These types of injuries do not typically require any formal activity modification.

26. Dr. Burris opined Claimant's only work-related diagnoses were minor knee and elbow contusions. He concluded Claimant was at maximum medical improvement ("MMI") with no permanent impairment, restrictions or need for additional care.

27. Dr. Draper placed Claimant at MMI on November 7, 2018 with the impairment ratings assigned by Dr. McCranie. Dr. Draper recommended maintenance care in the form of appointments with a primary occupational provider for medication management for one year. Claimant was not assigned any permanent work restrictions.

28. There is no evidence Dr. Draper or Dr. Smith reviewed video footage of Claimant's May 9, 2018 fall. Despite Claimant's reports of a head injury, cognitive issues, and other associated symptoms, Dr. Draper and Dr. Smith consistently noted normal psychiatric findings on physical examination.

29. Dr. Hamman reevaluated Claimant on November 8, 2018 for left knee and right shoulder issues. He recommended surgical intervention for the left knee.

30. On December 1, 2018, Dr. McCranie performed an additional medical record review to assess whether there was evidence of a mechanism of injury for a head injury. Dr. McCranie reviewed Claimant's May 15, 2018 recorded audio statement, Dr. Burris' IME report, Dr. Hamman's records, and video footage of the work event. She noted Claimant was able to give a very detailed history of her work injury in her audio statement, with no evidence of retrograde or anterograde amnesia or cognitive impairment. Dr. McCranie further noted that video footage of the incident revealed Claimant did not hit her head and there was no loss of consciousness.

31. Based on her review of the additional information, Dr. McCranie opined there was no longer an impairment for Claimant's brain due to a lack of work-related mechanism of injury. She explained,

> ...it is clear there was no head injury. There was no impact to the head. There was no significant force that was involved that would cause a coup or countercoup head injury. There was no evidence of loss of consciousness. There was no amnesia. Previous review of the emergency records indicated a Glasgow coma scale of 15. MRI of the brain was negative as was a CAT scan of the head. There was no objective evidence that the patient sustained an injury to her head. Although she reported headaches and initially a blurred vision and cognitive symptoms, medical records reviewed by Dr. Burris showed that these were also preexisting conditions. For this reason, it is not reasonable that the patient would have a permanent impairment of the brain for either cognitive symptoms or headaches as there is no mechanism of injury to warrant an impairment in this regard.

32. Dr. Burris testified at hearing as an expert in occupational medicine. He continued to opine Claimant did not sustain any concussion or head injury as a result of the May 9, 2018 work event, based on the medical records, video footage of the incident, Claimant's May 9, 2018 written statement, and Claimant's May 15, 2018 recorded statement. Dr. Burris testified the video footage of the work incident clearly shows Claimant did not strike her head, lose consciousness, or have disequilibrium. He testified Claimant's complaints to Concentra were inconsistent with the video footage of her fall, her ability to walk after the fall, and Claimant's May 9, 2018 written statement, which went into great detail and showed no impairment of mental functioning.

33. Dr. Burris testified there was nothing unusual about Claimant's presentation for elbow and knee contusions that would have required an emergency department visit, and the medical records establish that Dr. Draper sent Claimant to North Suburban Medical Center Emergency Department only because of Claimant's subjective complaints of striking her head with loss of consciousness with associated symptoms. Dr. Burris testified that despite Claimant's subjective complaints, Claimant's emergency room evaluation showed no head abnormalities and a normal mental examination with a

GCS score of 15, which is the maximum rating showing normal cognitive functioning. Dr. Burris noted Claimant did not begin complaining of slurred speech until some later point in her emergency room evaluation, and testified her increased complaints over time were inconsistent with a closed head injury, as symptoms of a concussion are almost always worse immediately after the fall and begin to lessen over time.

34. As part of his evaluation, Dr. Burris listened to the entire recorded statement Claimant gave on May 15, 2018 and testified Claimant's mental status during the recorded statement "seemed perfectly normal." He testified Claimant spoke in normal speech patterns, answered questions appropriately, and seemed very aware and detail-oriented during the recording. Dr. Burris opined Claimant displayed complete recall of events despite her making some subjective comments about her inability to recall certain things. Dr. Burris testified there was no evidence in the recorded audio statement on to substantiate Claimant's subjective complaints of memory loss, cognitive difficulties or communication problems to Dr. Draper on that same date.

35. Dr. Burris testified the care Claimant received at North Suburban Medical Center Emergency Department, Montgomery Eye Care, and Crosby and Chen were due to a presumed head injury that did not occur, and thus were not causally-related to Claimant's work injury. Dr. Burris testified that medical records evidenced complaints of blurred vision and other vision problems prior to the work injury. He further testified the work restrictions imposed on Claimant from May 11, 2018 through July 25, 2018 were not reasonable, necessary or related to Claimant's knee and elbow injuries.

36. Claimant testified at hearing but did not offer any testimony regarding the mechanism of injury or any purported inability to work due to her knee and elbow injuries. She testified she received treatment at North Suburban Medical Center, Montgomery Eye Care, Crosby and Chen, Diversified Radiology of Colorado, P.C. and Dr. Hamman per the referrals of Drs. Draper and Smith.

37. The medical bill for Diversified Radiology of Colorado, P.C. reflects charges for the x-rays, CT scans and MRI obtained at North Suburban Medical Center Emergency Department on May 11, 2018.

38. Claimant did not work or earn any wages from May 11, 2018 through June 23, 2018 because Employer could not accommodate her work restrictions. Employer began accommodating Claimant's work restrictions on June 24, 2018, when Claimant returned to work for two hours a day. Claimant continued working in a modified capacity through August 10, 2018, earning less than her normal wage. Claimant returned to making her normal wage on August 11, 2018 when she was released to work her entire shift.

39. The ALJ credits the opinions of Drs. Burris and McCranie, as supported by the medical records, employment records, video security footage and audio recorded statement, over the conflicting opinions of Drs. Draper and Smith and finds Claimant did not sustain a head injury or associated symptoms as a result of the May 9, 2018 work event.

40. Claimant failed to prove by a preponderance of the evidence the medical treatment she received at North Suburban Medical Center Emergency Department (including Diversified Radiology of Colorado) on May 11, 2018, Montgomery Eye Care on May 17, 2018 and May 23, 2018, and Crosby and Chen on May 31, 2018 was causally related to the May 9, 2018 work injury. This treatment was for the purpose of evaluating a presumed head injury and associated symptoms, which were unrelated to Claimant's May 9, 2018 work injury.

41. Claimant proved by a preponderance of the evidence the medical treatment provided by Dr. Hamman to address Claimant's left knee and right upper extremity on August 30, 2018 and November 8, 2018 was causally related to her May 9, 2018 work injury.

42. Claimant failed to prove by a preponderance of the evidence she is entitled to temporary indemnity benefits from May 9, 2018 through July 25, 2018. Claimant did not suffer any actual wage loss on May 9, 2018 or May 10, 2018. While Claimant suffered wage loss from May 11, 2018 through July 25, 2018, the wage loss was not the result of a disability caused by the industrial injury. Claimant's work restrictions from May 11, 2018 through July 25, 2018 specifically addressed Claimant's alleged head injury associated symptoms, were unrelated to the May 9, 2018 work injury.

43. Claimant proved by a preponderance of the evidence she is entitled to TPD from July 26, 2018 through August 10, 2018. During such time period, Claimant suffered actual wage loss due to restrictions that specifically addressed her upper and lower extremities, which were caused by the May 9, 2018 industrial injury.

44. Evidence and inferences contrary to these findings were not credible or persuasive.

CONCLUSIONS OF LAW

Generally

The purpose of the Workers' Compensation Act of Colorado (the "Act"), Sections 8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimants shoulder 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 claimants nor in favor of the rights of respondents. Section 8-43-201, C.R.S.

Assessing weight, credibility, and sufficiency of evidence in a workers' compensation proceeding is the exclusive domain of the administrative law judge. *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it

is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission,* 165 Colo. 504, 441 P.2d 21 (1968).

The ALJ's factual findings concern only evidence found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence 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).

Medical Treatment

A respondent is liable to provide such medical treatment "as may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee of the effects of the injury." Section 8-42-101(1)(a), C.R.S. *Colorado Compensation Insurance Authority v. Nofio*, 886 P.2d 714 (Colo. 1994). The determination of whether a particular treatment is reasonable and necessary to treat the industrial injury is a question of fact for the ALJ. *See generally Parker v. Iowa Tanklines, Inc.*, W.C. No. 4-517-537 (May 31, 2006); *Chacon v. J.W. Gibson Well Service Company*, W. C. No. 4-445-060 (February 22, 2002). The question of whether the need for treatment is causally related to an industrial injury is also one of fact for the ALJ. *Walmart Stores, Inc. v. Industrial Claims Office,* 989 P.2d 521 (Colo. App. 1999). Where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove a causal relationship between a work-related injury and the condition for which benefits or compensation are sought. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337, 1339 (Colo.App.1997).

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 authorized treating physician 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)

Claimant argues Respondent is liable for the cost of treatment provided by North Suburban Medical Center Emergency Department, Montgomery Eye Care, Dr. Chen, and Dr. Hamman because such treatment fell within the scope of authorized treatment. While Claimant received the aforementioned treatment upon the referral of her authorized treating physicians, this is not by itself, dispositive of whether the treatment was causally related to Claimant's work injury.

As found, the treatment provided by North Suburban Medical Center Emergency Department, Montgomery Eye Care, and Dr. Chen was not casually related to Claimant's May 9, 2018 industrial injury. The overwhelming evidence establishes Claimant did not sustain a head injury or associated symptoms as a result of the May 9, 2018 work injury. Video footage of the incident refutes Claimant's reported version of events, clearly showing Claimant did not strike her head, experience any whiplash-type motion, or lose consciousness. Claimant immediately got up from the floor after falling, spoke to her co-workers, laughed and smiled. Her detailed written incident report contains no mention of any alleged head trauma or associated symptoms. Claimant finished her shift on May 9, 2018 and worked her normal shift on May 10, 2018, with no evidence of any cognitive inability to perform her duties. While she alleges she got lost returning home from work on both days, there is no evidence Claimant reported this to Employer or sought medical attention at the time, which would be expected had such events actually occurred.

Claimant's course of treatment with respect to an alleged head injury and associated symptoms was based on Claimant's misrepresentations regarding the mechanism of injury and her subjective complaints. At her initial evaluation, Claimant informed Dr. Draper she thought she hit her head and had loss of consciousness during the May 9, 2018 work event. She complained of headaches, confusion, dysequilibrium and other cognitive issues. Claimant continued to misrepresent the mechanism of injury and report the same or increasing symptoms to her providers throughout the course of her treatment. Drs. Burris and McCranie are the only doctors who had the benefit of reviewing video footage of the work even and the recorded audio statement. Both Drs. Burris and McCranie credibly and persuasively opine Claimant did not sustain any injury to her head as a result of the May 9, 2018 work event.

Despite the absence of any objective findings of head trauma, Claimant was referred for evaluation of her head complaints based on an erroneous belief there was, in fact, a mechanism of injury to Claimant's head. Dr. Burris credibly testified that Dr. Draper sent Claimant to the emergency room due to a presumed head injury, and that Claimant's upper and lower extremity injuries did not require emergent care. Claimant was subsequently referred to Montgomery Eye Care and Dr. Chen for vision and neurological evaluations due to the presumed head injury. As Claimant did not sustain a head injury during her May 9, 2018 work event, this treatment was not causally related. Based on the totality of the evidence, Claimant failed to meet her burden to prove the treatment provided by North Suburban Medical Center Emergency Department,

Montgomery Eye Care, and Dr. Chen were causally related to the injuries Claimant sustained on May 9, 2018.

Claimant did meet her burden, however, to prove the treatment provided by Dr. Hamman on August 30, 2018 and November 8, 2018 was casually related to the May 9, 2018 work event. The treatment provided by Dr. Hamman was directed at Claimant's left knee and right extremity, which were injured in Claimant's fall on May 9, 2018.

Temporary Indemnity Benefits

To prove entitlement to temporary indemnity 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. *Anderson v. Longmont Toyota,* 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. *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). The existence of disability presents a question of fact for the ALJ.

As found, Claimant failed to prove by a preponderance of the evidence she is entitled to TTD or TPD benefits from May 9, 2018 through July 25, 2018. Claimant finished her shift on May 9, 2018 and worked her normal shift on May 10, 2018. As such, she did not suffer any wage loss for those two day. Claimant's subsequent wage loss from May 11, 2018 through July 25, 2018 was due to restrictions specifically imposed to address Claimant's alleged head injury, which was not causally related to the May 9, 2018 work event. Dr. Burris credibly testified Claimant's work restrictions during this time period were not reasonable, necessary or related to the upper and lower extremity injuries Claimant sustained as a result of the May 9, 2018 work event. There is insufficient credible and persuasive evidence establishing that the industrial injury, which consisted of injuries to Claimant's upper and lower extremities, produced a disability resulting in actual wage loss from May 11, 2018 through July 25, 2018.

As found, Claimant did, however, meet her burden to prove entitlement to TPD July 26, 2018 through August 10, 2018. During such time period, Claimant did not earn her normal wage due to work restrictions limiting her hours. The restrictions assigned by Dr. Smith during this time period specifically addressed Claimant's knee and upper extremity conditions, which were related to the May 9, 2018 work injury.

ORDER

It is therefore ordered that:

1. Respondent shall pay for the medical treatment provided by Dr. Hamman on August 30, 2018 and November 8, 2018, subject to the Medical Fee Schedule.

2. Respondent is not liable for the cost of medical treatment provided by North Suburban Medical Center Emergency Department and Diversified Radiology of Colorado on May 11, 2018, Montgomery Eye Care on May 17, 2018 and May 23, 2018, and Dr. Chen on May 31, 2018, as such treatment was not casually related to Claimant's May 9, 2018 industrial injury. Claimant's claim for these specific benefits is denied and dismissed.

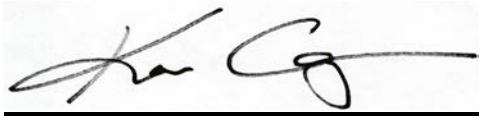
3. Respondent shall pay Claimant TPD from beginning July 26, 2018 through August 10, 2018.

4. Claimant claim for temporary indemnity benefits beginning May 9, 2018 through July 25, 2018 is denied and dismissed.

5. 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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. 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: January 17, 2019



Kara R. Cayce
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

ISSUES

- Did Claimant prove entitlement TTD benefits from March 8, 2018 to August 6, 2018?
- Did Respondents prove Claimant was responsible for termination of his employment?
- If Claimant is entitled to TTD, did Respondents prove entitlement to an offset for unemployment benefits?
- Did Respondents prove a March 20, 2018 motor vehicle accident was an "intervening event" sufficient to sever the causal relationship between Claimant's work injury and his wage loss?

FINDINGS OF FACT

1. Claimant worked for employer as a pest exterminator. His job duties included traveling to job sites in a company vehicle and providing extermination services.

2. Claimant suffered an admitted injury on June 23, 2016 when he rolled his ankle and tore his left Achilles tendon.

3. Dr. Michael Simpson surgically repaired the ruptured Achilles tendon on July 14, 2016. Claimant subsequently developed problems with keloid scar formation.

4. Claimant was put at MMI on December 20, 2016 with a permanent impairment rating. Respondents filed an FAL admitting for the rating and medical benefits after MMI.

5. Dr. Sandell subsequently took over as Claimant's primary ATP. Dr. Sandell referred Claimant to Dr. Heinz, a plastic surgeon, to consider keloid scar removal surgery.

6. Respondents obtained an IME from Dr. Kathy McCranie on March 15, 2017. Dr. McCranie agreed surgical scar revision was reasonably necessary but opined, "As this surgery is not likely to change the patient's overall function, I would recommend that this be done under maintenance care."

7. Dr. Heinz performed keloid excision surgery on May 17, 2017.

8. Notwithstanding Dr. McCranie's opinion surgery could have been done under maintenance care, Respondents reopened the case and paid additional TTD benefits. The admitted average weekly wage is $845.91, with a corresponding TTD rate of $562.97 per week.

9. Claimant recovered from the surgery in approximately two months, and Dr. Sandell put him back at MMI on July 31, 2017. Dr. Sandell assessed no work restrictions or additional permanent impairment.

10. Respondents filed another FAL on September 21, 2017 based on Dr. Sandell's July 31, 2017 MMI report. Claimant objected to the FAL and requested a DIME.

11. Claimant underwent a DIME with Dr. J. Stephen Gray on January 3, 2018. Dr. Gray agreed Claimant reached MMI on July 31, 2017 as determined by Dr. Sandell. He assigned a 7% scheduled lower extremity rating for range of motion and 10% whole person rating for Class II permanent skin impairment. Dr. Gray recommended bi-annual follow-up visits with Dr. Heinz for potential keloid scar revisions. He noted that, "[Claimant's] care may be handled under 'maintenance care,' although he may require temporary restrictions postoperatively."

12. Claimant followed up with Dr. Heinz on February 6, 2018. He was working full duty and "doing reasonably well." The scar was "much better than previous," and Dr. Heinz opined surgery was "certainly" not indicated at that time. He gave Claimant a Kenalog injection and advised him to wear a silicone insert under his sock.

13. Employer terminated Claimant's employment on February 20, 2018, due to discrepancies between Claimant's service tickets and corresponding "MOBI" reports showing Claimant's location from a GPS tracking system on his vehicle.

14. Respondents filed an FAL on March 5, 2018 based on Dr. Gray's DIME report. The FAL admitted for reasonable and necessary medical care.

15. Claimant had a follow-up appointment with Dr. Heinz on March 8, 2018. The recurrent keloid had progressed and was causing significant pain, particularly by the end of the workday. Dr. Heinz opined if Claimant were not improved by his next follow-up, he would revise the scar "one last time."

16. Claimant saw Dr. Sandell on March 20, 2018. He reported "increased pain" and return of the keloid. Dr. Sandell agreed surgery was appropriate but deferred to Dr. Heinz regarding the timing of surgery.

17. Also on March 20, 2018, Claimant was involved in a rear-end motor vehicle accident. Claimant presented the Penrose St. Francis emergency department on March 21, 2018. He indicated he hit his head, but did not lose consciousness. He described back pain, chest pain, headaches, nausea, neck pain, and vomiting. There is no indication Claimant injured his left leg or foot.

18. Claimant saw a chiropractor on March 21, 2018 for additional treatment relating to the MVA. On the intake form, he reported sore muscles, low back problems, and dizziness. He also checked a box stating, "I cannot do my usual work" due to neck pain. Claimant had six additional chiropractic visits through the end of April 2018.

19. Claimant followed up with Dr. Sandell on May 8, 2018. Dr. Sandell opined Claimant was no longer at MMI, stating, “I feel he should be off MMI status as of the date that his surgeon recommended that he have repeat surgery. That date is March 8, 2018.”

20. Dr. Heinz performed the scar revision surgery on May 21, 2018. Respondents covered the procedure, but believe surgery was “maintenance care” and Claimant remains at MMI.

21. Claimant saw Dr. Sandell on June 14, 2018, and reported, “This was one of the more painful surgeries he went through.” He was using a walking boot and following restrictions “as per his surgeon’s recommendations.” Dr. Sandell continued Claimant “off of MMI.”

22. On July 16, 2018, Dr. Sandell noted Claimant was restricted to working no more than six hours per day, with no work on ladders, stairs, or uneven ground. He was continuing to improve from surgery. Claimant was “anxious to get back to work” and hoping Dr. Heinz would remove the restrictions at his next appointment.

23. Claimant followed up with Dr. Sandell on August 6, 2018, who noted, “he continues to improve and recover from surgery. He is doing better with regards to pain control.” Dr. Sandell released Claimant to return to work without restrictions.

24. On October 2, 2018, Dr. Sandell described Claimant as “doing well” and “stable,” with “decreasing” pain. He refilled Claimant’s pain medication and released him to follow-up “as needed.” Dr. Sandell later opined Claimant had reached MMI on October 2, 2018 with no additional impairment.

25. Dr. McCranie testified at hearing for Respondents. Dr. McCranie explained keloids are essentially a fibrotic tumor that grows over a wound. Surgical excision is the most common treatment, but recurrence rates typically run between 70% and 100%. In Claimant’s case, the keloid formed because of the original Achilles tendon surgery. Dr. McCranie agreed the keloid surgeries were reasonably necessary but opined the surgery is best described as maintenance care. A keloid scar is a chronic condition that worsens over time as it slowly regrows. Dr. McCranie opined the purpose of the surgery was to keep Claimant’s condition from worsening due to the natural disease process inherent in keloid scar formation.

26. Claimant filed for unemployment (UI) benefits in mid-April 2018. He was eventually approved for $474 per week, commencing the week ending April 14, 2018. Claimant did not request or receive UI benefits from May 20, 2018 through June 23, 2018 (5 weeks) because of the surgery. Claimant’s UI benefits resumed effective June 24, 2018 and continued through October 6, 2018.

27. Dr. Sandell’s opinions regarding MMI are credible and more persuasive than the contrary opinions offered by Dr. McCranie. Claimant was no longer at MMI as of March 8, 2018.

28. The keloid revision surgery was intended to cure and relieve the effects of Claimant's injury. It was not "maintenance" care.

29. Respondents proved Claimant was responsible for termination of his employment on February 20, 2018.

30. Claimant proved his condition worsened and caused increased disability as of May 21, 2018, the date of the surgery. The worsened condition caused a wage loss starting on May 21, 2018. Claimant failed to prove he had increased disability or any injury-related wage loss before May 21, 2018.

31. Claimant's eligibility for TTD benefits ended on August 6, 2018 when Dr. Sandell released him to return to regular employment.

32. Respondents proved an offset for UI benefits from June 24, 2018 through August 5, 2018.

CONCLUSIONS OF LAW

A. Claimant's condition worsened after the July 31, 2017 MMI date

Section 8-43-303 authorizes an ALJ to reopen any award on the grounds of error, mistake, or a change in condition. The allowance for reopening reflects a "strong legislative policy" that the goal of achieving a fair and just result overrides the interests of litigants in obtaining final resolution of their dispute. *Padilla v. Industrial Commission*, 696 P.2d 273, 278 (Colo. 1985). Thus, a "final" award means only that the matter has been concluded subject to reopening if warranted under the applicable statutory criteria. *Renz v. Larimer County School District Poudre R-1*, 924 P.2d 1177 (Colo. App. 1996). The authority to reopen a claim is permissive, and whether to reopen a claim if the statutory criteria have been met is left to the ALJ's discretion. *Id*. The party requesting reopening bears the burden of proof. Section 8-43-304(4).

Claimant requests his claim be reopened based on mistake, error, or a change of condition. A "change in condition" refers either to a change in the condition of the original compensable injury, or a change in the claimant's physical or mental condition that can be causally related to the original injury. *Heinicke v. Industrial Claim Appeals Office,* 197 P.3d 220 (Colo. App. 2008); *Chavez v. Industrial Commission,* 714 P.2d 1328 (Colo. App. 1985). If a claimant's condition is shown to have changed, the ALJ should consider whether the change represents the natural progression of the industrial injury, or results from an intervening cause. *Goble v. Sam's Wholesale Club*, W.C. No. 4-297-675 (May 3, 2001).

As found, Claimant proved his condition worsened since he was put at MMI on July 31, 2017. Medical records from Dr. Heinz and Dr. Sandell show a steady worsening of the keloid and increasing pain in early 2018, culminating in the recommendation for surgery.

B. MMI and impact on Claimant's earning capacity

Even if a claimant's condition has worsened, reopening is only appropriate if additional benefits can be awarded. *Richards v. Industrial Claim Appeals Office*, 996 P.2d 756 (Colo. App. 2000). Here, Claimant seeks reopening for additional TTD benefits. Claimant's eligibility for TTD hinges on two questions. First, was the May 21, 2018 surgery "curative" or merely "maintenance" in nature? Second, did Claimant's worsened condition cause increased disability and contribute to a wage loss?

The type of treatment is not dispositive of whether the treatment is intended to "cure and relieve" or simply "relieve" the claimant's condition. It is the *purpose* for which treatment is provided, rather than the *nature* of the treatment, that determines whether the treatment is curative or provided for permissible post-MMI purposes. *Milco Construction v. Cowan*, 860 P.2d 539, 542 (Colo. App. 1992). Here, the ALJ is persuaded the May 21, 2018 surgery was intended to improve Claimant's condition rather than simply relieve symptoms or prevent deterioration. Claimant's condition had worsened, and the surgery was undertaken to restore him to his baseline level as of the original July 31, 2017 MMI date. Moreover, the surgery required a convalescence and recovery period of two and one-half months, which also supports a finding it was more than "maintenance." The ALJ credits Dr. Sandell's opinion Claimant was no longer at MMI as of March 8, 2018.

A worsening after MMI does not automatically entitle a claimant to additional TTD benefits, unless the worsened condition causes a "greater impact upon [the] claimant's temporary work capability." *City of Colorado Springs Disposal v. Industrial Claim Appeals Office*, 954 P.2d 677 (Colo. App. 1997). The dispositive question is whether the claimant proves "increased disability, as measured by [their] capacity to earn wages." *Friesz v. Wal-Mart Stores, Inc*., W.C. No. 4-823-944-01 (July 26, 2012). The ICAO has repeatedly held that *City of Colorado Springs* does not require a claimant to establish an "actual wage loss," and a claimant may recover TTD even if he not working immediately before his condition worsened. *E.g.*, *Hebert v. Blac Frac Tanks, Inc*., W.C. No. 4-919-279-01 (October 19, 2018); *Garcia v. Frontier Airlines*, W.C. No. 4-677-511 (August 17, 2011); *Moss v. Denny's Restaurants*, W.C. No. 4-440-517 (September 27, 2006). As the Panel explained in *Friesz v. Wal-Mart, supra*,

> [T]he critical issue in cases controlled by *City of Colorado Springs* is not whether the worsened condition actually resulted in additional temporary wage loss, but whether the worsened condition has had a greater impact on the claimant's temporary work "capacity." . . . It therefore follows that it is the impact on the claimant's work "capacity," not proof of an actual wage loss, which determines whether the claimant has established entitlement to TTD benefits in connection with a worsening of condition after MMI. [Internal citations omitted].

As found, Claimant's worsened condition caused a greater impact on his work capacity as of May 21, 2018, the date of surgery.

C. The termination statutes do not bar an award of TTD

Sections 8-42-103(1)(g) and 8-42-105(4) preclude an award of TTD benefits if a claimant was "responsible for termination" of his employment. The respondents must prove by a preponderance of the evidence that a claimant was terminated for cause or was responsible for the separation from employment. *Gilmore v. Industrial Claim Appeals Office*, 187 P.3d 1129, 1132 (Colo. App. 2008). To establish that a claimant was responsible for termination, the respondents must show the claimant performed a volitional act or otherwise exercised "some degree of control over the circumstances which led to the termination." *Colorado Springs Disposal v. Industrial Claim Appeals Office*, 5 P.3d 1061, 1062 (Colo. App. 2002); *Padilla v. Digital Equipment Corp*., 902 P.2d 414 (Colo. App. 1995); *Velo v. Employment Solutions Personnel*, 988 P.2d 1139 (Colo. App. 1988).

Respondents proved Claimant was responsible for termination of his employment on February 20, 2018. But the termination statutes are not a permanent bar to receiving temporary disability benefits, and a claimant can reestablish eligibility for TTD by showing a worsened condition that causes a subsequent wage loss. *Anderson v. Longmont Toyota*, 102 P.3d 323 (Colo. 2004). A post-termination wage loss is "caused by a worsened condition" if the worsening results in limitations or restrictions which did not exist at the time of the termination, and which cause a limitation on the claimant's temporary earning capacity that did not exist when she caused the termination. *Martinez v. Denver Health*, W.C. No. 4-527-415 (ICAO, August 8, 2005). The mere imposition of additional work restrictions does not automatically establish a worsened condition. *Apex Transportation, Inc. v. Industrial Claim Appeals Office*, 321 P.3d 630 (Colo. App. 2014). The burden of proof to establish a subsequent worsening and consequent decrease of earning capacity is on the claimant. *Green v. Job Site, Inc.*, W.C. No. 4-587-025 (ICAO, July 19, 2005).

As found, Claimant proved that his injury-related medical condition deteriorated and caused greater limitations on his ability to work than were present at the time of his termination. The ALJ is persuaded Claimant was precluded from performing any work activity for at least a brief period after surgery, and then remained under restrictions that prevented returning to his regular work. These facts are sufficient to commence TTD as of May 21, 2018.

D. Termination of TTD based on release to full duty

Once commenced, TTD benefits continue until one of the terminating events enumerated in § 8-42-105(3). Here, Dr. Sandell released Claimant to return to regular duty on August 6, 2018. *See* § 8-42-105(3)(c). Thus, Claimant is entitled to a closed period of TTD benefits from May 21, 2018 through August 5, 2018.

E. Respondents proved an offset for UI benefits

Section 8-42-103(1)(f) provides that TTD benefits shall be reduced by any concurrent unemployment benefits a Claimant received. As found, Claimant was paid UI

benefits from June 24, 2018 through the end of the closed period of TTD. Thus, Respondents are entitled to an offset for UI benefits from June 24 through August 5, 2018, a period of 6 1/7 weeks (43 days).

F. Respondents' intervening event defense is moot

Even if the ALJ found the March 20, 2018 MVA was an intervening event regarding Claimant's wage loss, the May 21 surgery substantially increased his disability and re-established a causal nexus between the injury and his wage loss. Since the ALJ has awarded no TTD benefits before the surgery, Respondents' intervening event defense is moot.

ORDER

It is therefore ordered that:

1. Claimant's request for TTD benefits from March 8, 2018 through May 20, 2018 is denied and dismissed.

2. Insurer shall pay Claimant TTD benefits at the admitted rate from May 21, 2018 through August 5, 2018, subject to an offset for UI benefits Claimant received from June 24, 2018 through August 5, 2018.

3. Insurer shall pay Claimant statutory interest of 8% per annum on all benefits not paid when due.

4. Respondents' intervening event defense is denied and dismissed as moot.

5. All issues not decided 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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. 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: January 23, 2019

s/Patrick C.H. Spencer II
Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 5-952-264-001

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

Claimant,

v.

Employer,

and

Insurer / Respondents.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on January 2, 2019, in Denver, Colorado. The hearing was digitally recorded (reference: 1/2/19, Courtroom 3, beginning at 1:30 PM, and ending at 2:00 PM).

Respondents' Exhibits A and A-1 were admitted into evidence, without objection.

At the conclusion of the unilateral hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to counsel for the Respondents, which was filed, electronically on January 11, 2019. After a consideration of the proposed decision, the ALJ has modified it and hereby issues the following decision.

ISSUE

The issue designated on Respondents' Application for Hearing and to be determined by this decision concerns an overpayment to the Claimant of $48,512.76.

Respondents bear the burden of proof by a preponderance of the evidence.

FINDINGS OF FACT

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

Notice

1. The ALJ takes administrative notice of the files and records of the Office of Administrative Courts (OAC) and the Division of Workers Compensation (DOWC), which disclose that the Claimant's last known, regular and registered address is xxxxxxx

2. Notice of the hearing, scheduled for January 2, 2019 at 1:30 PM, in Denver, CO, at the OAC, was mailed and emailed to the Claimant at his last known, regular and registered address; and, emailed to the Claimant at his registered email address on November 6, 2018. The ALJ takes administrative notice of the official acts of the OAC and the DOWC.

3. None of the Notices of the January 2, 2019 hearing mailed or emailed to the Claimant were returned as undeliverable. Therefore, there is a legal presumption of receipt, and the ALJ finds that the Claimant received notice of the hearing and elected not to appear.

4. Exhibit A-1 establishes that Respondents sent a letter to the Claimant at his last known, regular and registered address, 7656 Dusk Street, Littleton, CO 80125, via certified mail. The mailing was returned, marked "unclaimed." The ALJ infers and finds that the Claimant chose not to claim the letter.

Overpayment

5. Respondents paid a total of $126,587.95 in temporary total disability (TTD) benefits to the Claimant from June 20, 2016 through February 14, 2017 (Exhibit A).

6. ALJ Margot W. Jones, in her Order of June 6, 2018, determined that the Claimant's date of maximum medical improvement (MMI) was February 15, 2016, with a permanent 4% upper extremity impairment rating, thus, the Claimant was overpaid in TTD benefits.

7. Consistent with ALJ Jones' Order, Respondents filed a Final Admission of Liability (FAL) on July 20, 2018. In the FAL, Respondents admitted to payment of TTD benefits from June 20, 2014 through February 15, 2016 for a total of $75,786.36.

Respondents also admitted to a 4% upper extremity impairment rating resulting in permanent partial disability (PPD) benefits of $2,288.83. A total of $78,075.19 in indemnity benefits were admitted. Claimant did **not** timely contest the FAL. Therefore, the Claimant was overpaid $48,512.76 ($126,587.95 - $78,786.36 = $48, 512.76).

Ultimate Finding

8. The ALJ finds that Respondents have overpaid the Claimant in the amount of $48,512.76 (Exhibit A).

CONCLUSIONS OF LAW

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

Notice

a. As found, Notice of the hearing was sent to the Claimant at his last known, regular and registered address of 7656 Dusk Street, Littleton, CO 80125, and by email at thor4u@gmail.com The mailed notice was not returned to the sender, as undeliverable, and the email notice was not returned as "undeliverable." Therefore, as found, there was a legal presumption of receipt and the ALJ found that the Claimant received notice of the hearing and failed to appear.. *See Olsen v. Davidson,* 142 Colo. 205, 350 P.2d 338 (1960); *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993).

Overpayment

b. An overpayment is defined as "money received by a claimant that exceeds the amount that should have been paid, or which the claimant was not entitled to receive …" §8-40-201(15.5), C.R.S.

c. Respondents are entitled to recover an overpayment of TTD benefits. *In the Matter of the Claim of Brian Josue, Claimant*, W.C. No. 4-954-271-04, 2016 WL 3455466 [Indus. Claim Appeals Office (ICAO), June 17, 2016]; *Mattorano v. United Airlines*, W.C. No. 4-861-370 (ICAO, July 25, 2013); *Franco v. Denver Public Schools*, W.C. No. 4-818-570 (ICAO, November 13, 2014).

d. Further, §8-42-113.5(1)(c), C.R.S. provides that respondents can seek an order for repayment of an overpayment. §8-42-207(q), C.R.S. grants ALJs authority to conduct hearings to require repayment of an overpayment. *In the Matter of the Claim of: Leah Turner, Claimant*, W.C. No. 4-893-631-07, 2018 WL 852425 (ICAO,Feb. 8, 2018);

Simpson v. Indus. Claim Appeals Office, 219 P.3d 354 (Colo. App. 2009), *rev'd on other grounds, Benchmark/Elite, Inc. v. Simpson*, 232 P.3d 777 (Colo. 2010).

e. Based on ALJ Jones' Order, which was not appealed, an overpayment in the amount of $48,512.76. resulted.

Burden of Proof

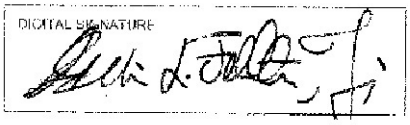
f. The burden of proof is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P.2d 535 (Colo. App. 1992). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page 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 [Indus. Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). "Preponderance" means "the existence of a c *v. Jones*, 688 P.2d 1116 (Colo. 1984). As found, Respondents have satisfied their burden that Claimant was overpaid $48,512.76.

ORDER

IT IS, THEREFORE, ORDERED THAT:

The Claimant shall pay the Respondents, in one lump sum, the amount of $48,512.76.

DATED this 23rd day of January 2019.



EDWIN L. FELTER, JR.
Administrative Law Judge

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts,**1525 Sherman Street, 4th Floor, Denver, CO 80203.** You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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* § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, *see* Rule 26, OACRP. You may access a form for a petition to review at** *http://www.colorado.gov/dpa/oac/forms-WC.htm*.

CERTIFICATE OF SERVICE

I hereby certify that I have sent true and correct copies of the foregoing **Full Findings of Fact, Conclusions of Law and Order** on this_____day of January 2019, electronically in PDF format, addressed to:

Division of Workers' Compensation
cdle_wcoac_orders@state.co.us

_____
Court Clerk

Wc.ord

ISSUES

- Whether the claimant has demonstrated, by a preponderance of the evidence, that she sustained a compensable injury as a result of her position with the employer.

- Whether the claimant has demonstrated, by a preponderance of the evidence, that she is entitled to an award of authorized, reasonable, necessary, and related medical benefits; specifically including the left shoulder surgery performed by Dr. John LeBlanc.

FINDINGS OF FACT

The parties submitted the following stipulated facts:

1. The claimant worked as a support specialist for the employer (a health care service provider for the disabled). The claimant has worked for the employer off and on for several years. The claimant began her most recent period of employment with the employer on May 11, 2018.

2. The claimant suffers from a chronic inflammatory autoimmune disorder. Since approximately 2010, the claimant has suffered from symptoms which include intermittent bouts of joint swelling, joint pain, and fatigue. At a visit with her primary care provider on January 26, 2018, the claimant was counseled regarding management of her condition, as she had not always been compliant with treatment.

3. Shortly before her alleged injury, the claimant received training from the employer regarding the mandatory reporting of workplace injuries. On May 24, 2018, the claimant signed a designated provider list, indicating that she was "aware of [the employer's] policy regarding medical treatment for work-related injuries and illnesses. I further understand that I must immediately report any work-related injury to my supervisor." The authorized providers identified were Steamboat Medical Group, Yampa Valley Medical Associates, Memorial Hospital, and The Clinic at Middle Park.

4. The claimant alleges that she sustained an injury to her left shoulder in the course and scope of her work duties on June 10, 2018. She claims that she was interacting with a dementia patient who pulled on her left arm.

5. The claimant was able to work her entire shift on June 10, 2018.

6. On the evening of June 10, 2018, after the alleged workplace injury occurred, the claimant had a discussion with her supervisor Michael Toothaker. She stated that she was tired but said nothing concerning a workplace injury or event.

7. On June 10, 2018, the claimant discussed with co-worker Brittany Jones that she was "sore from doing [patient] lifts" but did not allege any acute incident.

8. On June 11, 2018, the claimant discussed with co-worker Sam Myers that she "tweaked her shoulder." When asked by Ms. Myers how it happened, the claimant twice replied that she was not sure, and did not know whether it happened at work or not.

9. Despite having received and signed the designated provider form on May 24, 2018, the claimant proceeded to TMH Rapid Care for medical treatment on June 11, 2018. This provider was not on the employer's designated provider list. The claimant was not directed to treat at TMH by the insurer or the employer. The claimant was diagnosed with left shoulder pain and encouraged to follow up with an orthopedic surgeon.

10. The claimant worked her entire shift on June 12, 2018. After that shift, she did not work for the employer.

11. The claimant was ultimately referred for a left shoulder MRI which took place on July 3, 2018. The MRI showed AC joint tendinitis and a "defect" of the rotator interval. Dr. John LeBlanc later performed a surgical repair.

12. Based upon the stipulated facts presented, the ALJ finds that the claimant has failed to demonstrate that is it more likely than not that she sustained a workplace 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 8-43-201, C.R.S., 2008. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 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, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

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

reasonableness or unreasonableness (probability or improbability) of the testimony and 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 (2017).

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).

4. 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.*

5. As found, the claimant has failed to prove, by a preponderance of the evidence that she sustained a compensable injury. Prior to June 10, 2018, the claimant had received training regarding workplace injuries. Despite this, the claimant failed to timely report an injury despite having ample opportunity to do so, including during a call with her supervisor that same day. On the alleged date of injury and the next day, she failed to complain of any workplace injury and made nonspecific complaints to several co-workers. The claimant indicated to Ms. Myers that she did not know how she was injured and could not state that it happened at work. The claimant cannot prove that her condition is a result of any workplace incident, and accordingly her claim is denied and dismissed.

6. 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). "Authorization" refers to the physician's legal authority to treat, and is distinct from whether treatment is "reasonable and necessary" within the meaning of Section 8-42-101(1)(a), C.R.S. 2008. *Leibold v. A-1 Relocation, Inc.*, W.C. No. 4-304-437 (January 3, 2008).

7. As found, the claimant has failed to prove that she sustained a compensable injury. Therefore, the claimant is not entitled to an award of medical benefits, including the surgery performed by Dr. LeBlac. Any such medical benefits sought by the claimant were also unauthorized due to her failure to treat with the designated providers identified in the May 24, 2018 form, received and executed by claimant.

ORDER

It is therefore ordered that:

1. The claimant's claim for compensation is denied and dismissed.

2. The claimant's request for medical benefits, including the shoulder surgery, is denied and dismissed.

Dated January 24, 2019

Cassandra M. Sidanycz
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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 ALJ'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 ALJ; 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. 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. **In addition, it is recommended that you send a copy of your Petition to Review to the Grand Junction OAC via email at oac-gjt@state.co.us.**

ISSUES

I. Are the facet-joint injections, at levels L3-L4, L4-L5, and L5-S1, as recommended by Dr. Castrejon, reasonable and necessary for Claimant's medical maintenance treatment, and related to his original work injury?

FINDINGS OF FACT

Based upon the evidence received at Hearing, the ALJ makes the following Findings of Fact:

The Injury

1. Claimant was a patrol officer for the City of Pueblo when he sustained an injury to his low back on October 5, 2007. On the date of the injury, he was in pursuit of a stolen car. The driver of that car abandoned the vehicle, which continued to move without a driver on board. Claimant positioned his police cruiser to stop the moving vehicle. It struck the patrol cruiser's driver's side door. Claimant described the impact like someone "kicking him in the tailbone." He initially presented with radiculopathy on both the right and left.

Early Care Notes

2. After failed conservative care, Dr. James Bee recommended an L5-S1 decompression and fusion. This was performed the operation on April 8, 2008.

3. Claimant was placed at maximum medical improvement (MMI) by his authorized treating provider, Dr. Daniel Olson, on January 16, 2009. Dr. Olson assessed Claimant with an apportioned 16% whole person impairment rating. Dr. Ridings, who performed the Division Independent Medical Examination, agreed with the MMI date and assigned a 15% apportioned whole person rating. Respondent admitted to this rating and to post-MMI medical maintenance.

4. Claimant continued treatment, including with Dr. Bradley Sisson of the Colorado Clinic. On 7/20/2017, Claimant received Radio Frequency Ablation ("RFA") treatment, bilaterally, at L3, L4, L5 levels (Ex. 2, pp. 26-30). In the history provided at this visit, Dr. Sisson noted:

> About 3 or 4 years ago, the patient had lumbar radiofrequency nerve ablation done. *The patient states that that procedure reduce the local the pain by 80-90%* (sic). *Id at .27* (emphasis added).

It was further noted by Dr. Sisson:

> The patient reports that he had an SI joint injection performed by Dr. Jenks in July 26, 2016. He reports the SI joint pain reduced his SI generated pain by approximately 80%. He did not have to take Norco as a pain analgesic for several months after that specific injection……In

> November 2016, he felt that the SI joint injection was wearing off and Dr. Jenks ordered another SI joint injection which was denied by the insurance carrier.

Trigger point injections were administered by Dr. Sisson in lieu of the SI injection.

5. At his follow-up visit on 8/8/2017, Claimant reported to Dr. Sisson that this most recent RFA procedure was *90% helpful for pain relief* (Ex. 2, p. 22).

6. A lumbar MRI was taken at Parkview Medical Center on September 1, 2017. The primary care physician was not noted in the report. Under Findings, the following was noted:

> L3-L4: No significant disc bulge or spinal canal stenosis. *Minimal facet hypertrophy*. No significant foraminal narrowing.
>
> L4-L5: There is a broad-based disc bulge and *moderate facet hypertrophy* that minimally narrow the spinal canal. There is mild right greater than left foraminal narrowing.
>
> L5-S1: There are postsurgical changes from prior posterior decompression. An intervertebral disc spacer is identified. There is no significant spinal canal stenosis. *There is facet hypertrophy* and mild foraminal narrowing. (Ex. 1, p. 1) (emphasis added).

Recent Maintenance Medical Care

7. On January 11, 2018, maintenance care was transferred to Miguel Castrejon. Dr. Castrejon noted in his report that Dr. Jenks had provided multiple injections for pain management, including SI-Joint injections and facet joint injections. He also noted a prior SI-joint rhizotomy, and radiofrequency ablations. After Dr. Jenks lost his medical license, care was transferred to Dr. Shell of the Colorado Clinic, who resumed a series of injections. On his patient intake forms, Claimant reported pain in the SI area with constant ache and occasional stabbing on the right side into the groin area. This was worsened by sitting or standing on hard surfaces.

8. Claimant also reported pain in his buttocks and leg on the right side, with occasional shooting pain from hip down into the leg. He had a deep ache in his low back, and rated his pain as 4-5/10. Physical examination revealed that Claimant weighed 205 pounds, with a slow but normal gait. Facet loading was *equivocal* bilaterally. Claimant was neurologically intact, with negative straight leg raises but some evidence of pelvic obliquity. (Ex. 4, p. 80).

9. Based on Dr. Castrejon's review of the medical history, on 1/11/2018 he opined, "Having had the opportunity to discuss results of the prior SI-Joint injection as well as the risks associated with ongoing spinal injections, the recommendation of this examiner that the Claimant not undergo any further spinal injections including facet and sacroiliac." (Ex. J, p. 45, Ex. 4, p. 83).

10. Claimant returned to Dr. Castrejon on February 6, 2018. Physical examination revealed the same weight, along with slow but normal gait. He had mild tenderness in the area of the piriformis to a lesser degree than the SI-Joint. Facet loading was *negative.* There was evidence of pelvic obliquity. Straight leg raises were negative. Claimant remained neurologically intact. (Ex. K, p. 54).

11. Claimant returned to Dr. Castrejon on March 7, 2018. Physical examination remained relatively unchanged. However, he now noted that Claimant was *tender* at L5-S1 facet region, but that facet loading was still *negative*. Dr. Castrejon recommended physical therapy, but by this time, he had discussed a right SI-Joint injection. (Ex. L, p. 58, Ex. 4, p. 62).

12. At the next visit, on April 5, 2018, Dr. Castrejon noted improvement with physical therapy, and felt that Claimant could transition to his home exercise program. Claimant's physical examination remained relatively unchanged. Facet loading was still *negative.* Dr. Castrejon noted that patient was at risk for ongoing flare-ups, which would require treatment that may include spinal injections, physical therapy, and ongoing use of medications for indefinite period of time. (Ex. N, p. 65).

13. At a May 21, 2018 appointment with Dr. Castrejon, Claimant's physical examination remained largely unchanged. (Ex. O, p. 67). Facet loading was still *negative.* (Ex. 4, p 60). Claimant reported pain 4/10, with sciatic symptoms running down both legs occasionally. *Id at 69.* Dr. Castrejon recommended chiropractic care.

14. At a June 13, 2018 return visit, Claimant's physical examination remained largely unchanged. Facet loading was still *negative.* (Ex. P, p. 70, Ex. 4, p. 56). Dr. Castrejon recommended an SI-Joint injection. *Id at 71, 57.*

15. On June 27, 2018, Claimant reported withdrawal symptoms from switching between Butrans and Belbuca. The switch was initially made because of skin irritation caused by the Butrans patches. Based on Claimant's withdrawal symptoms and lack of pain control, Dr. Castrejon increased Claimant's dosage of Belbuca from 75 mg to 150 mg. (Ex. Q, pp. 72-73).

16. On July 18, 2018, Claimant reported that he was unsure of the benefit of the SI-Joint injection, indicating that he felt slightly worse. Claimant voiced right-sided low back pain extending into the buttock, with no referred pain or paresthesia. There was no groin pain. Claimant's physical examination remained unchanged. Facet loading still *negative.* (Ex. R, p. 74, Ex. 4, p. 52). Dr. Castrejon placed Claimant back on Butrans because of additional side effects with the Belbuca. He recommended six massage therapy sessions to decrease back muscles spasms. *Id*

17. On August 6, 2018, Claimant reported to Dr. Castrejon a severe flare-up of low back pain, which Claimant described as midline, and which worsened with extension. There was no radiation noted of pain into his legs. Physical examination revealed *moderate tenderness with extension* now with *positive facet loading* and tenderness at L5-S1

facet. Claimant continued to be neurologically intact. (Ex. S, p. 76, Ex. 4, p. 49). At this appointment, Dr. Castrejon noted:

> The patient is here for flare-up of low back pain *that presents as facet mediated pain.* I have discussed his medical condition and treatment recommendations. I am requesting authorization for bilateral L5, S1 facet joint injections with Dr. Steven Ford. Today, I have administered 5 trigger point injections utilizing a solution of 1% lidocaine and .25% Marcaine to the paraspinal musculature. I have dispensed a TENS unit for purchase to assist with muscle spasm. I have dispensed a tapering oral course of prednisone and robaxin 750 mg#60. He will return in 4 weeks. (Ex. 4, p. 50) (emphasis added).

18. On October 5, 2018, Dr. Allison Fall reviewed the request for bilateral L5-S1 facet joint injections. She opined that L5-S1 facet joints were not likely the cause of Claimant's symptoms. Claimant was fused at that level and therefore, there would be no movement in those joints to produce pain. (Ex. T, p. 78). She further opined that facet joint injections are not considered diagnostic under the Colorado Medical Treatment Guidelines; rather, medial branch blocks are the proper diagnostic tool. Additionally, Dr. Fall noted that Claimant had had multiple trigger point injections, prednisone, and a TENS unit, which would be more appropriate to addressing Claimant's flare-up than an interventional procedure. (Ex. T, p. 79).

19. A September 21, 2018 medical report from Dr. Castrejon indicated that Claimant was now on 300 mg of Belbuca (which had previously been ineffective in controlling Claimant's pain) because of a severe skin rash caused by the Butrans. Dr. Castrejon noted improvement in Claimant's pain level and function following massage therapy.

20. Claimant indicated that his pain was still 5/10. (Ex. U, p. 82). Physical examination now revealed *moderate* pain with *positive* facet loading and *tenderness* at L4-S1 and midline L3-S1. Dr. Castrejon prescribed LidoPro to provide additional pain control. Dr. Castrejon also noted:

> His examination *continues to support* ***facet mediated pain***…..A request for lumbar facet injections was not approved by the carrier…..**Please recall that a lumber MRI confirmed the presence of minimal facet hypertrophy at L3-4 and moderate at L4-5.** I am again requesting authorization for bilateral L3-4 and L4-5 facet injections wit Dr. Ford…(Ex. 4, p. 46)(emphasis added).

21. On November 14, 2018, Claimant indicated that his July 17, 2018 right SI-Joint injection did not result in any lasting benefit. (Ex. W, p. 86). In his medical report, Dr. Castrejon noted that Claimant's condition was actually worse by this time. Based on this finding, Dr. Castrejon began considering the L5-S1 region as a possible pain generator. (Ex. W, p. 87). At that appointment, Claimant reported a 25-pound weight gain; however, Dr. Castrejon's report continues to list Claimant's weight as 205 pounds.

22. Dr. Castrejon then provided a lengthy review of an article from the journal *Pain Medicine*. (Ex. AA.) Dr. Castrejon noted that the article showed evidence for post-fusion facet pain as being a possible pain generator; he thus supported his recommendation for bilateral L5-S1 facet joint injections. He believed that this article supported his decision to seek treatment of the fused joint, and undermined Dr. Fall's opinion that the fused facet could not be the pain generator. (Ex. W, p. 87).

23. Dr. Castrejon, also responded to Dr. Fall's report, noting these observations:

> This examiner notes that the patient underwent rhizotomy bilaterally at L3, L4, and L5 on 7/20/17. Record review documented 90% pain relief. Prior to the rhizotomy records document the patient as having undergone two prior facet injections at bilateral L3-4 and L4-5. At one point Dr. Fall argued that this did not follow diagnostic criteria. With all respect, the outcome was on of 90% benefit with pain having decreased to 1/10. This outcome in and of itself (sic). Deviating from "diagnostic criteria" <u>recommendations</u> is a medical decision that resulted in substantial benefit. Addressing the facet joints above the level of the fusion was medically reasonable on the basis of *adjacent level disease* that is often seen post fusion. In all medical probability the patient's treating physician was attempting to identify whether the patient's ongoing symptoms were *related to facet-mediated pain* coming from above the level of fusion. Excellent benefit was achieved with the rhizotomy procedure that satisfied the treatment guideline criteria….
>
> Given that there was no benefit following the SI injection I took into consideration the facet joints. I noted that the patient had previously undergone facet rhizotomy above the level of fusion with excellent benefit….Please recall that the patient underwent a surgical fusion procedure at this level (L5-S1). As a result, the structures contained at this level are no longer virgin territory having been violated by the surgical procedure and placing the patient *at risk for pain from structures directly manipulated, <u>as well as</u> adjoining and distal to the site of surgery*. (Ex. 4, p. 33) (emphasis added).

Dr. Fall's IME Report

24. On November 19, 2018, Dr. Fall issued a response to Dr. Castrejon's November 14 report. She also reviewed the journal article referenced by Dr. Castrejon. Dr. Fall pointed out that the article on which Dr. Castrejon was basing his treatment decisions showed no statistically significant change in facet joint pain between pre-and post-fusion for those with low back pain. (Ex. X, p. 89). Additionally, Dr. Fall opined that the article did not support Dr. Castrejon's assertion that a fused facet joint could be a possible pain generator. Instead, all of the patients with zygapophyseal pain in the study had the pain at adjacent levels to where the fusion was.

25. She concluded there was absolutely no documentation of facetogenic pain at the fused level in the entire article. (Ex. X, p. 90). Finally, Dr. Fall noted that the article was merely a preliminary look at some factors that may be implicated in ongoing low back pain after a fusion. There was nothing definitive in the article; further, one article would not be the proper basis for altering medical treatment parameters. i.e., the Colorado Medical Treatment Guidelines.

26. In her report, Dr. Fall further noted inconsistencies in the reported benefit from Claimant's July 2018 SI-Joint injection between his answers to interrogatories and what had been documented in Dr. Castrejon's reports. She explained that such inconsistencies are not uncommon in a chronic pain situation; that is in part why interventional procedures like facet injections are not recommended by the Colorado Medical Treatment Guidelines.

Deposition Testimony of Dr. Fall

27. Dr. Fall testified by evidentiary deposition on November 14, 2018. She was qualified as an expert in the field of physical medicine and rehabilitation. She further testified that she was Level II accredited and familiar with the Colorado Medical Treatment Guidelines.

28. Dr. Fall testified that facet joint injections are 'frowned upon', unless they are part of a functionally-directed rehabilitation program, but are not appropriate for patients with recurrent pain. She further opined that generally facet joint injections are not appropriate to address diffuse and divergent pain complaints.

29. Concerning Dr. Castrejon's L5-S1 request, she testified that this would not be a possible pain generator because of the fusion at that level. Moreover, because this was a chronic pain syndrome case, it was not appropriate to continue to manage Claimant's pain with spinal injections, particularly where Claimant had had inconsistent responses to those procedures. She further opined that this was consistent with Dr. Castrejon's *initial* recommendations in the case.

30. Dr. Fall testified that Claimant did have radiating pain down the back of his legs, but that it was not radicular in nature. Additionally, she testified that there was no indication that the fusion was unstable. She explained that the Colorado Medical Treatment Guidelines for chronic pain recommend against moving back and forth between various suspected pain generators with injections. She then explained that there was no basis in the medical records, or Claimant's fluctuating symptoms following Dr. Castrejon's initial January 11, 2018 report which would warrant a change in Dr. Castrejon's initial recommendation against continued spinal injections.

31. Dr. Fall explained that, at this point in the 11 years of treatment for chronic pain, the risks from continued spinal injections simply outweighed any benefit, which, at best, had been inconsistent throughout the case. The morbidities associate with continuing such

injections included deterioration of the joints being injected, allergic reaction, bleeding, infection, and spinal nerve injury. Additionally, she opined that in a chronic pain situation these types of interventional injections, specifically the facet joint injections, should not be utilized. Instead, it is more appropriate to treat a flare-up with anti-inflammatories, topical patches, massage, or a TENS unit. Moreover, the term "flare-up" indicates something short-lived, and Claimant's subjective reports were consistent with an underlying chronic pain condition with no specific pain generator. Additionally, she noted that facet joint injections should not be used to promote weight loss or facilitate exercise.

32. Concerning facet joint injections at levels above the fusion (specifically L3-L4 and L4-L5), Dr. Fall testified that this would be chasing diffuse complaints with no obvious pain generator. Additionally, she opined that the facet joints at those higher levels were pain generators from Claimant's pre-existing injury that was not related to this claim. However, no evidence in support of this proposition was cited by Dr. Fall.

33. Dr. Fall did acknowledge that facet joint pain is a potential pain generator in the lumbar spine, but disagreed that between 15% and 40% of low back pain is due to facet joints. Instead, she opined, and later confirmed her opinion, that 90% of all low back pain cases one cannot identify the source of the pain generator.

34. Further, after discussion of the interplay between Claimant's SI joint issues and the RFA on his facet joints, the following discussion was noted on p. 44 of her deposition:

> Q. Okay. So even if the RFA gives a patient 90 percent pain relief for a facet-mediated pain, you're saying that if they have pain that's *also* coming from the SI region they shouldn't get an RFA?
>
> A: That's correct.
>
> Q: That that's your interpretation of the [Medical Treatment] guidelines?
>
> A: Yes.

Claimant's Testimony

35. Claimant testified, at hearing. He stated that he was unable to engage in physical therapy because stretching was painful. He further indicated that he was not able to do home exercises. He testified that the TENS unit that was provided did not work. He also testified that massage therapy only provided momentary relief.

36. Claimant further testified that he did benefit significantly from the first Radio Frequency Ablation, and would like to repeat this process, since he had to take less Norco afterwards.

37. Claimant acknowledged that his sleep had improved since October 2017, but he had gained approximately 20 to 25 pounds during this period. He testified that following the July 17, 2018 SI-Joint injection performed by Dr. Stephen Ford, he noticed a decrease in the pain that he experienced while sitting. He noticed a lessening in the pain associated with walking on hard floors, and that he could now walk for longer periods of time. He acknowledged that following the facet rhizotomy that he received in 2017, that it did not improve his pain with sitting on hard surfaces or standing on hard ground. He did acknowledge that his condition improved with physical therapy conducted by Dr. Castrejon and that he was able to transition to a home exercise program.

38. Claimant testified that his reported weight did not accurately reflect his actual weight throughout the course of his treatment, including the November 14, 2018 report, which listed his weight at 205 pounds.

Testimony or Ray Wilbur

39. Ray Wilbur is a Claims Adjuster for Insurer. Mr. Wilbur testified about the claims process in this case, including his denial of the treatment being requested by Claimant. While the ALJ finds this witness to be truthful in his testimony, his professional decision making process is not pertinent to the issues currently before the ALJ.

CONCLUSIONS OF LAW

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

Generally

a. The purpose of the Workers' Compensation Act of Colorado (Act), §§ 8-40-101, *et seq.*, C.R.S. (2018), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. § 8-40-102 (1), C.R.S. (2018). The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. § 8-43-201 (1), C.R.S. (2018). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of the respondents. § 8-42-201 (1), C.R.S. (2018).

b. 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. § 8-43-201 (1), C.R.S. (2018).

c. In this case, the ALJ finds Claimant's testimony to be sincere and credible, limited though it is in addressing the medical issue presented. The ALJ further finds that both Dr. Castrejon and Dr. Fall have reported, and testified, to the best of their professional abilities. As such, the ALJ must analyze their medical opinions on the basis of relative *persuasiveness,* and not *credibility* per se.

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

Medical Treatment, Generally

e. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. § 8-42-101, C.R.S. (2018). However, the right to workers' compensation benefits, including medical benefits, arises only when an injured employee establishes by a preponderance of the evidence that the need for medical treatment was proximately caused by an injury arising out of and in the course of the employment. § 8-41-301 (1) (c), C.R.S. (2018); *Faulkner v. ICAO,* 12 P.3d 844, 846 (Colo. App. 2000).

f. The question of whether a particular medical treatment is reasonable and necessary is one of fact for determination by the ALJ. *Kroupa v. ICAO, supra*; *Wal-Mart Stores, Inc. v. ICAO,* 989 P.2d 251 (Colo. App. 1999). The 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).

Medical Treatment Guidelines

g. The Medical Treatment Guidelines ("Guidelines") are regarded as the accepted professional standards for care under the Workers' Compensation Act. *Hernandez v. University of Colorado Hospital*, W.C. No. 4-714-372 (January 11, 2008); see also *Rook v. Industrial Claim Appeals Office*, 111 P.3d 549 (Colo. App. 2005). The Medical Treatment Guidelines, Rule 17-2(A), W.C.R.P. provide: All health care providers shall use the Medical Treatment Guidelines adopted by the Division. In spite of this direction, it is generally acknowledged that the Guidelines are not sacrosanct and may be deviated from under appropriate circumstances. *See*, Section 8-43-201(3) (C.R.S. 2014). Nonetheless, they carry substantial weight. While the Guidelines provide substantial guidance, the ALJ is not bound by the Guidelines in deciding individual cases or the principles contained therein alone. Indeed, § 8-43-201(3) specifically provides:

> It is appropriate for the director or an administrative law judge to consider the medical treatment guidelines adopted under section 8-42-101(3) in determining whether certain medical treatment is reasonable, necessary, and related to an industrial injury or occupational disease. *The*

director or administrative law judge is *<u>not required</u>* *to utilize the medical treatment guidelines as the sole basis for such determinations.* (emphasis added).

h. As noted by Claimant, Dr. Castrejon actually largely adhered to the Guidelines when he recommended the usage of facet injections. The Guidelines in Rule 17, Exhibit 1(F)(3)(e)(iii) on p. 54 [re Zygapophyseal (Facet) Injection] provide:

> Indications- *Patients with pain 1) suspected to be facet in origin based on exam findings and 2) affecting activity;* OR patients who have refused a rhizotomy and appear clinically to have facet pain; OR patients who have facet findings with a thoracic component. The physician should document the findings which, for lumbar and cervical spine, consist of pain with *extension and lateral bending with referral patterns consistent with the expected pathologic level*. **In these patients, facet injections may be occasionally useful in facilitating a functionally-directed rehabilitation program <u>and</u> to aid in identifying pain generators.** Patients with recurrent pain should be evaluated with more definitive diagnostic injections, such as medial nerve branch injections, to determine the need for a rhizotomy. Because facet injections are not likely to produce long-term benefit by themselves and are not the most accurate diagnostic tool, they should not be performed at more than two levels, unilaterally or bilaterally. Due to the lack of proof that these injections improve outcome, *prior authorization is required*. A high quality meta-analysis provides good evidence against the use of lumbar facet or epidural injections for relief of non-radicular low back pain. All injections should be preceded by an MRI or a CT scan. (emphasis added).

i. Claimant met the 'Indications' criteria. The findings were sufficiently documented to note pain with extension, with consistent referral patterns. Dr. Castrejon felt that these facet injections could be useful for both treatment, and diagnostic purposes. The ALJ finds Dr. Castrejon had substantial evidence in support of his opinions. While it is duly noted that the Guidelines recommend no more than two levels of facet injections at one time, the ALJ finds that under the circumstances herein, and as documented by ATP Castrejon, that the three levels being requested are nonetheless justified in this case. This is especially so, given the existing fusion at L5-S1, and the prior beneficial effects of RFA at the same three levels. The ALJ is not persuaded by Dr. Fall's analysis that Dr. Castrejon's request does not adhere to the Guidelines. And, to paraphrase Dr. Castrejon, it's hard to argue with success. The point, after all, is to provide beneficial medical treatment to injured workers.

Reasonable, Necessary, and Related

j. The ALJ further concludes that the reason Dr. Castrejon selected the three levels he did for facet injections is that these are the three areas of concern that were documented in a MRI scan. The MRI of September 1, 2017, showed facet

hypertrophy at L3-4, L4-5, and L5-S1. The Guidelines also state that an MRI scan should precede a facet injection. A clear reason is that one can then focus on the areas where the facet joints are showing some hypertrophy as a possible source of facet-mediated pain. Dr. Michael Shell previously looked at the hypertrophy on the MRI scan and treated the levels at L3-4, and L4-5. Dr. Castrejon, reasonably enough, now wants to also explore the possibility of facet pain coming from the L5-S1 level, where hypertrophy is also present- either because of the fusion, or perhaps in spite of it. Either way, his request is medically reasonable.

k. While the ALJ is mindful that Dr. Fall harbors a different medical opinion, it cannot be ignored that Dr. Fall clearly opined that a pain generator cannot be identified in 90% of lower back pain cases. The ALJ finds Dr. Castrejon more persuasive on this issue. He is attempting to identify and treat Claimant's pain generators, instead of classifying it as chronic back pain and prescribing medication. Further, Dr. Fall opined that 90% relief from facet-mediated pain from a prior RFA treatment does not justify a second RFA treatment *if SI pain is also present.* This logic escapes the ALJ, and renders Dr. Fall's other medical opinions less persuasive.

l. While Independent Medical Examinations hold a justifiably significant role in the Workers Compensation system, it cannot be ignored that Dr. Castrejon has regularly treated Claimant, in his ATP capacity, for over a year. His treatment notes are detailed, and indicate that the possible risks of the proposed procedures were understood by both he and the patient. The ATP and Claimant are both willing to take said risks. Dr. Fall opines that nothing justified Dr. Castrejon's change of opinion regarding the advisability of facet injections along the way. The ALJ once again does not concur. The physical examination *began* to show facet loading, beginning in the summer of 2018. Tenderness was also now noted at the facet joints. Claimant was beginning to show pain from extension. Conservative care was not providing the degree of relief that had been hoped for. And Dr. Castrejon did what he could to separate the source of the pain from prior, but related, SI issues. Further, while a sudden spike in symptoms might be described as a 'flare-up', this does not connote that such condition must be temporary, and will somehow resolve on its own. While that might prove to be the case, this does not mandate, ipso facto, conservative care. A 'flare-up' could also be the sudden onset of symptoms which could remain indefinitely, if not treated. It could herald the onset of something long-term. Certainly as of this Hearing, Claimant's 'flare-up" had not resolved.

m. Time will tell if Claimant benefits from the procedures being proposed by Dr. Castrejon, but Claimant has earned the right to find out. The ALJ concludes, by a preponderance of the evidence, that the medical procedures being proposed by Dr. Castrejon are reasonable and necessary to treat Claimant for his work injury. The ALJ further finds that symptoms Claimant experiences in connection therewith are related to his work injury, and not due to some other, undefined non-work injury.

ORDER

It is therefore Ordered that:

1. Respondents shall pay for the facet-joint injections as recommended by Dr. Castrejon, at levels L3-L4, L4-L5, and L5-S1, and all costs associated therewith.

2. 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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. 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: January 25, 2019

/s/ William G. Edie

William G. Edie
Administrative Law Judge
Office of Administrative Courts
2864 South Circle Drive, Suite 810
Colorado Springs, Colorado 80906

ISSUES

- Did Claimant prove he suffered a compensable injury on April 21, 2016 (W.C. No. 5-066-773)?

- Did Claimant prove he suffered a compensable injury on June 21, 2016 (W.C. No. 5-051-687)?

If Claimant proved one or more compensable injuries, the ALJ will address the following questions:

- What is Claimant's average weekly wage?

- Did Claimant prove entitlement to TTD benefits on or after June 22, 2016?

- Did Respondents prove Claimant's temporary disability benefits should be reduced under § 8-43-102(1)(a) based on "late reporting"?

- Did Claimant prove Respondents should be penalized under § 8-43-304 for failure to comply with discovery orders of Prehearing Administrative Law Judge Broniak dated June 22, 2018 and July 25, 2018?

- Issues relating to Claimant's concurrent employment were reserved for future determination.

FINDINGS OF FACT

1. Claimant worked for Employer as a part-time "preloader" and delivery driver.

2. Concurrently with his job for Employer, Claimant worked for his family's drywall business. His primary duties involved billing and bidding for jobs. Most of the drywall installation was subcontracted to another company, but Claimant occasionally performed drywall-finishing work.

3. W.C. No. 5-066-773 involves an alleged low back injury on April 21, 2016. Claimant alleges he lifted a 150-pound tire onto a loading dock and developed right-sided low back pain. Claimant did not report the injury to any supervisor and finished his shift.

4. On April 21 or 22, Claimant told his supervisor, Jacob Sanchez, he was having back pain. There is no persuasive evidence to corroborate he told Mr. Sanchez the pain was because of a work-related injury. In the past, Claimant had told Mr. Sanchez about episodic back strains from moving drywall, and Mr. Sanchez assumed the pain was related to lifting drywall or some other nonwork-related issue.

5. Claimant saw a chiropractor, Dr. John Warner, a few days after the April 2016 incident. The evidentiary record contains no corresponding medical record from that appointment, but Dr. Warner wrote a letter on April 20, 2018 stating:

> On April 26, 2016 [Claimant] came to our practice, Colorado Health and Wellness, Inc. seeking an evaluation and treatment for lower back pain. On April 26, 2016, [Claimant] stated he had injured his lower back lifting a tire at his UPS job the week prior and it had not gotten better. [Claimant] was thoroughly evaluated and diagnosed with a severe lower lumbar strain, and instructed to cease lifting or bending to prevent further injury until it was healed.

6. The appointment referenced in Dr. Warner's letter is corroborated by a text message Claimant sent to Mr. Sanchez on April 26, 2016, stating, "[I] went to get checked out they said I'm going to be just fine but not to do any lifting for a week."

7. Claimant was evaluated by Dr. Laura Buckley at Valley Wide Health Systems urgent care clinic on May 15, 2016. His chief complaint was "8/10" low back pain that started "2 to 3 weeks ago . . . lifting a heavy object . . . in April." Claimant had been treating the pain with stretching and exercise and had seen a chiropractor. Physical examination revealed muscle spasm in the lumbar area and moderate pain with range of motion. Neurological signs and straight leg raise testing were negative. Dr. Buckley diagnosed a back strain and imposed work restrictions of no lifting over 15 pounds, and no prolonged sitting more than 30 minutes at a time. She prescribed a Medrol Dosepak and muscle relaxer and advised Claimant to follow-up with his PCP if the symptoms did not improve.

8. After the appointment on May 15, Claimant texted a photograph of Dr. Buckley's work restrictions to Mr. Sanchez. The text message does not indicate the injury occurred at work, and Mr. Sanchez continued to assume it was a personal medical issue.

9. Claimant continued working off and on during May and June 2016.

10. Claimant saw his PCP, Dr. Martin Sowards, on June 9, 2016. The intake nurse's note states, "lower back pain, hurt end of April hasn't gotten better has seen chiropractor and other doctor." The evidentiary record contains two conflicting reports from Dr. Sowards regarding the appointment. In the first report, Dr. Sowards described the history as, "He has injured his low back lifting sheetrock and is here for treatment." On January 17, 2017, Dr. Sowards amended the report to state, "He has injured his low back lifting boxes at UPS and is here for treatment. . . . He hurt his back in the end of April and the pain has not improved." Dr. Sowards did not explain why he amended the report, but the change appears to have been triggered by an email Claimant sent to Dr. Sowards' office on January 16.

11. Claimant provided testimony at hearing to explain the source of the "sheetrock" reference in Dr. Sowards' original report. Claimant testified he "aggravated"

his back lifting a sheet of drywall with his brother sometime after April 21, 2016. He testified he told Dr. Sowards about both the tire incident at work and the drywall incident.

12. Dr. Sowards' physical examination findings at the June 9 appointment were relatively benign, showing only pain in the right lumbar paravertebral musculature, but no neurological deficits. Dr. Sowards diagnosed an acute lumbar strain and recommended ibuprofen, stretching, and core strengthening.

13. Claimant's second claim (W.C. No. 5-051-687) involves an alleged low back injury on June 21, 2016. Claimant was making deliveries and alleges he lifted a box weighing approximately 20-30 pounds from a high shelf in the truck. A large package on the floor prevented him from stepping next to the shelf, so he had to reach out to lift the box off the shelf. As he did so, he felt a "pop" in his low back and a numbing sensation in his right leg.

14. A co-worker named Patrick was riding in the vehicle with Claimant on June 21 to test a new GPS delivery system. Claimant testified Patrick "knew I was having a hard time. So he helped me. I would drive, and he would carry the packages out."

15. Claimant's symptoms escalated dramatically on the morning of Thursday, June 23, 2016. Later that day, he had the following text conversation with Mr. Sanchez:

> [Claimant] So Tuesday I twisted the back pretty good so I'm going to try to get an x-ray today my insurance should cover me for how long?
>
> [Sanchez] The last week you worked
>
> [Sanchez] Unless you file for short term disability
>
> [Claimant] I'm at the ER now. I'll keep you posted.

16. Claimant was seen at the San Luis Valley Regional Medical Center emergency department on the afternoon of June 23, 2016. His primary complaint was low back pain wrapping around his right hip into his buttocks area and of the upper right leg. Claimant told the triage person he had "hurt[ ] his back 2mnths ago lifting a spare tire, and states he aggravated it again on Tuesday[1], while twisting." The ER physician noted,

> A 1.5 month history of back pain. He states symptoms began after lifting a heavy tire. Symptoms gradually improved however worsened after lifting a box at work approximately one week[2] ago. Again, symptoms were improving until he attempted to get out of bed this morning.

Claimant was diagnosed with a "lumbar strain/sprain," given a Medrol Dosepak, and discharged with instructions to follow-up with his personal physician.

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[1] The claimed date of injury (June 21, 2016) was a Tuesday.

[2] The reference to "one week ago" is clearly an error by the physican, because Claimant had already told Mr. Sanchez and the intake person he aggravated his back on "Tuesday."

17. Claimant subsequently requested medical leave from UPS commencing June 22, 2016. The reason for the medical leave was listed as "my own medical condition." Claimant also received short-term disability benefits. Clinton Brown, a regional manager who supervised several UPS facilities, credibly testified that to obtain short-term benefits the employee must check a box stating whether or not the injury was work-related and would not be approved for disability if they said the injury happened at work. Claimant's request for medical leave and short-term disability further cemented Mr. Brown's and Mr. Sanchez's perception Claimant's back problems were not work-related.

18. Claimant saw Dr. Warner on June 29, 2016. Dr. Warner noted Claimant's back had been bothering him "since an injury two months ago" which "happened when he lifted something at work." Dr. Warner referred Claimant for an MRI, which was completed later that day. The MRI showed an extruded disc fragment at L3-4 impinging the right L4 nerve root.

19. On July 22, 2016, Claimant saw Nathan Carpenter, PA-C at Colorado Springs Orthopedic Group. Claimant described the etiology of his problem as,

> On June 21, 2016, while working as a UPS truck driver he was lifting a box off a top shelf. There were some boxes in front of him on the floor and so he was leaning forward while lifting up the box. He did not realize how heavy it was when he lifted it off the shelf and as he drew the box backward he was lunged forward and dropped the box.

20. Mr. Carpenter reviewed the MRI images and noted a herniated disc fragment at L3-4 impinging on the right L4 nerve root and slightly displacing the right L3 nerve. Lower extremity strength was normal except for 4/5 right quadriceps weakness. Sensation was decreased in the right leg in an L3 dermatome, and straight leg raise testing was positive on the right. Mr. Carpenter recommended an L3-4 microdiscectomy. Claimant was surprised by the surgical recommendation and wanted time to think about it.

21. On July 26, Dr. Sowards referred Claimant for a second surgical opinion. The referral states, "[Claimant] is a 40-year-old male who hangs drywall for a living. He developed low back pain with right-sided radicular symptoms after work one day." It does not appear the second opinion ever occurred.

22. Claimant saw Dr. Sowards on January 17, 2017 to have disability paperwork completed. The report notes "initial injury June 2016" and "he hurt his back in June 2016." The report says nothing about the April 2016 incident, even though Claimant had just given Dr. Sowards an email outlining the history and specifically referencing the April 21 incident lifting the tire. Dr. Sowards then amended his original June 9, 2016 report, as discussed in Finding of Fact No. 10.

23. Claimant returned to Dr. Buckley on May 1, 2017 to request a letter regarding the nature of the injury and that it was work-related. The report indicates

Claimant "sprained his back picking up a spare tire on June 21. . . . Was hurt initially at UPS." After the appointment, Dr. Buckley wrote a letter stating,

> [Claimant] was under my medical care for an injury that occurred in April 2016. He reported that the injury was due to lifting a heavy object. He reported that the incident happened at work but that he did not pursue workman's [sic] compensation at that time.

24. On July 18, 2017, a Workers' Claim for Compensation form was filed on Claimant's behalf, with an injury date of April 21, 2016. The form stated the injury occurred "lifting a tire" and identified Brandi Peterson as a witness.

25. Employer completed a First Report of Injury on August 15, 2017, stating "Employee went out on disability. Then over a year later claimant was on the job. . . . Employee stated that instead of being a disability claim it happened when lifting a tire." Respondents filed a Notice of Contest on August 21, 2017.

26. On January 12, 2018, Claimant's counsel filed a second Workers' Claim for Compensation form regarding the June 21, 2016 injury date. The form stated Claimant injured his low back "removing heavy package off of shelf in delivery truck" and identified "Patrick [last name unknown, employee of UPS]" as a witness. Respondents filed a Notice of Contest on February 14, 2018.

27. Dr. Paz performed an IME for Respondents on April 6, 2018. Dr. Paz opined Claimant's symptoms were likely caused by the L3-4 extruded disc fragment. Regarding causation, Dr. Paz opined, "the alleged mechanism of injury, i.e., lifting a spare tire weighing 150 pounds, could be consistent with herniation of a lumbar spine disc." But Dr. Paz noted the conflicting medical records from Dr. Sowards dated June 9, 2016, one stating Claimant injured his back lifting sheetrock, the other stating the injury occurred lifting a tire at UPS. He opined the contradictions between the original report and the amended report "cannot be resolved based on medical opinions, but certainly are concerning." Despite that, he went on to state a definitive opinion that it is "not medically probable" that the L3-4 herniated disc is causally related to the incident at UPS. He also opined that the described June 21, 2016 mechanism of injury — twisting and lifting a 20-30 pound box in an overhead location — it is not consistent with a herniated lumbar disc. He ultimately concluded Claimant sustained no work-related injury in April 2016 or June 2016.

28. Dr. Paz testified in a deposition on November 9, 2018 to elaborate on the opinions expressed in his IME report. He explained that Dr. Sowards neglected to follow the procedures set forth by COPIC regarding amendment of medical records.

29. Dr. Paz's opinion that the conflicting histories in the medical records "cannot be resolved based on medical opinion" is persuasive. Dr. Paz's opinion Claimant's symptoms are probably due to the extruded disc fragment at L3-4 is persuasive. Dr. Paz's opinion Claimant suffered no work-related injury in April or June 2016 is not persuasive.

Dr. Paz's opinion that lifting a 20-30 pound box in an overhead position and twisting could not cause a herniated disc is not persuasive.

30. Claimant proved by a preponderance of the evidence he suffered compensable work-related injuries on April 21, 2016 and June 21, 2016. The condition was probably started by lifting the tire on April 21 and aggravated by lifting the box on June 21. At this stage of the claim, there is no need for the ALJ to determine the precise contribution of each accident to Claimant's overall condition.

31. Claimant proved he has been disabled from his work at UPS and suffered a wage loss since June 22, 2016.

32. It is undisputed Claimant made no written report of injury until July 18, 2017. The parties have considerable disagreement regarding whether Claimant verbally reported the injuries to Mr. Sanchez or Mr. Brown before that date. Claimant testified he told Mr. Sanchez about the April 21 tire incident the next day, but Mr. Sanchez denied the conversation. Mr. Sanchez testified Claimant mentioned hurting his back lifting drywall around April 21, 2016. Absent any persuasive corroborating documentation, the ALJ finds insufficient persuasive evidence to establish Claimant verbally informed Mr. Sanchez he suffered a work-related back injury before July 18, 2017.

33. Claimant also testified to a conversation with Mr. Brown regarding his injury in August 2016. Claimant testified Mr. Brown suggested — "as your friend and not your boss" — that he not pursue a workers' compensation claim because "it's going to turn your life upside down," and Claimant could not see his own doctors. Claimant further testified Mr. Brown said he would deny the conversation if asked about it later. At hearing, Mr. Brown denied any such conversation ever took place. Mr. Brown considers Claimant a friend but would not jeopardize his job by discouraging a claim because "after 17 years of doing this and my time in the Marine Corps in combat, you've got to keep things separate." Claimant's testimony regarding the alleged conversation with Mr. Brown appeared credible. But Mr. Brown's testimony also appeared credible. Thus, the ALJ finds Claimant's account of the alleged conversation does not cross the threshold of "more likely than not."

34. In any event, crediting Claimant's testimony over Mr. Brown's would not change the outcome in the ALJ's mind. According to Claimant's testimony, Mr. Brown was merely giving him "advice" as a "friend." Mr. Brown did not prohibit or otherwise prevent Claimant from filing a claim. Furthermore, Claimant alleged the conversation occurred in August 2016, so it could not have influenced his decisions before that time. Claimant had multiple alternative avenues to report a claim, including through the union. Based on the totality of evidence presented, the ALJ finds Claimant's failure to report and pursue his claim before July 18, 2017 resulted from his volitional choices and not any undue pressure from his supervisors.

35. Respondents proved Claimant's eligibility for TTD benefits should be suspended until July 18, 2017 for failure to report his injuries in writing.

36. Claimant earned gross wages of $9,881.35 in the 36 weeks before April 21, 2016, resulting in an average weekly wage of $274.48.

37. Claimant's employer-sponsored health insurance was terminated effective September 25, 2016. Claimant was given two COBRA continuation options: Full Coverage for $255.52 per week, and Core Coverage for $216.40 per week. The Core Coverage option excludes dental, vision, life insurance, and eligibility for retiree health coverage. No evidence was presented to allow the ALJ to determine which portion of the Full Coverage option was for dental and vision versus life insurance and retiree health coverage.

38. Claimant proved by a preponderance of the evidence his base AWW should be increased by $216.40 to account for his COBRA continuation cost. Claimant's overall AWW from his employment with UPS is $490.88, with a corresponding TTD rate of $327.25 ($274.48 + $216.40 = $490.88 x 2/3 = $327.25).

39. Claimant failed to prove Respondents should be penalized for violating PALJ Broniak's orders dated June 22, 2018 and July 25, 2018. Claimant failed to prove there were additional materials in his employment file that were not exchanged, and Claimant's counsel conceded Mr. Brown was disclosed as the records custodian.

CONCLUSIONS OF LAW

A. Compensability

To receive compensation or medical benefits, a claimant must prove he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *Pacesetter Corp. v. Collett*, *33 P.3d 1230* (Colo. App. 2001). The claimant must prove an injury directly and proximately caused the condition for which he seeks benefits. *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).

As found, Claimant proved he suffered compensable injuries on April 21, 2016 and June 21, 2016. Although the inconsistencies in Dr. Sowards' records give the ALJ pause, on balance the evidence tips in favor of compensability. The ALJ has given great weight to the June 23, 2016 emergency room report, which ascribes the onset of symptoms to lifting a tire, subsequently aggravated by lifting a box. PA-C Carpenter's July 22, 2016 report also supports Claimant's assertion he suffered a substantial aggravation lifting a box off a high shelf in the UPS truck. Both histories were given well before Claimant had filed any claim or decided to pursue workers' compensation benefits. Dr. Warner also corroborated that Claimant reported the tire incident to him in April 2016. Claimant's testimony at hearing regarding the two accidents appeared forthright and sincere. Claimant identified two co-worker witnesses, neither of whom were presented at hearing to refute Claimant's allegations with sworn testimony. The ALJ also accepts Claimant's explanation that Dr. Sowards was probably confused about the source of the injury when he initially attributed it to hanging sheetrock. Of the possible causes for Claimant's back

problems, the ALJ finds the industrial incidents he described at UPS to be the most probable.

B. TTD and late reporting penalty

A claimant is entitled to TTD benefits if the injury causes a disability, the disability causes the claimant to leave work, and the claimant misses more than three regular working days. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The claimant must establish a causal connection between a work-related injury and the subsequent wage loss to obtain TTD benefits. *Id*. 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). Impairment of earning capacity may be evidenced by a complete inability to work, or by restrictions that impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998). Once the claimant establishes temporary disability, the right to benefits is measured by the degree of the wage loss, not the claimant's willingness to seek employment or the claimant's hypothetical ability to perform modified employment. *See Black Roofing Inc. v. West*, 967 P.2d 195 (Colo. App. 1998); *Denny's Restaurant, Inc. v. Husson*, 746 P.2d 63 (Colo. App. 1987).

As found, Claimant proved he was disabled from his work at UPS and suffered an injury-related wage loss commencing June 22, 2016. Ordinarily, Claimant would be entitled to TTD benefits retroactive to the date he left work. But Respondents have requested the ALJ impose a "late reporting" penalty until July 18, 2017, the day he filed his claim with the Division.

Section 8-43-102(1)(a) requires a claimant to notify his employer of the injury *in writing* within four days of its occurrence. If the claimant does not timely report the injury in writing, the ALJ "may" impose a penalty of "up to one day's compensation for each day's failure to so report." The term "may" means the imposition of a "late reporting" penalty is not mandatory but is left to the ALJ's discretion. *Lefou v. Waste Management*, W.C. Nos. 4-519-354 & 4-536-799 (March 6, 2003). The penalty for late reporting is an affirmative defense on which the respondents bear the burden of proof. *Postlewait v. Midwest Barricade*, 905 P.2d 21 (Colo. App. 1995).

In this case, the ALJ agrees with Respondents that Claimant's TTD benefits should be reduced in full until the date of his July 18, 2017 Workers Claim for Compensation form. The requirement to report an injury in writing serves several functions, not the least of which is to ensure a record of exactly when an injury was reported and remove ambiguity as to whether the claimant believes a medical problem is potentially work-related. Another important purpose is to allow the respondents to timely comply with their statutory obligations regarding the provision of medical benefits and mitigate their liability for indemnity benefits. Those concerns were directly implicated here. Although Mr. Sanchez knew Claimant was having problems with his back, he reasonably assumed it was a personal issue. Claimant subsequently reinforced that perception by requesting and receiving short-term disability that he attributed to "my own medical condition." The

written notice need not take any particular form, and Claimant could have easily referenced the work injuries in a text message to Mr. Sanchez. Had Respondents known Claimant was alleging a work-related injury, they could have exercised their right to designate a provider and decide whether to offer modified duty. It would be unfair to hold Respondents liable for more than a year of TTD benefits when Claimant elected to use his health insurance and pursue short-term disability benefits during that period. Based on the foregoing factors, the ALJ concludes it is appropriate to penalize Claimant one day's compensation for each day from June 22, 2016 through July 17, 2017.

C. Average weekly wage

Section 8-42-102(2) provides compensation is payable based on the employee's average weekly earnings "at the time of the injury." The statute sets forth several computational methods for workers paid on an hourly, salary, per diem basis, etc. But § 8-42-102(3) gives the ALJ wide discretion to "fairly" calculate the AWW in any manner that seems most appropriate under the circumstances. The entire objective of AWW calculation is to arrive at a "fair approximation" of the claimant's actual wage loss and diminished earning capacity because of the industrial injury. *Campbell v. IBM Corp*., 867 P.2d 77 (Colo. App. 1993).

Section 8-40-201(19)(b) provides that the term "wages" includes "the employee's cost of continuing the employer's group health insurance plan and, upon termination of the continuation, the employee's cost of conversion to a similar or lesser insurance plan." The statutory reference to "health insurance" includes employer-sponsored dental and vision coverage. *Cortese v. Kaiser Space Products*, W.C. No. 4-171-138 (April 8, 2010); *Sickler v. City Market*, W.C. No. 4-638-377 (July 25, 2008). It does not include other benefits such as life insurance. *City of Lamar v. Koehn*, 968 P.2d 164 (Colo. App. 1998). There is no requirement that a claimant actually purchase insurance for the continuation or conversion cost to be included in their AWW. *Industrial Claim Appeals Office v. Ray*, 145 P.3d 661 (Colo. 2006).

As found, Claimant's base AWW from his UPS wages is $274.48, and the AWW should be increased by $216.40 per week based on the COBRA cost of continuing the "Core Coverage." Although the Full Coverage option includes dental and vision, it also includes ineligible items such as life insurance and maintaining eligibility for retiree health coverage. Claimant has the burden of proof on AWW and the evidence presented does not allow the ALJ to determine how much of the difference between the two options can be included consistent with the Act. The preponderance of persuasive evidence demonstrates Claimant's AWW should include the cost of the Core Coverage. Combining the base AWW with the includable COBRA cost produces an overall AWW of $490.88 ($274.48 + $216.40 = $490.88).

D. Penalties for violation of PALJ Broniak's orders

Section 8-43-304(1) provides that an insurer "who violates any provision of [the Workers' Compensation Act], or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for

which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director," shall be punished by penalties of up to $1,000 per day.

The assessment of penalties is governed by an objective standard of negligence and involves a two-step analysis. The ALJ must first determine whether the insurer or employer violated the Act, a rule, or an order. Second, the ALJ must determine whether the violation was objectively reasonable. *Pioneers Hospital v. Industrial Claim Appeals Office*, 114 P.3d 97 (Colo. App. 2005); *Diversified Veterans Corporate Center v. Hewuse*, 942 P.2d 1312 (Colo. App. 1997); *City Market, Inc. v. Industrial Claim Appeals Office*, 68 P.3d 601 (Colo. App. 2003).

As an initial matter, the ALJ notes Claimant did not address the penalty issue in his position statement, which raises questions regarding the strength of his own conviction that Respondents should be subject to penalties. In any event, Claimant failed to prove Respondents violated PALJ Broniak's orders. Specifically, PALJ Broniak ordered Respondents to provide Claimant's employment file and identify Employer's custodian of records. Respondents' counsel timely exchanged all employment records he received from Employer. Claimant speculates there are additional materials that were not exchanged, but has no persuasive proof of that. Claimant's counsel also conceded Mr. Brown was disclosed as the records custodian. Mr. Brown was not questioned at hearing regarding any missing materials from Claimant's employment file. The ALJ concludes Respondents complied with PALJ Broniak's orders and no penalty is warranted.

ORDER

It is therefore ordered that:

1. Claimant's claims for injuries on April 21, 2016 and June 21, 2016 are compensable.

2. Insurer shall pay Claimant TTD benefits based on an AWW of $490.88 commencing July 18, 2017 and continuing until terminated by law.

3. Claimant's claim for TTD benefits from June 22, 2016 through July 17, 2017 is denied and dismissed.

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

5. Claimant's claim for penalties for violation of PALJ Broniak's orders is denied and dismissed.

6. All issues not decided 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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. 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: January 29, 2019

s/Patrick C.H. Spencer II
Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

ISSUES

1. Whether Claimant established by a preponderance of the evidence that she sustained a compensable injury on or about June 11, 2016?

2. Whether Claimant established by a preponderance of the evidence that she is entitled to an order awarding reasonably necessary and related medical benefits to cure and relieve Claimant of the effects of the alleged work-related motor vehicle accident of June 11, 2016?

3. Whether Claimant established by a preponderance of the evidence that the right of selection passed to Claimant to choose her authorized treating provider?

STIPULATION OF FACT

The parties stipulated to an average weekly wage of $1,153.84.

FINDINGS OF FACT

1. Claimant was involved in a motor vehicle accident on June 11, 2016. In this matter, Claimant contends that her motor vehicle accident occurred within the course and scope of her employment for Employer. Respondents contend that Claimant injuries to not arise out of or occur within the course and scope of her employment.

2. Employer formerly employed Claimant as a District Manager. Claimant held this position from May 8, 2014, to May 10, 2017, when she was terminated for violating company policy by taking overtime hours away from a manager. As a District Manager, some of Claimant's duties included hiring staff, assuring every restaurant had proper management personnel and assuring restaurants were ready for inspections.

3. Prior to her promotion to the District Manager position, Claimant was a Shift Leader with Employer. Her duties as a Shift Leader included managing shifts, managing a restaurant location and closing and/or opening the restaurant before the general manager's arrival. Claimant made sure the restaurant was customer-ready, checked inventory and handled monies.

4. After her promotion to Shift Leader, Claimant was subsequently promoted to Assistant Manager, a position Claimant held for approximately six years before her promotion to Restaurant Manager.

5. As District Manager, Claimant was aware of and understood Employer's worker's compensation policy as early as May 8, 2014. Claimant testified that at the time of her alleged work related motor vehicle accident she had known for over two

years that if she became injured while working she is to report the incident to Employer's management immediately.

6. At the time of Claimant's alleged work injury, Claimant was aware that several specific documents are generated as a result of calling in a reported work related injury. Records reflect that within a month of Claimant's alleged work injury at issue here, Claimant was responsible for generating several workers' compensation documents related to a reported work related injury experienced by her subordinate employee.

7. Despite Claimant's testimony regarding her knowledge of the Employer's workers' compensation procedures, Claimant also testified that she was not aware of workers' compensation procedures at the time of her motor vehicle accident on June 11, 2016, the motor vehicle accident.

8. According to State of Colorado Motor Vehicle Traffic Records, Claimant was involved in a motor vehicle accident on Saturday June 11, 2016 at 2:00 p.m. in Aurora, CO.

9. Claimant was a District Manager on the day of her motor vehicle accident. As such, Claimant was paid a salary, did not "clock-in or clock-out," and made her own work schedule.

10. According to Claimant's testimony, on the morning of her motor vehicle accident, she had been working at the Employer's location in Green Valley Ranch. While allegedly working at the Green Valley Ranch location, Claimant testified that she received a call from the manager at Employer's Illiff Avenue and Buckley Road location in Aurora, Colorado. Claimant testified that the manager allegedly called her to remind her to help with a training being conducted at the Illiff and Buckley location.

11. Claimant testified that she got into her car and left the Employer's Green Valley Ranch location at about 11:30 or 11:45. Claimant testified that she was driving to the Employer's Illiff Avenue and Buckley Road location heading southbound on I-225. Claimant testified she was turning left to exit at the Illiff off ramp when another vehicle hit the left side of her car.

12. Approximately two hours and thirty minutes passed between the time that Claimant testified that she left Employer's Green Valley Ranch location and the time of her motor vehicle accident at the Illiff exit in Aurora, Colorado, according to the police report.

13. Claimant first sought treatment on Monday June 13, 2016, with Dr. Brian Voytecek, at which time Claimant had retained counsel for her motor vehicle accident claim. Since her initial treatment, Claimant expressly indicated to various medical providers that the June 11, 2016, auto collision should be documented and treated as a personal motor vehicle accident and not a work related incident.

14. Claimant treated for the injuries she sustained in her motor vehicle accident for about two years, from June 13, 2016, to June 8, 2018.

15. Claimant's medical providers billed Claimant for treatment they expressly related to Claimant's motor vehicle accident claim and not her employment or other accident.

16. Claimant testified that she did not receive the result she desired from her motor vehicle accident claim that was filed over two years ago.

17. The instant worker's compensation claim was filed after the initial motor vehicle accident yielded undesirable results for Claimant.

18. Claimant testified that: she was in shock after the collision and before exiting the vehicle; she was still in shock, after the paramedics arrived on the scene and checked her vitals; and later, Claimant was still in shock when she took pictures of her vehicle and allegedly sent them to Tim Gingles and Kristi Peterson to notify them of her accident.

19. Claimant testified that within 24 hours of the June 11, 2016, motor vehicle accident, she notified her managers, Tim Gingles, Kristi Peterson, and payroll personnel, Patty Snyder that the motor vehicle accident occurred while she was working for Employer. Claimant claimed that these managers did not express concern for Claimant's work injury, offered no medical treatment and did not indicate a workers' compensation first report of injury would be filed. This testimony by Claimant was not deemed credible.

20. Mr. Gingles testified that on the day of the motor vehicle accident, Claimant called him while she was still at the scene. Mr. Gingles explained that, at the time, he and Claimant had been very close friends, however, they had recently broken up at Claimant's instigation. Mr. Gingles testified that Claimant did not indicate, at any point during their phone conversation, that she had been working when the motor vehicle accident occurred.

21. Mr. Gingles testified he understood that at the time of the accident Claimant had dropped off her daughter, Sasha, and Claimant would have been on her way to somewhere on Illiff. Mr. Gingles testified he was Claimant's supervisor at the time

of the accident and he was not aware she was even working that day. Mr. Gingles did not draft an Employer's First Report of Injury for Claimant's motor vehicle accident because Claimant never indicated the auto accident was work related. Claimant's assertions regarding her alleged immediate reporting to Employer of the work related nature of the accident is not credible.

22. Claimant did not follow up with Employer's managers regarding workers' compensation paperwork after she alleged reporting the incident as work related on June 11, 2016.

23. Mr. Gingles testified, and it is found, that Claimant first mentioned to Mr. Gingles that her motor vehicle accident was work related either in January or February of 2018. It is found that Claimant's late reporting of the work related injury, her inconsistency in testimony and her actions throughout the life of the instant claim support the finding that Claimant's assertion that her motor vehicle accident is work related is not credible. Claimant failed to prove by a preponderance of the evidence that her motor vehicle accident and injuries arose out and in the course and scope of her employment.

CONCLUSIONS OF LAW

General Legal Principles

1. The purpose of the Workers' Compensation Act of Colorado, Section 8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-201, C.R.S. The claimant shoulders the burden of proving by a preponderance of the evidence that she is a covered employee who suffered an "injury" arising out of and in the course of employment. Section 8-43-301(1), C.R.S.

2. The claimant must prove by a preponderance of the evidence that her 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) and (c), 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).

3. An injury occurs "in the course of" employment when it takes place within the time and place limits of the employment relationship and during an activity connected with the employee's job-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The arising out of element is narrower and requires the claimant to show a causal connection between the employment and the injury such that the injury had 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.*

4. In rendering a decision, the ALJ must make credibility determinations, draw plausible inferences from the record, and resolve essential conflicts in the evidence. *See*

Davison v. Industrial Claim Appeals Office, 84 P.3d 1023 (Colo. 2004). In determining credibility, the ALJ considers 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.

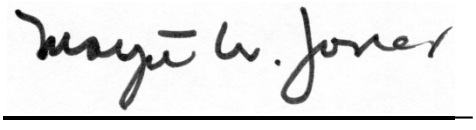
Compensability

5. The ALJ finds that Claimant's testimony regarding the motor vehicle accident of June 11, 2016, was incredible and unpersuasive. Considering Claimant's manner and demeanor on the witness stand, inconsistency in her testimony and actions, the unreasonableness of her testimony and actions, the improbability of Claimant's testimony and actions and Claimant's motives and interest in the outcome of the case, it is found and concluded that Claimant failed to establish by a preponderance of the evidence that she was involved in a motor vehicle accident on June 11, 2016, arising out of and in the course and scope of Claimant's employment.

ORDER

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

This 30h day of January, 2019.



Margot W. Jones

Administrative Law Judge

Office of Administrative Court

1525 Sherman Street, 4th Floor

Denver, CO 80203

ISSUES

1. Whether Respondents have overcome by clear and convincing evidence the DIME physician's opinion on Claimant's permanent partial disability impairment causally related to Claimant's injury.

2. If the DIME physician's opinions on permanent impairment causally related to the work injury are overcome, determination of Claimant's appropriate permanent partial disability impairment rating and whether the impairment is scheduled or whole person.

3. Determination of Claimant's average weekly wage (AWW).

4. Whether Claimant has established by a preponderance of the evidence an entitlement to increased temporary partial disability (TPD) benefits based on an increased AWW.

5. Whether Respondents have established by a preponderance of the evidence that Claimant was responsible for his termination on July 10, 2017 and that the resulting wage loss is not attributable to the May 26, 2017 injury.

6. Whether Claimant has established by a preponderance of the evidence that he is entitled to a gym membership as a specific medical maintenance benefit.

FINDINGS OF FACT

1. Claimant worked for Employer as a forklift operator and was so employed from approximately 2013 until his termination July 10, 2017. Claimant's job duties were heavy and involved pulling orders, loading boxes, lifting boxes, and operating a forklift.

2. On May 26, 2017, while so employed, Claimant sustained an admitted work related injury. On that date, Claimant was loading boxes weighing between 50 and 100 pounds from waist level to a forklift pallet that was at ground level. Claimant pulled a box weighing approximately 92 pounds toward his body when he felt a dislocation in his left shoulder.

3. On May 26, 2017, Claimant was evaluated at Concentra. Claimant reported that he was pulling cases when he felt a twinge and burning in his left shoulder. Claimant reported the pain was in the left posterior shoulder, the pain was sharp and burning, and that the pain was constant. Claimant reported the pain level was an 8/10 and worse with shoulder movement and rotation. Claimant was diagnosed with left shoulder strain. *See* Exhibits 3, C.

4. Claimant was referred to and underwent physical therapy during the next month for his left shoulder. He continued to complain of pain in the left shoulder. *See* Exhibits 3, C.

5. On June 1, 2017, NP Halat evaluated Claimant. Claimant had continued pain at the AC joint in his left shoulder, popping and clunking with movement, and tenderness. Claimant underwent x-rays on his left shoulder that showed AC separation. Clamant was referred for an orthopedic evaluation. *See* Exhibits 3, C.

6. On June 15, 2017, Mark Failinger, M.D. evaluated Claimant. Claimant reported pain in the upper back and with reaching. Dr. Failinger noted that Claimant's strength was fairly good, range of motion was decent, and that Claimant did have some shoulder pain to the side and reaching to the side. On examination, Dr. Failinger found left shoulder weakness and pain, minimal AC joint pain, some pain in the greater tuberosity, and forward flexion at about 50 degrees with some pain in medium ranges. Dr. Failinger reviewed an MRI of the left shoulder that showed a small tear of the supraspinatus and he diagnosed left shoulder rotator cuff supraspinatus tear. Dr. Failinger administered a cortisone injection to the left shoulder. *See* Exhibits 5, D.

7. Claimant alleges he sustained a separate injury to his right shoulder on July 5, 2017. This separate injury was not consolidated into this claim nor is the separate injury part of this case. In his evaluation on July 6, 2017 for his left shoulder, there is no mention of a new right shoulder injury or right shoulder problems. *See* Exhibit 3.

8. On July 13, 2017, Dr. Failinger evaluated Claimant. Claimant reported that the cortisone injection did not provide much relief. Claimant reported that he had the same pain and had no new injuries. Claimant reported pain at the worst was 5-6/10 and at best was 1-2/10. Claimant reported that he did not want surgery because he had surgery on the right shoulder previously that did not really help him at all. Claimant reported the pain woke him up at times and that reaching overhead bothered him some. Claimant's strength and range of motion were noted to be decent. Dr. Failinger performed another cortisone injection. *See* Exhibits 5, D.

9. Claimant continued to be evaluated for his left shoulder. In his left shoulder, Claimant had continued pain, joint stiffness, weakness, tenderness to palpation at the AC joint area, and achiness. Providers continued to note that Claimant's left shoulder had discomfort on flexion, abduction, and internal/external rotation. *See* Exhibits 3, C.

10. On August 10, 2017, Dr. Failinger evaluated Claimant. Dr. Failinger noted again that Claimant did not want surgery, but that he had little else to offer Claimant. Dr. Failinger recommended a second opinion. *See* Exhibits 5, D.

11. On August 24, 2017, John Papillion, M.D. evaluated Claimant. Dr. Papilion noted that Claimant had a prior right shoulder injury in 2014 repaired surgically but that Claimant had no prior problems with the left shoulder. Dr. Papilion found on examination

of the left shoulder pain above 90 degrees, a markedly positive impingement sign type I and II, a mildly positive drop arm test, and pain with testing the supraspinatus. Dr. Papilion diagnosed moderated grade articular sided partial tear rotator cuff lesion (PASTA lesion) in the left shoulder. Dr. Papilion recommended surgical repair. Claimant was hesitant to undergo surgery due to a prior right shoulder surgery that he had undergone and due to the fact that following his prior right shoulder surgery, his right shoulder had continued symptoms. Dr. Papilion explained to Claimant that the 2014 right shoulder injury had involved a very large central tear compared to Claimant's current left shoulder tear which was much smaller and could likely be managed nicely with the recommended surgery and could likely heal completely. Claimant decided to go forward with surgery on his left shoulder. *See* Exhibits 6, E.

12. On September 8, 2017, Dr. Papilion performed surgery on Claimant's left shoulder. Dr. Papilion performed arthroscopic debridement of the labrum and rotator cuff, arthroscopic subacromial decompression with a release of the coracacromial ligament, and arthroscopic rotator cuff repair. In the operative not, Dr. Papilion noted that there was a full thickness tear of the rotator cuff. *See* Exhibits 6, E.

13. On September 19, 2017, Claimant was evaluated by Scott Richardson, M.D. Claimant was noted to still be in a sling following surgery and Claimant reported pain at a level of 5/10 with joint pain, joint stiffness, and night pain. Dr. Richardson noted that the surgical wound looked good, but noted ecchymosis and tenderness to palpation generally about the glenohumeral joint. Dr. Richardson ordered post surgery physical therapy three times per week. *See* Exhibits 3, C.

14. Claimant underwent physical therapy in October of 2017 with Chris Traut, PT. Claimant had a little bit of increased pain at a 6/10 for about 2 hours following a treatment but generally reported his pain at about a 1/10 during October. Claimant reported that he had cervical thoracic joint pain since his surgery and that he had pain with abduction in the impingement position. Claimant reported his shoulder was improving with low pain level at the anterior superior shoulder. PT Traut noted improvement in active range of motion. *See* Exhibits 10. C.

15. On November 2, 2017, Dr. Richardson evaluated Claimant. Claimant reported that his pain level was now at a 0/10 at rest and at a 2/10 with movement. Claimant was noted to be out of the sling and advancing with physical therapy. Claimant reported continued trouble with sleeping and with pain in the left cape area. Claimant was found to have tenderness to palpation at the anterior and superior glenohumeral area and the left trapezius area. *See* Exhibits 3, C.

16. On November 2, 2017, Claimant underwent physical therapy with Autumn Grove, PT. Claimant reported he was doing well with no change. Claimant reported reduced symptoms and benefit from his current treatment. *See* Exhibits 10. C.

17. On November 7, 2017, Claimant underwent physical therapy with PT Traut. Claimant reported that his shoulder felt good but weak and that his current pain was at a

1/10. Claimant reported that he still had trouble sleeping and that his shoulder pain increased at night, up to a 7/10 on days he had therapy and up to a 5/10 on days that he did not have therapy. PT Taut noted that Claimant was progressing well per protocol but was limited by neck pain. PT Traut adjusted Claimant's neck and recommended they continue to monitor and address the neck pain for regional interdependence while also continuing Claimant'' left shoulder rehabilitation. *See* Exhibits 10. C.

18. On November 9, 2017, Claimant underwent physical therapy with PT Traut. Claimant reported increased left superior shoulder pain at night and increased left cervical spine pain at night. On November 14, 2017, Claimant underwent physical therapy with PT Traut. Claimant reported his left shoulder felt tight but had no other symptoms. Claimant reported that he could elevate his shoulder and was happy about that but that his flexion was still limited. PT Traut noted that Claimant could begin resistance. PT Traut noted improved abduction and flexion and that Claimant was progressing as expected. *See* Exhibits 10. C.

19. On November 16, 2017, Claimant underwent physical therapy with PT Traut. Claimant reported pain at a 2/10. Claimant reported that he had gotten up in the middle of the night to go to the bathroom and that he experienced pain in his left cervical from the occiput to the AC joint and that all cervical motions caused pain. Claimant reported that he was doing the home exercise program two times per day and had some pain after doing the home exercise program. PT Traut noted that Claimant's active range of motion decreased from the prior visit and noted concerns over Claimant's cervical pain. Claimant reported that he was seeing a surgeon on the 30th to address his cervical pain. *See* Exhibits 10. C.

20. On November 30, 2017, Dr. Papilion evaluated Claimant. Claimant reported that he was doing well and progressing in therapy. Claimant reported that he still had some pain with overhead use and some cervical paraspinous spasms and tension that bothered him at night. Dr. Papilion found good motion of the cervical spine but some paraspinous tenderness with mild spasm. Dr. Papilion also found tenderness in the trapezius and minimally in the subacromial space. Dr. Papilion found good early strength in the rotator cuff. Dr. Papilion was very pleased with Claimant's progress and recommended Claimant continue therapy and progress to a work conditioning program primarily for strengthening and functional rehab. *See* Exhibits 6, E.

21. Claimant started strengthening and work simulation physical therapy on December 1, 2017 with PT Traut. Claimant reported he was still weak in abduction and reported soreness/pain into the left cervical spine at C5-6 worse with rotation, flexion, and extension. On December 7, 2017 at therapy, Claimant reported no new complaints and that he was doing well. PT Traut noted that Claimant was handling work conditioning well and was progressing with activity tolerance and strength. *See* Exhibits 11, C.

22. On December 7, 2017, Dr. Richardson evaluated Claimant. Claimant reported pain levels at a 1-2/10 with movement. Claimant reported continued joint pain and night pain. On exam, Claimant had tenderness in the trapezius muscle and in the

anterior shoulder but was noted to be at near full range of motion with some lacking in internal rotation. *See* Exhibits 3, C.

23. On December 11, 2017, Claimant underwent therapy with PT Traut. Claimant reported the pain in his anterior shoulder was minimal. Claimant reported that he had neck pain since surgery that was unchanged and was at a 3/10 with neck motions in his left lower cervical area/suprascapular area. PT Traut noted that Claimant continued to have neck pain with relief from manual therapy. The next day, December 12, 2017, Claimant reported feeling more sore in his neck than normal. PT Traut noted Claimant's therapy and progress were as expected. PT Traut opined that Claimant's cervical pain was likely due to weak deep cervical flexors and a tight left levator. PT Traut planned to progress cervical exercises and to continue work simulation for the left shoulder. *See* Exhibits 11, C.

24. On December 13, 2017, Claimant underwent therapy with Michael Griffin, PT. Claimant reported that he had 5/10 soreness in his left shoulder/neck area following a massage the day prior. *See* Exhibits 11, C.

25. On December 18, 2017, Stephanie Best, PT noted that Claimant was there for visit 1/18 for work conditioning. Claimant reported neck/upper trapezius pain that increased with overhead activity and with sleeping. *See* Exhibits 11, C.

26. Claimant continued to undergo work-conditioning therapy. He reported continued soreness/tightness along the left upper trapezius towards the base of the skull, a headache, and tightness from his shoulder to his neck. *See* Exhibits 11, C.

27. On January 11, 2018, Dr. Papilion evaluated Claimant. Dr. Papilion noted that Claimant was doing exceedingly well and had completed therapy. Claimant reported some paracervical and trapezial muscle soreness and pain but reported no shoulder pain. On exam, Dr. Papilion found full active motion in the shoulder and excellent strength in the rotator cuff. Dr. Papilion found some mild tenderness over the trapezius and cervical paraspinous muscles and opined that those symptoms were not related to the shoulder surgery. Dr. Papilion opined that Claimant was approaching MMI with regard to his left shoulder rotator cuff repair and that Claimant had sustained permanent impairment. *See* Exhibits 6, E.

28. Claimant continued to undergo work-conditioning therapy. During this time, he reported continued pain from the shoulder up to the neck bothering him the most at night and reported that it was just always tight.

29. On January 25, 2018, Dr. Richardson evaluated Claimant. Claimant continued to have pain at a 1-2/10 with movement. Claimant also continued to have tenderness and pain in the left trapezius muscle and left anterior shoulder. It was noted that roughly 75% of anticipated healing had taken place. *See* Exhibits 3, C.

30. On February 8, 2018, Dr. Richardson evaluated Claimant. Claimant reported he had been doing physical therapy for strengthening and that his arm still felt weak. Claimant reported pain at a 4/10. Dr. Richardson noted on examination that Claimant lacked about 20-30 degrees of internal rotation but otherwise was at/very near full range of motion. Dr. Richardson noted that Claimant's healing was almost sufficient for the safe return to regular duty work but that Claimant required another recheck prior to discharge. *See* Exhibits 3, C.

31. At work conditioning therapy on February 27, 2018, Claimant reported that he continued with the same feeling of tightness and soreness through the area of the upper trapezius. *See* Exhibits 11, C.

32. On March 8, 2018, Dr. Richardson evaluated Claimant. Claimant reported feeling stronger in his left shoulder and that he had no arm numbness. Dr. Richardson noted that Claimant had not yet found a gym to use yet and discussed finding one near Claimant's residence. Claimant reported shoulder pain at night with pressure in shoulder and joint pain and that his pain medications wore off by 2 a.m. On exam, Claimant's neck was normal and his left shoulder had tenderness to palpation at the about the glenohumeral/trapezius area. Dr. Richardson noted that Claimant was at his functional goal and ready for discharge. Dr. Richardson discussed that Claimant was at maximum medical improvement and provided an impairment rating of 3% upper extremity, 2% whole person. Dr. Richardson opined that Claimant could return to full work/activity. Dr. Richardson noted that for post MMI and future care, Claimant needed six months of maintenance care with him and Dr. Papilion and that Claimant continued to need a gym membership. *See* Exhibits 3, C.

33. On July 12, 2018, Thomas Higginbotham, D.O. performed a division independent medical examination (DIME). Dr. Higginbotham noted that the parts of the body to be evaluated included neck, bilateral shoulders, left rotator cuff injury status post surgery, injury to labrum, injury to coracoacromial ligament, separation of the left acromial joint, leg pain, insomnia, and depression. Dr. Higginbotham noted dates of injury of May 26, 2017 for the left shoulder and another date of injury of July 5, 2017 for the right shoulder that was apparently exacerbated from compensatory use as the left shoulder was healing. Dr. Higginbotham noted that it appeared that both shoulder claims were coupled together. *See* Exhibits 14, B

34. Claimant reported that on July 5, 2017 he injured his right shoulder while pulling and lifting heavy boxes and at the same time trying to protect his injured left shoulder and that his boss denied filling out a new report of injury form. Claimant reported that he retained an attorney in August or September of 2017 and that a new claim was made for the right shoulder. Claimant reported a prior injury to his right shoulder and prior surgery to his right shoulder. Claimant reported that the prior right shoulder injury settled sometime in 2015 and that he was unsure of a rating that he was provided. *See* Exhibits 14, B

35. Claimant reported pain and discomfort in both his shoulder about the left suprascapular and cervical paraspinal areas. Claimant reported headaches, muscle cramps, joint pain and stiffness, depression and nervousness, trouble falling and staying asleep, mood swings, hot flashes, tinging and hot sensation to the hands, nausea and photophobia. Claimant reported that he had a lack of movement in both arms. On exam, Claimant had mild tenderness on moderate pressure palpation about the left deltoid muscle insertion. Claimant had no AC joint tenderness. Claimant had moderate bicipital groove tenderness. Claimant also had mild-moderate left upper trapezius and levator scapular tenderness in his cervicospinal muscles and mild left tenderness in the suboccipitals. Claimant's cervical spine range of motion was mildly limited with pain about the left paraspinal areas. *See* Exhibits 14, B

36. Dr. Higginbotham assessed pull/push/lift strain events to the bilateral shoulders, structural diagnostic evidence of a partial thickness tear of the left distal rotator cuff with surgery, and cervicalgia with strain from post-operative splintage without specific trauma to the neck at the time of the injury. Dr. Higginbotham agreed that Claimant was at MMI as of March 8, 2018 as opined by Dr. Richardson. Dr. Higginbotham opined that a whole person impairment consideration was for both shoulders and for the loss of cervical spine range of motion because of the shoulder condition and without specific injury to the cervical spine itself. Dr. Higginbotham provided an upper extremity impairment for the left shoulder at 15%, which converts to 9% whole person. He noted that included 10% upper extremity impairment for subacromial decompression/acromioplasty, and 6% for range of motion deficits. For the right shoulder, Dr. Higginbotham provided an upper extremity impairment of 6%, which converts to 4% whole person. For the cervical spine, Dr. Higginbotham provided a spine impairment of 6% whole person based entirely on range of motion deficits. Dr. Higginbotham noted that there was no specific disorder of the cervical spine and no specific injury to the cervical spine at the time of the injury but opined that Claimant had a loss or range of motion due to the bilateral shoulder conditions. Dr. Higginbotham opined that the total combined whole person impairment rating was 17%. Dr. Higginbotham opined that there was no apportionment of the cervical loss of range of motion or the left shoulder and that there were no disabling conditions of the left shoulder and neck at the time of the injury. Dr. Higginbotham noted that apportionment of the right shoulder would be appropriate but that there were no records of the prior injury and Claimant was unsure of any impairment. Thus, Dr. Higginbotham noted specifically that the 17% value was without apportionment of the right shoulder. *See* Exhibits 14, B

37. Dr. Higginbotham noted that further medical care needed and that the ongoing care would be primarily in the form of self-care and mindfulness of excessive physical activities of the shoulder along with a concerted stretching and strengthening exercise routine and auto massage techniques with tennis ball and/or foam roller. Claimant's lifting restriction was put at a maximum of 45 pounds and his above shoulder activity was limited to intermittently up to 2 hours. *See* Exhibits 14, B.

38. On October 31, 2018, John Burris, M.D. performed an independent medical evaluation. Claimant reported that he injured his left shoulder at work on May 26, 2017.

Claimant reported undergoing physical therapy, injections, and surgery. Claimant reported there were no complications and that he completed physical therapy after surgery. Claimant reported pain at a 7/10 directly in his left shoulder. Claimant reported the pain could vary between 2-9/10 and on a pain diagram, Claimant localized the pain to the superior trapezius region. Claimant did not report neck pain, radiation of symptoms into his extremities or persistent numbness/weakness in extremities. Dr. Burris reviewed medical records and performed a physical examination. On exam, Claimant's cervical spine was normal, non-tender, with full fluid range of motion in all planes and negative Spurlings bilaterally. On left shoulder exam, Claimant was non-tender over the lateral edge of the acromion and bicipital groove, focally tender over the superior aspect of the left trapezius musculature, with no muscle spasm or trigger points. Claimant was non-tender through the posterior shoulder girdle. Claimant had full strength.

39. Dr. Burris noted that Claimant reported that he had a good response from his prior right shoulder workers' compensation claim with complete relief of pain that was contradicted by the medical records. Dr. Burris also noted the claimed new right shoulder injury on July 5, 2017 is not noted or documented by providers in this claim who were treating the left shoulder. Dr. Burris opined that there was clear consensus that Claimant reached MMI on March 8, 2018 for the left shoulder injury. Dr. Burris opined that Claimant's permanent impairment was 3% upper extremity for range of motion loss. Dr. Burris opined that this was consistent with Claimant's range of motion documented by all of his treating providers. Dr. Burris noted that while the rating could be converted to a 2% whole person rating, in Claimant's case there was no evidence of proximal involvement on examination so the rating remains an upper extremity rating.

40. Dr. Burris opined that DIME physician Dr. Higginbotham made several significant errors in the impairment rating calculations including rating the cervical spine without a table 53 disorder, rating the right shoulder that was unrelated to this claim, and rating for the subacromial decompression. Dr. Burris opined that Claimant did not injure the cervical spine or right shoulder on May 26, 2017. Dr. Burris noted that the Division of Workers' Compensation specifically instructs providers that "in shoulder cases with accompanying neck pain, the clinician must determine whether an additional objective work related Table 53 cervical pathology qualifies for a rating or the symptoms the patient has are those expected from the shoulder pathology and do not qualify for an additional rating." Dr. Burris opined that Claimant currently has some myofascial tenderness in the left trapezius musculature without cervical spine pain. He opined that was an expected finding after shoulder surgery and does not qualify for an additional cervical rating. Dr. Burris further noted that for shoulder surgery, the Division of Workers' Compensation instructs that "subacromial arthroplasty should be rated using range of motion, and when appropriate, joint crepitation with motion from the other disorders section." Dr. Burris noted that although there was an allowance for up to 10% upper extremity, it was recommended only if "other factors have not adequately rated the extent of the impairment." Dr. Burris opined that given the concepts, DIME physician Dr. Higginbotham's inclusion of a 10% impairment for the subacromial decompression was inconsistent with the instructions. Further, Dr. Burris opined that the DIME physician's range of motion was significantly different from all the range of motion measurements in

the records which were relatively consistent including from Dr. Richardson, Dr. Papilion, the physical therapists, and his measurements. Dr. Burris opined that no permanent work restrictions or maintenance care was indicated and that Claimant should be encouraged to actively and regularly participate in a self-directed home exercise program. See exhibit A.

41. Dr. Burris testified at hearing consistent with his independent medical evaluation report. Dr. Burris testified that he disagreed with DIME physician Higginbotham and that it was not appropriate to give a 10% rating for the subacromial decompression since range of motion should characterize most losses and that the use of the additional rating is only in extreme cases where range of motion doesn't capture the anatomical loss. Dr. Burris opined there was no reason on exam for an additional rating of 10% and that the physical therapy records, authorized treating provider records, and surgeon's records did not support the 10% additional rating. Dr. Burris noted that Claimant had good range of motion, full strength, and no work restrictions and that his range of motion adequately rated Claimant's loss as Claimant had done very well following surgery. Dr. Burris noted that his rating of 3% was supported by the range of motion measurements done by Dr. Richards, Dr. Papilion, and the physical therapists. He noted that Dr. Higginbotham's rating of 6% was not as consistent as the consistent ratings between himself and multiple other providers. Dr. Burris further noted that Claimant's irritation of musculature including the trapezius, paraspinals, rhombus can be related to shoulder surgery and can get irritated during a recovery, but that the musculature irritation is not a cervical spine injury nor does it qualify for a Table 53 diagnosis or cervical spine permanent impairment. Dr. Burris opined that the musculature irritation was a very common and expected outcome from shoulder surgery and that DIME physician Dr. Higginbotham rated the cervical spine in error since you should not rate range of motion limitations without a Table 53 diagnosis. Dr. Burris testified that in unusual cases with severe shoulder pathology there is an exception but that Claimant did not have severe pathology and had a great outcome.

42. Records show that Claimant previously received a 7% upper extremity rating of his right shoulder. This was for a work related right shoulder injury on August 12, 2014. Claimant has better range of motion in his right shoulder now than he did at the time he received a prior impairment rating. Claimant did not present testimony or persuasive evidence to support his contention that he sustained a new right shoulder injury in this case or that he is entitled to a right shoulder rating in this case. *See* Exhibits 15, I, J.

43. Wage records show that prior to his injury on May 26, 2017, Claimant's gross pay varied from week to week based on the number of hours that he worked. Claimant had some weeks with higher hours and pay and some weeks with lower hours and pay. A variance throughout his pay existed from wage records November 2015 and through his injury. In the 21 weeks prior to his injury, Claimant earned gross wages of $18,081.15, amounting to an average weekly wage of $861.01. Respondents admitted to an average weekly wage of $862.03 using 53 weeks of wages prior to the injury. Claimant argues that the ALJ should use a 5-week period prior to the injury to calculate

Claimant's average weekly wage. Claimant has not presented persuasive argument or evidence to establish that a five-week period accurately reflects Claimant's earnings or lost income potential. Rather, as the records consistently show from 2015 through the injury, Claimant's wages varied and the ALJ finds that a fair calculation includes a larger period than just 5 weeks prior to the injury. Claimant's average weekly wage is $862.03.

44. Claimant was terminated by Employer on July 10, 2017. Prior to his May 26, 2017 injury, Claimant had received two corrective action forms. On April 17, 2017 Claimant received and signed a corrective action form for insubordination. On May 19, 2017, Claimant received a corrective action noting he had accumulated 8 points against his attendance. The corrective action noted that if Claimant received 2 more points he would be terminated and noted that it was a final warning. Claimant had accumulated points for being late on March 4, 2017, March 8, 2017, March 23, 2017, April 5, 2017, April 17, 2017, and April 21, 2017. All of these were prior to his injury. Claimant accumulated two additional points for being late on May 20, 2017, May 26, 2017, June 2, 2017, and July 1, 2017 before he was terminated.

CONCLUSIONS OF LAW

Generally

The purpose of the Workers' Compensation Act of Colorado, §§ 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. *See* § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 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).

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceeding is exclusive domain of administrative law judge. *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. 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); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may

resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission,* 441 P.2d 21 (Colo. 1968).

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

Average Weekly Wage

Section 8-42-102(2) C.R.S. requires the ALJ to base claimant's AWW on her earnings at the time of injury. Under some circumstances, the ALJ may determine a claimant's TTD rate based upon her AWW on a date other than the date of injury. *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993). Section 8-42-102(3), *supra*, grants the ALJ discretionary authority to alter that formula if for any reason it will not fairly determine claimant's AWW. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). The overall objective of calculating AWW is to arrive at a fair approximation of claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997). Where her earnings increase periodically, claimant's AWW should be calculated based upon her earnings during a given period of disability, and not based upon earnings at the time of injury. *Campbell v. IBM Corp.*, *supra*. Earnings from concurrent employment may be included in a claimant's AWW where the injury impairs earning capacity from such employment. *Jefferson County Schools v. Dragoo*, 765 P.2d 636 (Colo. App. 1988).

Wage records show that prior to his injury on May 26, 2017, Claimant’s gross pay varied from week to week based on the number of hours that he worked. Claimant had some weeks with higher hours and pay and some weeks with lower hours and pay. A variance throughout his pay existed from wage records November 2015 and through his injury. In the 21 weeks prior to his injury, Claimant earned gross wages of $18,081.15, amounting to an average weekly wage of $861.01. Respondents admitted to an average weekly wage of $862.03 using 53 weeks of wages prior to the injury. Claimant argues that the ALJ should use a 5-week period prior to the injury to calculate Claimant’s average weekly wage. Claimant has not presented persuasive argument or evidence to establish that a five-week period accurately reflects Claimant’s earnings or lost income potential. Rather, as the records consistently show from 2015 through the injury, Claimant’s wages varied and the ALJ finds that a fair calculation includes a larger period than just 5 weeks prior to the injury. Claimant’s average weekly wage is $862.03.

DIME Physician Opinion

A DIME physician must apply the AMA Guides when determining the claimant’s medical impairment rating. Section 8-42-101(3.7), C.R.S.; §8-42-107(8)(c), C.R.S. The finding of a DIME physician concerning the claimant’s medical impairment rating shall be overcome only by clear and convincing evidence. Clear and convincing evidence is that

quantum and quality of evidence which renders a factual proposition highly probable and free from serious or substantial doubt. Thus, the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

As a matter of diagnosis the assessment of permanent medical impairment inherently requires the DIME physician to identify and evaluate all losses that result from the injury. *Mosley v. Industrial Claim Appeals Office,* 78 P.3d 1150 (Colo. App. 2003). Consequently, a DIME physician's finding that a causal relationship does or does not exist between an injury and a particular impairment must be overcome by clear and convincing evidence. *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186 (Colo. App. 2002); *Qual-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590 (Colo. App. 1998). The rating physician's determination concerning the cause or causes of impairment should include an assessment of data collected during a clinical evaluation and the mere existence of impairment does not create a presumption of contribution by a factor with which the impairment is often associated. *Wackenhut Corp. v. Industrial Claim Appeals Office,* 17 P.3d 202 (Colo. App. 2000).

The questions of whether the DIME physician properly applied the AMA Guides, and ultimately whether the rating was overcome by clear and convincing evidence present questions of fact for determination by the ALJ. *Wackenhut Corp. v. Industrial Claim Appeals Office,* 17 P.3d 202 (Colo. App. 2000). A mere difference of opinion between physicians does not necessarily rise to the level of clear and convincing evidence. *See Gonzales v. Browning Ferris Industries of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

Right Shoulder

As found above, the medical records lack any mention to treating providers of an acute right shoulder injury on July 5, 2017. Rather, the evidence is persuasive that after a work related right shoulder injury in 2014 and after surgery for that injury, Claimant continued to have issues with his right shoulder. Claimant received a permanent impairment rating for his prior right shoulder injury, which was a 7% scheduled impairment. DIME physician Dr. Higginbotham noted in his report that any prior impairment of the right shoulder should be apportioned out of this claim (where he provided a 6% right shoulder extremity rating). DIME physician Dr. Higginbotham also noted his belief that there had been a right shoulder injury and belief that the right shoulder had been consolidated into this case in his preliminary page. These "beliefs" in his report are in error. DIME physician Dr. Higginbotham clearly erred by rating and including the right shoulder. Rather than finding a causal relationship of the right shoulder to this claim, the DIME physician just rated the right shoulder. The records clearly lack any demonstrated acute right shoulder injury actually occurred on July 5, 2017 and lack any demonstrated evidence that a right shoulder injury would be in any way related to this claim where Claimant sustained an acute left shoulder injury on May 26, 2017. Even if hypothetically Claimant sustained a right shoulder injury on July 5, 2017 that was somehow consolidated into this claim, the rating for the right shoulder would be 0. The

DIME physician correctly noted that a prior right shoulder rating would have to be apportioned out yet did not have records or request records to determine how much should be apportioned out and just rated the right shoulder. The DIME physician erred by rating the right shoulder as there was no right shoulder injury and, even if there were a right shoulder injury, a prior higher rating on the same shoulder would require this rating to be 0. Claimant's right shoulder is better now than it was at the time he was rated following his 2014 injury. It is very difficult to conceive why Claimant did not concede that the right shoulder was not part of this claim and/or concede that the right shoulder was not ratable due to the prior rating and apportionment requirements. Respondents have overcome the DIME physician opinion on permanent partial impairment and have established by clear and convincing evidence that the right shoulder is not part of this claim and is not ratable.

Cervical Spine

Respondents also have stablished by clear and convincing evidence that DIME physician Dr. Higginbotham erred by providing a cervical spine impairment rating. Claimant did not injure his cervical spine on May 26, 2017. Claimant has no cervical spine objective pathology or diagnosis. Claimant has no structural change to his cervical spine. DIME physician Dr. Higginbotham noted in his report that Claimant had no injury to the cervical spine at the time of the injury event and that there is no specific disorder of Claimant's cervical spine under Table 53. Despite this, Dr. Higginbotham rated Claimant as having a cervical spine impairment. This was in error. DIME physician Dr. Higginbotham even notes in his report that the range of motion impairment he rated flowed from both of Claimant's shoulders and not from a specific cervical spine problem or Table 53 diagnosis. Although some of the muscles between the shoulder and neck were irritated after shoulder surgery, Claimant did not sustain a permanent impairment to his cervical spine allowing or requiring a rating. Claimant has no intervertebral disc lesion and no soft tissue lesion in his cervical spine. Unlike other cases where a specific scalene muscle injury was diagnosed and documented as part of an injury and was allowed to be rated, Claimant has no such diagnoses. Cervicalgia, or neck pain, is not a specific diagnosis of injury to a structure or specific muscle but is a term for neck pain. Surgeon Dr. Papilion believed Claimant's neck muscle symptoms were not related to the shoulder surgery. The DIME physician opined that the symptoms were due to post-operative splintage. However, this opinion is in error and contradicted by the overall medical records showing a lack of complaints during the splintage period. Even Claimant argues contrary to the DIME opinion on post-operative splintage and Claimant argues that he actually injured his cervical spine during a physical therapy manipulation treatment in November of 2017, two months after his left shoulder surgery. Records from therapy show an increase in neck pain and decrease in motion after waking up from sleeping during the night. Here, there was no documented injury to any areas of the cervical spine. Rather, as testified persuasively by Dr. Burris, Claimant had expected muscle soreness in areas next to his shoulder following surgery. Not only did Claimant not have a medically documented injury to his cervical spine (or any diagnosis to a specific lesion or muscle area during his treatment), to rate there also is a requirement of pain AND rigidity. The records fail to show rigidity. Rather, Claimant does exceedingly well in physical

therapy and has near full range of motion and strength. Claimant further argues that he would be allowed a cervical spine rating under the Spinal Rating Tips even if he did not qualify for a Table 53 rating, because his case is an unusual case with established severe shoulder pathology accompanied by treatment of the cervical musculature. Not only does this tip require it be to be well justified by the clinician (and DIME physician Dr. Higginbotham provides very little justification) but it also requires the case to be unusual with severe shoulder pathology. Claimant does not have severe shoulder pathology nor is his case unusual. Claimant had a shoulder tear corrected by surgery and has had an excellent outcome. Thus, the rating provided by Dr. Higginbotham is in error and has been overcome. Claimant is not entitled to a rating for his cervical spine.

DIME physician opinion – after overcome by clear and convincing evidence

Deleon v. Whole Foods Market, Inc., W.C. No. 4-600-477 (ICAO, November 16, 2006), addressed the proper evidentiary standard for determining a claimant's impairment rating after an ALJ finds that a portion of the DIME physician's impairment rating has been overcome by clear and convincing evidence. In the *Deleon* case the ALJ determined the respondents overcame by clear and convincing evidence a DIME physician's finding that the claimant sustained 5 percent impairment for lost range of motion in the lumbar spine. However, the ALJ also found that the respondents failed to overcome by clear and convincing evidence the DIME physician's finding that the claimant sustained 5 percent impairment for a specific disorder of the lumbar spine. Consequently the ALJ upheld the specific disorder portion of the rating. The ICAO ruled that once an ALJ determines "the DIME's rating has been overcome in any respect" the ALJ is "free to calculate the claimant's impairment rating based upon the preponderance of the evidence" standard. The ICAO further stated that when applying the preponderance of the evidence standard the ALJ is "not required to dissect the overall impairment rating into its numerous component parts and determine whether each part or sub-part has been overcome by clear and convincing evidence."

Left shoulder- determination of appropriate rating- scheduled vs. whole person

As the DIME physician's opinions on permanent partial disability rating has been overcome, the determination of the appropriate permanent partial disability rating may be calculated and determined based on a preponderance of the evidence. The DIME physician provided a rating for the left shoulder that included both a 10% rating for the subacromial decompression/acromioplasty and a 6% rating for range of motion deficits.

A preponderance of the evidence establishes that the appropriate permanent partial disability rating for the left shoulder range of motion deficit is 3% upper extremity and not the 6% provided by DIME physician Dr. Higginbotham. The 3% rating is consistent with the overall weight of the evidence and medical records and is consistent with the ratings provided by the authorized treating provider Dr. Richardson, Dr. Burris, the physical therapists measurements, and the opinion of Dr. Papilion the surgeon. The range of motion permanent impairment deficit in Claimant's left shoulder is 3%.

Further, as found above, DIME physician Dr. Higginbotham provided an additional 10% rating of the left shoulder for the subacromial decompression/acromioplasty. Although the rating tips allow a 10% rating if other factors have not adequately rated the extent of Claimant's impairment, Dr. Burris is persuasive that there were no other factors in this case to provide an additional 10% rating and is persuasive that the range of motion impairment adequately rates and captures Claimant's true impairment given Claimant's excellent result following surgery. The opinion of Dr. Burris is consistent with the opinions of Dr. Richardson, Dr. Papilion, and of the records from physical therapy which show excellent progress. DIME physician Dr. Higginbotham did not explain his basis for including the extra 10% rating or explain why the range of motion did not adequately rate the extent of Claimant's impairment. The overall medical records show very little residual impairment following surgery, physical therapy, and work conditioning. Claimant cites to an untitled case where an additional 10% rating was provided and upheld as being appropriate, as range of motion did not adequately rate the extent of an impairment. In that case, the Claimant had a metal plate and multiple pins and screws permanently inserted and fixed in his shoulder. This case is entirely different. Here, Claimant had a left shoulder surgery with normal resection and stitching. Claimant had no metal plates, screws, or pins inserted. In this case, Claimant had an excellent outcome with very minimal remaining impairment. The ALJ finds, by a preponderance of the evidence and the persuasive medical evidence, that the appropriate rating for Claimant's left shoulder injury is 3% left upper extremity.

Claimant has established by a preponderance of the evidence that his 3% left upper extremity impairment should be converted to a 2% whole person impairment rating. Section 8-42-107(1)(a), C.R.S., provides that when an injury results in permanent medical impairment and the "injury" is enumerated in the schedule set forth in subsection (2) of the statute, "the employee shall be limited to the medical impairment benefits as specified in subsection (2)." If the claimant sustains an injury not found on the schedule § 8-42-107(1)(b), C.R.S., provides the claimant shall "be limited to medical impairment benefits as specified in subsection (8)," or whole person medical impairment benefits. As used in these statutes the term "injury" refers to the part or parts of the body that sustained the ultimate loss, not necessarily the situs of the injury itself. Thus, the term "injury" refers to the part or parts of the body that have been functionally disabled or impaired. *Warthen v. Industrial Claim Appeals Office,* 100 P.3d 581 (Colo. App. 2004); *Strauch v. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo. App. 1996). Under this test the ALJ is required to determine the situs of the functional impairment, not the situs of the initial harm, in deciding whether the loss is one listed on the schedule of disabilities. *Strauch v. PSL Swedish Healthcare System, supra.* Pain and discomfort that limit the claimant's use of a portion of the body may constitute functional impairment. *Johnson-Wood v. City of Colorado Springs,* W.C. No. 4-536-198 (ICAO June 20, 2005); *Vargas v. Excel Corp.,* W.C. No. 4-551-161 (ICAO April 21, 2005). The ALJ may also consider whether the injury has affected physiological structures beyond the arm at the shoulder. *Brown v. City of Aurora,* W.C. No. 4-452-408 (ICAO October 9, 2002).

Section 8-42-107(2)(a), C.R.S., provides for scheduled compensation based on "loss of an arm at the shoulder." The claimant bears the burden of proof by a preponderance of the evidence to establish functional impairment beyond the arm at the shoulder and the consequent right to PPD benefits awarded under § 8-42-107(8)(c). Whether the claimant met the burden of proof presents an issue of fact for determination by the ALJ. *Delaney v. Industrial Claim Appeals Office,* 30 P.3d 691 (Colo. App. 2001); *Johnson-Wood v. City of Colorado Springs, supra.*

Claimant's functional impairment due to his May 26, 2017 left shoulder injury, by a preponderance of the evidence, is found to extend beyond the arm at the shoulder. Claimant has pain and discomfort in the primary site of his injury to the left shoulder and pain and discomfort that refers out into musculature beyond the arm at the shoulder. The referred pain and muscular discomfort from his left shoulder can be expected as a result of the type of surgical procedure Claimant underwent. Although has no rigidity, specific lesion, or objective structural change beyond the arm at the shoulder, Claimant has established by preponderant evidence that he has pain and discomfort beyond the arm at the shoulder that cause some functional impairment beyond the arm at the shoulder. His injury, pain, and discomfort limit his overhead usage of the left arm and limit the usage of surrounding muscles that extend beyond the arm at the shoulder. Thus, Claimant has established by a preponderance of the evidence that his 3% scheduled left shoulder impairment should be converted to a 2% whole person impairment rating for his May 26, 2017 left shoulder injury.

Medical Maintenance Benefits

The respondents are liable to provide such medical treatment "as may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee of the effects of the injury." Section 8-42-101(1)(a), C.R.S. Colorado courts have ruled that the need for medical treatment may extend beyond the point of MMI where the claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury or prevent further deterioration of her condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995).

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

Claimant has failed to meet his burden to establish that a gym membership is reasonable and necessary to maintain his condition after MMI or to relieve his ongoing symptoms. Claimant did not explain why the home exercise program needs to be completed in a gym and why the exercises cannot be completed at home. There is insufficient evidence in the record to establish that a gym is necessary to complete his continued home exercises program.

Temporary Partial Disability Benefits and Termination

Claimant requested the ALJ order additional temporary partial disability benefits based only on Claimant's argument that Claimant's average weekly wage should have been higher and thus the benefits should be higher. As found above, the ALJ has declined to increase the average weekly wage and found Claimant's average weekly wage argument not persuasive. Therefore, the temporary partial disability benefits will not be adjusted or increased as requested.

Respondents requested that the ALJ find Claimant was responsible for the termination of his employment on July 10, 2017 and thus argued that Claimant is not entitled to benefits after that date. Section 8-42-103(1)(g), C.R.S., and § 8-42-105(4)(a), C.R.S., 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). 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 *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.*

Violation of an employer's policy does not necessarily establish the claimant acted volitionally with respect to a discharge from employment. *Gonzales v. Industrial Commission,* 740 P.2d 999 (Colo. 1987). However, a claimant may act volitionally if he is aware of what the employer requires and deliberately fails to perform accordingly. *Gilmore v. Industrial Claim Appeals Office, supra*. This is true even if the claimant is not specifically warned that failure to comply with the employer's expectations may result in termination. *See Pabst v. Industrial Claim Appeals Office,* 833 P.2d 64 (Colo. App. 1992). 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 found above, Claimant violated employer's attendance and tardiness policy. Claimant accumulated 10 points for repeated violations of the policy. Claimant presented no testimony or evidence surrounding these violations documented by Employer. Respondents established through evidence that Claimant accumulated these points, leading to his termination, on multiple dates. There are no medical records indicating sleep problems interfering with work attendance. Respondents have established, by a preponderance of the evidence that Claimant was responsible for his termination from employment on July 10, 2017 and that the resulting wage loss is not attributable to his injury.

ORDER

IT IS HEREBY ORDERED that:

1. Respondents have overcome by clear and convincing evidence DIME physician Dr. Higginbotham's opinion on Claimant's permanent partial disability impairment causally related to Claimant's May 26, 2017 injury.

2. Claimant is not entitled to a rating for his right shoulder or cervical spine.

3. Claimant's left shoulder rating is 2% whole person impairment.

4. Claimant's average weekly wage is $862.03 and he is not entitled to an increase in temporary partial indemnity benefits, as his AWW has not been increased.

5. Claimant has failed to establish by a preponderance of the evidence that a gym membership is reasonable and necessary as a specific medical maintenance benefit.

6. Respondents have established by a preponderance of the evidence that Claimant was responsible for his termination on July 10, 2017 and that the resulting wage loss is not attributable to the injury.

7. All other issues not determined 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, 1525 Sherman St., 4th Floor, Denver, CO 80203. 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. 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: January 31, 2019

/s/ Michelle E. Jones

_____

Michelle E. Jones
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, CO 80203

STATE OF COLORADO OFFICE OF ADMINISTRATIVE COURTS 1525 Sherman Street, 4th Floor Denver, CO 80203	
In the Matter of the Workers' Compensation Claim of: , Claimant, vs. , Employer, and , Insurer, Respondents.	▲ COURT USE ONLY ▲ **CASE NUMBER:** **WC 5-012-594-01**
ORDER FOLLOWING REMAND FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER	

PROCEDURAL HISTORY

Hearing in this matter was held on December 19, 2017, before Margot W. Jones, Administrative Law Judge (ALJ). At hearing, Claimant was represented by ----------, Esq. Respondents were represented by ----------, Esq. Following the December 19, 2017, hearing, the ALJ entered Specific Findings of Fact, Conclusions of Law and Order (full findings) on March 15, 2018.

In the March 15, 2018, full findings, the ALJ concluded that Respondents proved by clear and convincing evidence that the opinion of the Division of independent medical examiner (DIME), Dr. Caroline Gellrick, is most probably incorrect. On April 4, 2018, Claimant filed a petition for review of the full findings, and, on October 4, 2018, the Industrial Claims Appeal Office, (ICAP) affirmed the full findings regarding the DIME opinion and remanded the matter to the ALJ for resolution of the question whether Claimant sustained her burden of proof to establish by a preponderance of the evidence that she is entitled to a general award of maintenance medical benefits. This order follows the remand order from ICAP.

In this order, ---------- will be referred to as "Claimant," the ---------- will be referred to as "Employer," ---------- will be referred to as "Insurer" and Employer and Insurer, collectively, will be referred to as "Respondents." Also in this order, "ALJ" or

"Judge" refers to the Administrative Law Judge, "C.R.S." refers to the Colorado Revised Statutes, "OACRP" refers to the Office of Administrative Courts Rules of Procedure, 1 CCR 104-1 and "WCRP" refers to Workers' Compensation Rules of Procedure, 7 CCR 1101-3.

ISSUE

Whether Claimant proved by a preponderance of the evidence that she is entitled to a general award of maintenance medical benefits.

FINDINGS OF FACT

1. Claimant suffered injury to her back in the course and scope of her employment on March 24, 2016. Claimant received authorized, reasonably necessary and related medical treatment from Dr. Samuel Chan. Dr. Chan placed Claimant at maximum medical improvement (MMI) on January 18, 2017. At MMI, Dr. Chan recommended an additional set of SI joint injections on a maintenance medical basis over the course of four to six months. Dr. Chan also recommended cardiovascular strengthening exercise and a core stabilization program.

2. On March 13, 2017, Respondents filed a Final Admission of Liability based on Dr. Chan's report. Respondents admitted liability for maintenance medical benefits for the lumbar spine, SI joint injections. Claimant objected to the FAL and requested a Division independent medical examination (DIME). Dr. Caroline Gellrick performed a DIME and prepared a report dated May 30, 2017. Dr. Gellrick recommended maintenance medical benefits consistent with Dr. Chan's recommendation for SI joint injections on the right side over four to six months. Dr. Gellrick also recommended a home exercise program, including use of a pool, and massage therapy and physical therapy in association with the SI injections.

3. Claimant testified that she did not want to undergo further SI joint injections, nor take prescription medications and did not want further massage therapy. Claimant also testified that she already has a self-directed gym membership with pool usage and was not seeking it as a benefit from Respondents.

4. On October 18, 2017, Claimant underwent an independent medical examination (IME) with Dr. Ethan Moses. Dr. Moses indicated that the next level of treatment was a SI neurotomy. Dr. Moses did not believe that further SI joint injections were warranted.

5. Dr. Moses recommended SI neurotomy, with four to ten visit for rehabilitation in accordance with the medical treatment guidelines and low back pain treatment guidelines. Dr. Cebrian referred to the SI neurotomy procedure as a SI rhizotomy. Claimant testified that she wants the recommended treatment, the SI neurotomy, and post procedure rehabilitation. Even though no other physician made a recommendation for Claimant to receive a SI neurotomy or

SI rhizotomy, Claimant testified that she has confidence in Dr. Moses's medical skills. Yet, Claimant also testified that she has not previously treated with Dr. Moses.

6. Dr. Carlos Cebrian also conducted an IME of Claimant and reviewed her medical records. Dr. Cebrian opined that further medical treatment was not warranted. Dr. Cebrian credibly opined that a self-directed home exercise program was all Claimant required going forward. Dr. Cebrian opined that further SI joint injections were not warranted because Claimant did not respond positively to the injection and under the treatment guidelines repeat injection is not warranted. Dr. Cebrian opined that SI neurotomy or SI rhizotomy was not reasonably necessary treatment. With regard to Claimant's thoracic spine complaints, Dr. Cebrian opined that there was no specific diagnosis of an injury to the thoracic spine and no treatment going forward was reasonably necessary. Dr. Cebrian's opinion was found to be more credible and persuasive than the opinions of Dr. Chan, Moses, and Gellrick.

7. It is found and concluded that Claimant failed to prove by a preponderance of the evidence that she requires maintenance medical treatment and therefore is not entitled to a general award of maintenance medical benefits.

8. CONCLUSIONS OF LAW

General Legal Principles

1. The purpose of the Workers' Compensation Act of Colorado, Section 8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-201, C.R.S. The claimant shoulders the burden of proving by a preponderance of the evidence that he is a covered employee who suffered an "injury" arising out of and in the course of employment. Section 8-43-301(1), C.R.S.

2. The claimant must prove by a preponderance of the evidence that his 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) and (c), 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).

3. In rendering a decision, the ALJ must make credibility determinations, draw plausible inferences from the record, and resolve essential conflicts in the evidence. *See Davison v. Industrial Claim Appeals Office,* 84 P.3d 1023 (Colo. 2004). In determining credibility, the ALJ considers 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.

Maintenance Medical Benefits

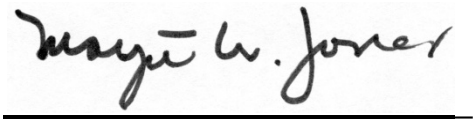
5. The need for medical treatment may extend beyond the point of maximum medical improvement where claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury or to prevent further deterioration of his condition. *Grover v. Industrial 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. *Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003).

6. Claimant failed to establish by a preponderance of the evidence that she is entitled to a general award of maintenance medical benefits. In this matter, Dr. Cebrian's opinions are found to be more credible and persuasive than the opinions of Drs. Chan, Gellrick or Moses opinions regarding maintenance medical treatment.

ORDER ON REMAND

1. Claimant's claim for a general award of maintenance medical benefits is denied and dismissed.

This 17th day of January, 2019.



Margot W. Jones

Administrative Law Judge

Office of Administrative Court

1525 Sherman Street, 4th Floor

Denver, CO 80203

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 5-078-666-001

CORRECTED FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

Claimant,

v.

Employer,

and

Insurer / Respondents.

No further hearings have been held in the above-captioned matter. On January 28, 2019, counsel Claimant filed a Motion for Corrected Order, based solely on the proposition that temporary partial disability (TPD) benefits were improperly calculated. The Motion is well taken and the Full Findings of Fact, Conclusions of Law and Order, served on the parties on January 24, 2019, is hereby corrected accordingly.

Hereinafter ---------- shall be referred to as the “Claimant." ---------- shall be referred to as the “Employer.” All other parties shall be referred to by name.

Claimant’s Exhibits 1 through 10 were admitted into evidence, without objection. Respondents’ Exhibits A through F were admitted into evidence, without objection.

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to counsel for the Claimant, which was filed, electronically, on December 24, 2018. Respondent was given two working days within which to file objections as to form. No timely objections were filed. After a consideration of the proposed decision, the ALJ has modified it and hereby issues the following decision.

ISSUES

The issues to be determined by this decision concern compensability; if compensable, temporary partial disability (TPD) benefits from March 23, 2018 through June 22, 2018. At the commencement of the hearing, the parties stipulated that the Claimant's average weekly wage (AWW) is $547.40, and the ALJ so finds.

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 33-year old woman employed by the Employer. Prior to March 23, 2018, she worked as a waitress on the "Event" staff, and as a busser in the restaurant. Her stipulated AWW is $547.40.

2. The Claimant has had no prior injuries to her cervical spine or right shoulder.

3. Prior to the date of the Claimant's industrial injury she was able to perform her full work duties as both a waitress and busser.

The Compensable Event of March 23, 2018

4. The Claimant sustained a work-related injury on Friday March 23, 2018. The incident happened around 11:00 AM on the Employer's property as the Claimant was walking into her place of employment. The Claimant was roughly 12-15 feet from the Employer's entrance when the wind randomly blew a nearby plastic "A-Frame" sign into a 3 to 4 foot tall light post; the top of which broke off and sent debris into the air. The Claimant was talking on her cell phone when she noticed the debris was flying toward her. This caused the her to quickly turn away from the debris and attempt to protect herself with her bag which was draped over her right shoulder. Despite the attempt to protect herself, the Claimant was stuck in the right side of the face by the debris. She quickly developed facial pain, headache, and vision issues with her left eye.

First Reporting of the Work Injury

5. The Claimant's manager, Cassandra Dunning, was walking behind the Claimant and witnessed the incident. Dunning approached the Claimant immediately thereafter to check on her wellbeing. Dunning then escorted the Claimant into the Employer's offices and helped the Claimant report a work injury.

6. An “Employer’s First Report of Injury” was filed on March 23, 2018 at approximately 11:00 AM. Cassandra Dunning is listed as a witness. The incident as described in paragraph 4 above, is described as the mechanism of injury in the First Report.

Medical Treatment

7. The Claimant had an initial evaluation at Concentra around 1:00 PM on March 23, 2018. She was treated for an injury to her left eye, facial pain, and headache. She was given eye drops, instructed to wear protective eye wear while at work, and she scheduled for a follow-up appointment for Monday March 26, 2018.

8. After being discharged from Concentra, the Claimant returned to work for the Employer as a busser for the night. While working, the Claimant began experiencing pain in her neck and right shoulder. She did not work the next two days but continued to have issues with her neck and right shoulder.

9. The Claimant was evaluated at Concentra on Monday March 26, 2018 and she reported neck and right shoulder pain that began a few hours after being discharged on March 23, 2018. The Claimant was diagnosed with a cervical strain, prescribed medication, and referred for physical therapy (PT).

10. Thereafter, the Claimant underwent a course of cervical and right shoulder treatment inclusive of evaluations, work restrictions, PT, massage therapy, acupuncture, and injections.

11. The Claimant was placed at maximum medical improvement (MMI) on June 22, 2018.

Corrected Temporary Partial Disability

12. The Claimant suffered temporary, partial wage loss resulting from her work injury. The wage loss was in part due to temporary work restrictions, and in part due to her inability to buss tables after injuring work injury on March 23, 2018. TPD benefits are as follows

- Pay Period 3/20/18 – 4/2/2018: Only 11 days are counted from this pay period (3/23/2018 to 4/2/2018). The Claimant earned $591.91 for these 11 days (**14 days wages = $753.53; 11 days wages = $591.91; AWW = $547.40; 11 days is $860.20).** This produces a temporary wage loss of $268.12 per week, and yields a TPD rate of $178.74 per week for this pay period, **for aggregate subtotal TPD benefits of $280.88.**
- Pay Period 4/3/2018 – 4/16/2018, **a total of 14 days.** The Claimant earned $531.38 per week. This produces a temporary wage loss of

$16.02, and yields a TPD rate of $10.68 per week for this pay period **[10.68 divided by 7 days =$1.53 X 14 days, both dates inclusive=$21.42 X 14=$299.88].**

- Pay Period 4/17/2018 – 4/30/2018, **a total of 14 days** The Claimant earned $177.79 per week. This produces a wage loss of $369.61, and yields a TPD rate of $246.41 per week for this pay period **[246.41 divided by 7=$35.20 per day X 14 days, both dates inclusive= $492.82]**.
- Pay Period 5/1/2018 – 5/14/2018, **a total of 14 days** The Claimant earned $750.40 per week Pay Period 5/15/2018 – 5/28/2018, **a total of 14 days, both dates inclusive.** The Claimant earned $214.81 per week. This produces a wage loss of $332.59 per week, and yields a TPD rate of $221.73 per week for this pay period **[221.73 divided by 7=$31.68 X 14=$443.46].**
- Pay Period 5/29/20**18 – 6/11/2018, both dates inclusive, a total of 14 days.** The Claimant earned $363.31 per week. This produces a wage loss of $184.09 per week, and yields a TPD rate of $122.73 per week for this pay period **[122.73 divided by 7=17.53 X 14=$245.46]**.
- Pay Period 6/12/2018 – 6/25/2018: Only 11 days are counted from this pay period (6/12/2018 – 6/21/2018). The Claimant earned $281.15 for these 11 days (14 days wages = $357.83; 11 days wages = $281.15; AWW = $547.40; 11 days is $860.20). This produces a temporary wage loss of $579.05, and yields a TPD rate of $386.03 **per week** for this pay period. **[386.03 divided by 7=54.72 X 11=$601.92].**

The Claimant is entitled to a grand total of **$2,364.42** in TPD benefits **[280.88+299.88+492.82+443.46+245.46+601.92=$2,364.42].**

<u>Ultimate Findings</u>

13. The ALJ has considered the opinions regarding causation submitted by the Claimant's IME, Dr. Stephen Gray, Respondents' IME, Dr. William Ciccone, and Dr. Robert Kawasaki. Dr. Ciccone's opinions do not support a work-related injury and largely rely on his perceived inconsistent statements by the Claimant regarding the mechanism of injury. Dr. Kawasaki's opinions do not support a work related injury in large part due to the findings on the Claimant's MRI. However, when presented with knowledge that Dunning witnessed the incident Dr. Ciccone refused to appropriately consider this new information in his assessment of how the alleged work incident happened. Therefore, his ultimate opinions lack credibility. Further, Dr. Kawasaki gives no credence to the notion of aggravation and/or acceleration of a preexisting medical condition. This substantially detracts from his causation opinions. Dr. Gray's opinions support a work-related injury, and are based on Claimant's credible statements and

supporting medical documents. The ALJ accepts Dr. Gray's opinions on causation and rejects any conflicting opinions concerning causation.

14. Between conflicting medical opinions, the ALJ makes a rational choice, based on substantial evidence, to accept Dr. Gray's causation opinions and to reject opinions to the contrary.

15. The ALJ finds that the Claimant suffered a work-related injury to her head, cervical spine, and right shoulder area on March 23, 2018, thus, sustaining compensable injuries on that date.

16. The Claimant has sustained her burden of proof, by a preponderance of the evidence, that she sustained compensable work injuries on March 23, 2018.

17. The ALJ further finds that the medical treatment the Claimant received to her cervical spine, right shoulder was authorized, reasonably necessary, and causally related to her compensable work injuries of March 23, 2018.

17. The Claimant has also sustained her burden of proof, by preponderant evidence, that she suffered a partial loss of wages from the date of her injuries, March 23, 2018, through June 21, 2018, both dates inclusive. During this period of time, she had not been released to return to full duty, and she had not reached maximum medical improvement (MMI). The Claimant is entitled to TPD benefits in the aggregate grand total amount of **$2,364.42** as detailed in Finding No. 12 herein above.

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 Bodensleck v. Indus. Claim Appeals Office,* 183 P.3d 684 (Colo. App. 2008);*Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Rockwell International v. Turnbull,* 802 P.2d 1182, 1183 (Colo. App. 1990); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The ALJ determines the credibility of the witnesses. A*renas v. Indus. Claim Appeals Office*, 8 P.3d 558

(Colo. App. 2000). The weight and credibility to be assigned evidence is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Youngs v. Indus. Claim Appeals Office,* 297 P.3d 964, **2012 COA 85.** The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913); *also see Heinicke v. Indus. Claim Appeals Office,* 197 P.3d 220 (Colo. App. 2008). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential Ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). The ALJ has broad discretion to determine the admissibility and/or weight of evidence based on an expert's knowledge, skill, experience, training and education. *See* § 8-43-210, C.R.S; *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P.2d 501 (Colo. App. 1995). As found, the ALJ considered the opinions regarding causation submitted by the Claimant's IME, Dr. Stephen Gray, Respondents' IME, Dr. William Ciccone, and Dr. Robert Kawasaki. Dr. Ciccone's opinions do not support a work-related injury and largely rely on his perceived inconsistent statements by the Claimant regarding the mechanism of injury. Dr. Kawasaki's opinions do not support a work related injury in large part due to the findings on the Claimant's MRI. However, when presented with knowledge that Dunning witnessed the incident Dr. Ciccone refused to appropriately consider this new information in his assessment of how the alleged work incident happened. Therefore, his ultimate opinions lack credibility. Further, Dr. Kawasaki gives no credence to the notion of aggravation and/or acceleration of a preexisting medical condition. Under the present circumstances, this substantially detracts from his causation opinions and renders his opinions lacking in credibility. As found, Dr. Gray's opinions support a work-related injury, and are based on Claimant's credible statements and supporting medical documents. As further found, the ALJ accepted Dr. Gray's opinions on causation and rejected any conflicting opinions concerning causation.

<u>Substantial Evidence</u>

b. An ALJ's factual findings must be supported by substantial evidence in the record. *Paint Connection Plus v. Indus. Claim Appeals Office,* 240 P.3d 429 (Colo. App. 2010); *Leewaye v. Indus. Claim Appeals Office,* 178 P.3d 1254 (Colo. App. 2007); *Brownson-Rausin v. Indus. Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005). *Also see Martinez v. Indus. Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007). Substantial evidence is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co.v. Gussert,* 914 P.2d 411 (Colo. App.

1995). Reasonable probability exists if a proposition is supported by **substantial evidence** which would warrant a reasonable belief in the existence of facts supporting a particular finding. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985). It is the sole province of the fact finder to weigh the evidence and resolve contradictions in the evidence. See *Pacesetter Corp. v. Collett,* 33 P. 3d 1230 (Colo. App. 2001). An ALJ's resolution on questions of fact must be upheld if supported by substantial evidence and plausible inferences drawn from the record. *Eller v. Indus. Claim Appeals Office,* 224 P.3d 397, 399-400 (Colo. App. 2009). As found, between conflicting medical opinions, the ALJ made a rational choice, based on substantial evidence, to accept Dr. Gray's causation opinions and to reject opinions to the contrary.

Compensability

c. A compensable injury is one that arises out of and in the course of employment. § 8-41-301(1) (b), C.R.S. The "arising out of" test is one of causation. If an industrial injury aggravates or accelerates a preexisting condition, the resulting disability and need for treatment is a compensable consequence of the industrial injury. Thus, a claimant's personal susceptibility or predisposition to injury does not disqualify the claimant from receiving benefits. *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). An injured worker has a compensable new injury **if the employment-related activities aggravate, accelerate, or combine with a pre-existing condition to cause a need for medical treatment or produce the disability for which benefits are sought.** § 8-41-301(1) (c), C.R.S. *See Merriman v. Indus. Comm'n,* 120 Colo. 400, 210 P.2d 448 (1949); *Anderson v. Brinkoff,* 859 P.2d 819 (Colo. 1993); *National Health Laboratories v. Indus. Claim Appeals Office,* 844 P.2d 1259 (Colo. App. 1992); *Snyder v. Indus. Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). An injury resulting from the concurrence of a preexisting condition and a hazard of employment is compensable. *H & H Warehouse v. Vicory*, *supra*. *Duncan v. Indus. Claims App. Office*, 107 P.3d 999 (Colo. App. 2004). Even where the direct cause of an accident is the employee's preexisting disease or condition, the resulting disability is compensable where the conditions or circumstances of employment have contributed to the injuries sustained by the employee. *Ramsdell v. Horn*, 781 P.2d 150 (Colo.App. 1989). *Also see* § 8-41-301(1) (c), C.R.S; *Parra v. Ideal Concrete,* W.C. No. 4-179-455 [Indus. Claim Appeals Office (ICAO), April 8, 1998]; *Witt v. James J. Keil Jr.,* W.C. No. 4-225-334 (ICAO, April 7, 1998). As found, the Claimant suffered work-related injuries to her head, cervical spine, and right shoulder area on March 23, 2018, thus, sustaining compensable injuries on that date.

Medical

d. To be a compensable benefit, medical care and treatment must be causalld related to an industrial injury or occupational disease. *Dependable Cleaners v. Vasquez,* 883 P. 2d 583 (Colo. App. 1994). As found, Claimant's medical treatment is causally related to the compensable aggravation and acceleration of her compensable

inuries of march 23, 2018. Also, medical treatment must be reasonably necessary to cure and relieve the effects of the industrial occupational disease. § 8-42-101 (1) (a), C.R.S. *Morey Mercantile v. Flynt,* 97 Colo. 163, 47 P. 2d 864 (1935); *Sims v. Indus. Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). As found, the Claimant's medical care and treatment was and is reasonably necessary. As found, the medical treatment the Claimant received for her cervical spine, right shoulder was authorized, reasonably necessary, and causally related to her compensable work injuries of March 23, 2018.

Temporary Partial Disability Benefits

e. To establish entitlement to temporary disability benefits, a claimant must prove that the industrial injury has caused a "disability," and that he has suffered a wage loss that, "to some degree," is the result of the industrial disability. § 8-42-103(1), C.R.S; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Disability from employment is established when the injured employee is unable to perform the usual job effectively or properly. *Jefferson Co. Schools v. Headrick*, 734 P.2d 659 (Colo. App.1986). This is true because the employee's restrictions presumably impair his opportunity to obtain employment at pre-injury wage levels. *Kiernan v. Roadway Package System*, W.C. No. 4-443-973 [Indus. Claim Appeals Office (ICAO), December 18, 2000]. There is no statutory requirement that a claimant must present medical opinion evidence from of an attending physician to establish her 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." *Id*. As found, the Claimant was temporarily and partially disabled from March 23, 2018, through June 21, 2018, both dates inclusive.

f. Once the prerequisites for TPD are met (*e.g.,* no release to return to full duty, MMI has not been reached, and a temporary wage loss is occurring in modified employment, TPD benefits are designed to compensate for temporary wage loss. As found, the Claimant suffered a partial loss of wages from the date of her injuries, March 23, 2018, through June 21, 2018, both dates inclusive. During this period of time, she had not been released to return to full duty, and she had not reached MMI.She is entitled to TPD benefits in the aggregate grand total amount of **$2,364.42**, as detailed in Finding No. 12 herein above.

Burden of Proof

g. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Indus. Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Indus. Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000). *Kieckhafer v. Indus. Claim Appeals.Office*, 284 P.3d 202, 205 (Colo. App. 2012). 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 [Indus. Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). "Preponderance" means "the existence of a contested fact is more probable than its nonexistence." *Indus. Claim Appeals Office v. Jones*, 688 P.2d 1116 (Colo. 1984). As found, the Claimant has sustained her burden with respect to compensability, medical benefits and TPD benefits.

CORRECTED ORDER

IT IS, THEREFORE, ORDERED THAT:

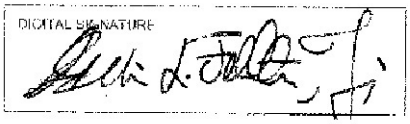
A. Respondents shall pay the costs of all authorized, reasonably necessary and causally related medical care and treatment, arising out of the compensable injuries of March 23, 2018, subject to the Division of Workers Compensation Medical Fee Schedule.

B. Respondents shall pay the Claimant temporary partial disability benefits in the aggregate grand total amount of **$ 2,364.42** which is payable retroactively and forthwith.

C. Any and all claims for temporary disability benefits from June 22, 2018, through December 18, 2018, the date of hearing, are hereby denied and dismissed.

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

DATED this 30th day of January 2019.



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EDWIN L. FELTER, JR.

Administrative Law Judge

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts,**1525 Sherman Street, 4th Floor, Denver, CO 80203.** You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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* § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, *see* Rule 26, OACRP. You may access a form for a petition to review at** *http://www.colorado.gov/dpa/oac/forms-WC.htm*.

CERTIFICATE OF SERVICE

I hereby certify that I have sent true and correct copies of the foregoing **Corrected Full Findings of Fact, Conclusions of Law and Order** on this_____day of January 2019, electronically in PDF format, addressed to:

Division of Workers' Compensation
cdle_wcoac_orders@state.co.us

_____
Court Clerk

Wc.cord