

ISSUE

Whether Claimant has established by a preponderance of the evidence that he is entitled to receive reasonable, necessary and related medical maintenance benefits designed to relieve the effects of his admitted June 27, 2005 lower back injury or prevent further deterioration of his condition pursuant to *Grover v. Industrial Comm'n.*, 759 P.2d 705 (Colo. 1988).

FINDINGS OF FACT

1. On June 27, 2005 Claimant suffered an admitted industrial injury to his lower back while working for Employer. Claimant received conservative medical treatment through Authorized Treating Physician (ATP) Robert Kawasaki, M.D.

2. In February 2006 Gary Ghiselli, M.D. performed microdiscectomy surgery at the L5-S1 level of Claimant's lumbar spine. However, Claimant continued to report lower back and left lower extremity symptoms. A lumbar MRI revealed recurrent disc herniation at the L5-S1 level that displaced the left S1 nerve root. Dr. Ghiselli informed Claimant that a repeat microdiscectomy would likely relieve his left lower extremity symptoms. However, because of concerns about Claimant's lower back pain, Dr. Ghiselli referred Claimant back to Dr. Kawasaki for diagnostic/therapeutic epidural steroid injections (ESIs).

3. Dr. Kawasaki administered ESIs and medial branch blocks. He also prescribed physical therapy. On November 14, 2006 Dr. Kawasaki determined that Claimant had reached Maximum Medical Improvement (MMI) and assigned a 16% whole person impairment rating.

4. In a November 28, 2006 visit with Dr. Kawasaki Claimant reported occasional decreased sensation in his genital area and erectile dysfunction (ED). Although Claimant had been experiencing the ED symptoms for several months, he was reluctant to report them to Dr. Kawasaki. Dr. Kawasaki noted that the ED symptoms failed to represent an acute change in Claimant's condition. He subsequently referred Claimant for a repeat lumbar spine MRI.

5. On January 11, 2007 Dr. Ghiselli reviewed the repeat MRI findings with Claimant. The MRI continued to reflect the recurrent disc herniation that existed on the initial MRI. Dr. Ghiselli commented that Claimant's radicular symptoms were not significant. He explained that "[d]ue to the confounding ED, it would be unreasonable to decompress the L5-S1 level. I do not think that this is the reason for his [ED] and it may be contributing to his lower back and left lower extremity complaints." Dr. Ghiselli

recommended a second surgery but Claimant was reluctant to proceed. He thus referred Claimant back to Dr. Kawasaki to discuss additional treatment options.

6. Dr. Kawasaki referred Claimant to urologist Seth Glick, M.D. Dr. Glick recommended a trial of Viagra for Claimant's ED. He did not believe there were any problems with Claimant's lower urogenital tract and noted that the ED could be related to psychological issues or back pain.

7. On March 15, 2007 Claimant returned to Dr. Ghiselli for an examination. Dr. Ghiselli again recommended surgery to decompress the L5-S1 level. He reasoned that surgery would likely improve Claimant's left lower extremity complaints but would not likely correct his back pain or ED symptoms.

8. On April 24, 2007 Claimant underwent a Division Independent Medical Examination (DIME) with Greg Reichhardt, M.D. Claimant reported decreased sensation throughout the entire left side of his body including his face, arm, trunk and leg. Dr. Reichhardt noted diffuse weakness throughout the entire left upper and lower extremity. He diagnosed Claimant with lower back pain, left hemi-body sensory loss unlikely related to his industrial injury, sexual dysfunction and gross numbness of uncertain etiology. Dr. Reichhardt detailed that "Claimant's presentation raises several concerns. His sexual dysfunction is not well explained based on the lumbar MRI. In addition, he has neurologic symptoms and findings which are unexplained based on his back injury. This likely represents a neurologic condition unrelated to his work-related injury or manifestation of a non-physiologic presentation." He recommended a psychological evaluation, further urologic testing and electrodiagnostic testing. Dr. Reichhardt agreed with Dr. Kawasaki that Claimant had reached MMI on November 14, 2006. He assigned a 10% impairment for a specific disorder of the lumbar spine and a 17% rating for range of motion deficits for a total 25% whole person impairment. Dr. Reichhardt did not assign impairment ratings for sexual dysfunctions or depression because the conditions were not related to his June 27, 2005 industrial injury.

9. On October 29, 2007 Claimant visited clinical psychologist Rebecca Hawkins, PhD. for an examination. Claimant reported that he had not experienced ED problems prior to his February 2006 back surgery. Dr. Hawkins noted that, after the discectomy in February 2006, Claimant no longer had typical morning erections and did not respond to sexual stimulation. Claimant's ED did not improve with Viagra.

10. On October 31, 2007 Administrative Law Judge Michael E. Harr issued Findings of Fact, Conclusions of Law and an Order in the present matter. ALJ Harr concluded that Claimant had demonstrated his condition worsened as of September 25, 2007 and he was no longer at MMI. He thus determined that Dr. Kawasaki's recommendations for further urological testing and a psychological evaluation were reasonably necessary to cure and relieve the effects of Claimant's June 27, 2005 industrial injury. Nevertheless, ALJ Harr reasoned that Claimant's "ongoing prescription for Viagra or similar medication" was not reasonable and necessary.

11. On November 6, 2007 Claimant returned to Dr. Hawkins for an evaluation. Claimant reported multiple issues including ED, psychological concerns and postsurgical problems. Dr. Hawkins diagnosed major depressive disorder, probable male erectile disorder and a pain disorder. She determined that psychological factors were likely contributing to his experience of pain and suffering. Dr. Hawkins also noted that Claimant's ED might be multifactorial. She recommended up to 10 psychotherapy sessions and treatment with Wellbutrin. Dr. Hawkins summarized that Claimant's depressive symptoms appeared to be "reactive to his injury, chronic pain, and limitations in his ability to function occupationally and sexually."

12. On May 5, 2008 Claimant's treating urologist Fred Grossman, M.D. addressed the cause of his ED and hypogonadism after Insurer's adjuster denied treatment for the conditions. Dr. Grossman explained that Claimant had hypogonadism or reduced testosterone as a result of "sustained action oral opioids" that subsequently caused his ED. He included "a copy of a recent article from the Journal of Pain that documented the occurrence of hypogonadism in men consuming sustained action oral opioids."

13. On May 15, 2008 urologist Richard R. Augspurger, M.D. provided his opinion on the cause of Claimant's ED after reviewing Dr. Grossman's report. He noted that he could not demonstrate that a neurological condition was causing Claimant's ED. However, he remarked that low testosterone levels may be attributed to narcotic use. Dr. Augspurger reasoned that, if Claimant's ED was related to narcotic use, the ED would be "indirectly related" to his industrial lower back injury.

14. After additional conservative medical treatment, diagnostic testing and psychological counseling Claimant returned to Dr. Kawasaki on August 25, 2009. Claimant reported that he continued to suffer leg pain and back stiffness. Dr. Kawasaki noted that he had multiple discussions with Claimant about decreasing opioid medications to restore endocrine function and "potentially" restore sexual function. He diagnosed Claimant with the following: (1) L5-S1 discectomy with postlaminectomy syndrome; (2) chronic left S1 radiculopathy; (3) chronic opioid dependence; (4) hypogonadism with hypotestosteronism secondary to opioid use that resulted in sexual dysfunction; and (5) adjustment disorder with depressed mood. Dr. Kawasaki determined that Claimant had reached MMI. However, Claimant would require significant medical maintenance treatment including a gym membership for 12 months and 10 psychological visits with Dr. Hawkins over the following 12 months. Dr. Kawasaki explained that Claimant would continue the following medications for an indefinite period: (1) Ambien CR; (2) Wellbutrin XL; (3) Ibuprofen and (4) Zoloft. He also remarked that Claimant would require follow-up care with Dr. Grossman. Dr. Grossman was prescribing Cialis, Androgel and penile injections. Finally, Dr. Kawasaki commented that Claimant was not interested in any additional surgical interventions.

15. On January 25, 2011 Claimant returned to Dr. Kawasaki for maintenance treatment. Dr. Kawasaki remarked that Claimant had been taken off multiple medications because of an elevation in liver function results after being treated for tuberculosis. Claimant reported that subsequent additional liver function testing

revealed that his blood levels were returning to normal. He commented that he would be returning to Mali at the end of the week but would return in mid-March.

16. During 2015 and 2016 Claimant visited an emergency room for right-sided neck, back and hip pain. Claimant did not seek additional urological treatment during the period.

17. After additional maintenance visits with Dr. Kawasaki in 2017, Claimant returned to Dr. Hawkins for psychological treatment on January 16, 2018. Claimant reported that he had returned to the area because he had an independent medical examination scheduled with Brian D. Lambden, M.D. for the following day. He reported significant anxiety and depression as well as nocturnal panic attacks.

18. On January 17, 2018 Claimant visited Dr. Lambden for an independent medical examination. Dr. Lambden performed a physical examination and thoroughly reviewed Claimant's medical records. Claimant reported continued lower back symptoms that included low-level radiating pain down his left leg. Dr. Lambden concluded that Claimant's ED was not likely caused by opioid use, borderline low testosterone levels or surgery because his symptoms preceded his opioid use and surgery. He noted that medical literature suggested a likely psychological cause for Claimant's ED symptoms. Dr. Lambden thus determined that he was "not sure anything else" needed to be done for Claimant's ED. In addressing Claimant's chronic pain, Dr. Lambden reasoned that no further treatment was necessary because Claimant was not interested in surgical intervention and it was questionable whether surgery would provide a benefit 10 years after Claimant's industrial injury. Claimant had thus reached MMI. Regarding opioid dependence, Dr. Lambden agreed that Claimant should be switched from Opana to Percocet but attempt opioid tapering to reduce dependence. He also questioned whether Claimant required Lyrica and recommended reduction in Ibuprofen use. Finally, Dr. Lambden noted that Claimant's depression would resolve over time with case closure. He also stated that Claimant's use of anti-depressants was not unreasonable, but suggested the discontinuation of Sertraline because Claimant was not exhibiting depressive symptoms and the medication has a negative effect on ED.

19. In a March 22, 2018 report Dr. Lambden reviewed additional medical records from Dr. Kawasaki and Dr. Hawkins. He also considered a January 30, 2018 urine toxicology report that reflected Claimant's testosterone level was 291 with a normal range of 250-827.

20. On April 3, 2018 Claimant visited urologist John W. Tillett, M.D. for an examination. He evaluated Claimant's ED and hypogonadism. Claimant recounted that he had suffered an industrial lower back injury on June 27, 2005, subsequently underwent surgery and continued to experience back pain. Dr. Tillett noted that Claimant has received narcotic pain medications since 2005 and had visited Dr. Grossman since 2007 for ED and hypogonadism until Dr. Grossman's retirement. Claimant denied any ED prior to surgery and has managed his ED well with Cialis 10mg since 2008. He remarked that he currently lives in Mali but spends significant time in

Denver to visit his ex-wife and children. Dr. Tillett noted that Claimant was taking the following medications: (1) Oxycodone HCL capsule; (2) Ibuprofen 800 mg oral capsule; (3) Lyrica 75 mg oral capsule; (4) Temazepam 7.5 mg oral capsule; (5) Bupropion HCL tablet; (6) Cialis 10 mg oral tablet; and (7) Sertraline HCL 100 mg oral tablet. After conducting a physical examination, Dr. Tillett diagnosed Claimant with ED and hypogonadism or low testosterone.

21. On April 5, 2018 Dr. Tillett conducted a medical records review of Claimant's case. He recounted that Claimant had suffered an industrial lower back injury on June 27, 2005, subsequently underwent surgery and continued to experience back pain. In an addendum report dated April 24, 2018 Dr. Tillett noted that Dr. Lambden determined Claimant's ED was unrelated to chronic opioid use, low testosterone or surgery because the condition preceded surgery and opioid use. In contrast, Dr. Tillett explained that there was no evidence in the medical records that Claimant's ED existed prior to his surgery or opioid use. He also disagreed that low testosterone was unrelated to ED.

22. Claimant and Dr. Kawasaki testified at the hearing in this matter that Claimant currently takes the following medications:

- a. 100 milligrams of Sertraline (an anti-anxiety medication for panic disorders);
- b. Bupropion (an anti-depressant medication for major depressive disorders);
- c. Ibuprofen (an anti-inflammatory medication for pain);
- d. Lyrica, 75 milligrams (a neuropathic pain medication);
- e. Oxycodone, 10 milligrams every six hours (a narcotic medication for pain),
- f. Cialis 10 milligrams (for ED);
- g. Temazepam (for sleep).

23. Respondents clarified at hearing that they were challenging the medications prescribed by Drs. Kawasaki and Tillett. Respondents specifically contested prescriptions for Cialis, Oxycodone, Lyrica and Bupropion. They did not seek a denial of all medical maintenance treatment.

24. Claimant testified at the hearing in this matter that he began suffering from constant back pain, depression and ED shortly after his June 27, 2005 industrial injury. He emphasized that he had not experienced ED prior to his lower back injury. Claimant noted that his pain medications reduce his symptoms. Although the medications do not completely eliminate his pain, they allow improved sleep and function. Claimant remarked that his psychotropic medications help him deal with anxiety and depression. Nevertheless, he continues to suffer panic attacks that are typically worse at night.

25. Dr. Kawasaki testified at the hearing in this matter. He stated that he has been Claimant's ATP since August 2005. Dr. Kawasaki explained that Claimant suffers from chronic pain as a result of his June 27, 2005 industrial injury. He requires opioid pain medications to improve his function. Without the medications Claimant would likely become non-functional and have difficulty getting out of bed. Dr. Kawasaki noted that

Claimant takes a reasonable amount of opioid medications and there are no plans for weaning. Claimant specifically takes about 60 milligrams of morphine equivalent. The amount does not place Claimant in the “danger zone.” In contrast, when individuals take 90-120 milligrams of morphine equivalent, they tend to develop opioid-related problems. Dr. Kawasaki summarized that opioid medications assist Claimant in performing activities of daily living. He noted that Claimant has never presented with any addictive or aberrant behavior since he began treatment in August 2005.

26. Dr. Kawasaki explained that chronic pain can increase depression, anxiety and other psychosocial issues. He summarized that Claimant requires anti-depressant medications because of his industrial injury. Dr. Kawasaki specifically prescribed Bupropion 300 mg, Temazepam 75 mg and Sertraline 100 mg on January 15, 2018 for Claimant’s symptoms of anxiety and depression. Furthermore, because Claimant has exhibited both objective and subjective pain symptoms consistent with the injured nerve in his lower back, Dr. Kawasaki prescribed Lyrica 75 mg on January 15, 2018.

27. Dr. Kawasaki explained that Claimant’s extended opioid use for pain is partially responsible for his ED. He remarked that long-term use of opioid medications generally affects the endocrine system. Specifically, the use of opioids impairs the gonadal system that produces testosterone. Dr. Kawasaki commented that, although Claimant’s ED was secondary to chronic opioid use, psychologic issues also contributed to his sexual dysfunction. He explained that Claimant felt powerless, had a shift in identity, lost his job, suffered pain, felt fear and experienced performance anxiety. Dr. Kawasaki commented that the preceding factors contribute to Claimant’s sexual dysfunction. He detailed that Claimant underwent unsuccessful ED treatment modalities with penile injections, testosterone, clomid and Viagra. However, Claimant had success treating his ED when he began taking Cialis. Dr. Kawasaki thus continues to prescribe Cialis.

28. Dr. Tillett testified at the hearing in this matter. He explained that ED is a distressing medical condition in which a man is unable to achieve or sustain an erection. Hypogonadism refers to suboptimal production of sperm or testosterone. Dr. Tillett diagnosed Claimant with both ED and hypogonadism. He maintained that Claimant’s chronic opioid use constituted a significant causative factor in his ED and hypogonadism conditions. Dr. Tillett remarked that the longer an individual is taking opioid medications, the greater the effect on erectile and testicular function. Moreover, Claimant’s anxiety and depression may be contributing to his ED. Dr. Tillett determined that reducing Claimant’s opioid medication now would likely not have much impact on his ED and testosterone function. The chronicity of opioid therapy has damaged Claimant’s ability to recover erectile function and testosterone secretion.

29. Dr. Tillett recommended additional diagnostic testing for Claimant’s hypogonadism condition. He explained that hypogonadism therapy can produce benefits such as increased sexual desire, libido, energy and lean muscle mass while also improving a general sense of well-being. The therapy can also cause improvements in emotional/psychologic parameters, lipid profiles/cholesterol levels and ED. Thus, beginning testosterone treatment could help decrease Claimant’s depression

while increasing his energy and level of functioning. Dr. Tillett explained that testosterone levels and erectile function are intertwined. He commented that the American Urology Association (AUA) guidelines on the management of ED recommend that every man presenting with ED have a serum testosterone work-up. Dr. Tillett agreed with Dr. Kawasaki that Claimant should continue to use Cialis 10 mg. for treatment of his ED.

30. Dr. Lambden testified at the hearing in this matter. He maintained that Claimant should be gradually tapered from opioid medications. He specifically recommended ceasing Sertraline, Temazepam, Oxycodone, Bupropion, Lyrica and Ibuprofen. Dr. Lambden remarked that his preference for chronic pain management is to decrease opioids whenever possible. He also commented that opioids and Lyrica negatively impact ED. He explained that ED is a multifactorial problem not associated with Claimant's testosterone levels. Therefore, Claimant's use of opioids for his June 27, 2005 industrial injury did not cause his ED and Cialis should be discontinued. Furthermore, Dr. Lambden noted that Claimant was not having sufficient depressive symptoms to warrant continuing Sertraline in light of its negative effect on ED. He summarized that, once the case has been closed and Claimant has adjusted to living in Mali, his depression symptoms should resolve without medication.

31. Claimant has established that it is more probably true than not that he is entitled to receive reasonable, necessary and related medical maintenance treatment designed to relieve the effects of his admitted June 27, 2005 lower back injury or prevent further deterioration of his condition. Initially, Claimant suffered an industrial lower back injury on June 27, 2005, subsequently underwent surgery and continued to experience back pain. The record is replete with evidence that Claimant continues to suffer chronic pain, sleep disturbances, psychological problems and urological issues as a result of his June 27, 2005 injury.

32. Dr. Kawasaki has been Claimant's ATP since August 2005. He persuasively explained that Claimant suffers from chronic pain as a result of his June 22, 2005 industrial injury. He requires opioid pain medications to improve his function. Without the medications Claimant would likely become non-functional and have difficulty getting out of bed or completing activities of daily living. Dr. Kawasaki noted that Claimant takes a reasonable amount of opioid medications and there are no plans for weaning. Furthermore, Claimant noted that his pain medications reduce his symptoms. Although the medications do not completely eliminate his pain, they allow improved sleep and function.

33. Claimant remarked that his psychotropic medications help him deal with anxiety and depression. Nevertheless, he continues to suffer panic attacks that are typically worse at night. Dr. Kawasaki explained that chronic pain can increase depression, anxiety and other psychosocial issues. He summarized that Claimant requires anti-depressant medications because of his industrial injury. Dr. Kawasaki specifically prescribed Bupropion 300 mg. Temazepam 75 mg and Sertraline 100 mg on January 15, 2018 for Claimant's symptoms of anxiety and depression. Furthermore, because Claimant has exhibited both objective and subjective pain symptoms

consistent with the injured nerve in his lower back, Dr. Kawasaki also prescribed Lyrica. Finally, Dr. Hawkins summarized that Claimant's depressive symptoms appeared to be "reactive to his injury, chronic pain, and limitations in his ability to function occupationally and sexually."

34. Dr. Kawasaki further explained that Claimant's extended opioid use for pain is partially responsible for his ED. He remarked that long-term use of opioid medications generally affects the endocrine system. Specifically, the use of opioids impairs the gonadal system that produces testosterone. Dr. Kawasaki commented that, although Claimant's ED is secondary to chronic opioid use, psychologic issues also contribute to his sexual dysfunction. Similarly, Dr. Tillett diagnosed Claimant with both ED and hypogonadism. He maintained that Claimant's chronic opioid use constituted a significant causative factor in his ED and hypogonadism conditions. Dr. Tillett remarked that the longer an individual is taking opioid medications, the greater the effect on erectile and testicular function. He determined that reducing Claimant's opioid medication now would not likely have much impact on his ED and testosterone function. Furthermore, Dr. Grossman explained that Claimant had hypogonadism or reduced testosterone as a result of "sustained action oral opioids" that subsequently caused his ED. Moreover, Dr. Augspurger remarked that low testosterone levels may be attributed to narcotic use. He reasoned that, if Claimant's ED was related to narcotic use, the ED would be "indirectly related" to his industrial lower back injury.

35. Dr. Tillett also recommended additional diagnostic testing for Claimant's hypogonadism condition. He explained that hypogonadism therapy can produce benefits such as increased sexual desire, libido, energy and lean muscle mass while also providing a general sense of well-being. The therapy can also cause improvements in emotional/psychologic parameters, lipid profiles/cholesterol levels and ED. Thus, beginning testosterone treatment could help decrease Claimant's depression while increasing his energy and level of functioning.

36. In contrast, Dr. Lambden maintained that Claimant should be gradually tapered from opioid medications. Dr. Lambden concluded that Claimant's ED is a multifactorial problem not likely caused by opioid use, borderline low testosterone levels or surgery because his symptoms preceded his opioid use and surgery. He reasoned that Claimant's use of opioids as a result of his June 27, 2005 industrial injury did not cause his ED and Cialis should be discontinued. Furthermore, Dr. Lambden noted that Claimant was not having sufficient depressive symptoms to warrant continuing Sertraline in light of its negative effect on ED. He summarized that, once the case has been closed and Claimant has adjusted to living in Mali, his depression symptoms should resolve without medication. However, the persuasive evidence reveals that Claimant began suffering from constant back pain, depression and ED as a result of his June 22, 2005 industrial injury. The record and medical opinions of Drs. Kawasaki, Hawkins and Tillett reflect that Claimant's pain medications, psychotropic prescriptions and ED medications have not only reduced his pain but also maximized his level of function over an extended period of time consistent with the Division of Workers' Compensation *Medical Treatment Guidelines (Guidelines)*. Moreover, the testosterone therapy recommended by Dr. Tillett will likely decrease Claimant's depression while improving

his level of functioning. Accordingly, Claimant shall receive reasonable, necessary and related medical maintenance benefits designed to relieve the effects of his June 27, 2005 industrial injury or prevent further deterioration of his condition.

CONCLUSIONS OF LAW

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

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

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

4. To prove entitlement to medical maintenance benefits, a claimant must present substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of the industrial injury or prevent further deterioration of his condition. *Grover v. Industrial Comm’n.*, 759 P.2d 705, 710-13 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office*, 916 P.2d 609, 611 (Colo. App. 1995). Once a claimant establishes the probable need for future medical treatment he “is entitled to a general award of future medical benefits, subject to the employer's right to contest compensability, reasonableness, or necessity.” *Hanna v. Print Expeditors, Inc.*, 77 P.3d 863, 866 (Colo. App. 2003); see *Karathanasis v. Chilis Grill & Bar*, W.C. No. 4-461-989 (ICAP, Aug. 8, 2003). Whether a claimant has presented substantial evidence justifying an award of *Grover* medical benefits is one of fact for determination by the Judge. *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 919 P.2d 701, 704 (Colo. App. 1999).

5. The *Guidelines* provide, in relevant part, that “medications should be clearly linked to improvement of function, not just pain control.” WCRP 17, Exhibit 9

(H)(6). Furthermore, the *Guidelines*, specify that, “examples of routine functions include the ability to perform work tasks, drive safely, pay bills or perform math operations, remain alert and upright for 10 hours per day, or participate in normal family and social activities.” WCRP 17, Exhibit 9(H)(6).

6. As found, Claimant has established by a preponderance of the evidence that he is entitled to receive reasonable, necessary and related medical maintenance treatment designed to relieve the effects of his admitted June 27, 2005 lower back injury or prevent further deterioration of his condition. Initially, Claimant suffered an industrial lower back injury on June 27, 2005, subsequently underwent surgery and continued to experience back pain. The record is replete with evidence that Claimant continues to suffer chronic pain, sleep disturbances, psychological problems and urological issues as a result of his June 27, 2005 injury.

7. As found, Dr. Kawasaki has been Claimant’s ATP since August 2005. He persuasively explained that Claimant suffers from chronic pain as a result of his June 22, 2005 industrial injury. He requires opioid pain medications to improve his function. Without the medications Claimant would likely become non-functional and have difficulty getting out of bed or completing activities of daily living. Dr. Kawasaki noted that Claimant takes a reasonable amount of opioid medications and there are no plans for weaning. Furthermore, Claimant noted that his pain medications reduce his symptoms. Although the medications do not completely eliminate his pain, they allow improved sleep and function.

8. As found, Claimant remarked that his psychotropic medications help him deal with anxiety and depression. Nevertheless, he continues to suffer panic attacks that are typically worse at night. Dr. Kawasaki explained that chronic pain can increase depression, anxiety and other psychosocial issues. He summarized that Claimant requires anti-depressant medications because of his industrial injury. Dr. Kawasaki specifically prescribed Bupropion 300 mg, Temazepam 75 mg and Sertraline 100 mg on January 15, 2018 for Claimant’s symptoms of anxiety and depression. Furthermore, because Claimant has exhibited both objective and subjective pain symptoms consistent with the injured nerve in his lower back, Dr. Kawasaki also prescribed Lyrica. Finally, Dr. Hawkins summarized that Claimant’s depressive symptoms appeared to be “reactive to his injury, chronic pain, and limitations in his ability to function occupationally and sexually.”

9. As found, Dr. Kawasaki further explained that Claimant’s extended opioid use for pain is partially responsible for his ED. He remarked that long-term use of opioid medications generally affects the endocrine system. Specifically, the use of opioids impairs the gonadal system that produces testosterone. Dr. Kawasaki commented that, although Claimant’s ED is secondary to chronic opioid use, psychologic issues also contribute to his sexual dysfunction. Similarly, Dr. Tillett diagnosed Claimant with both ED and hypogonadism. He maintained that Claimant’s chronic opioid use constituted a significant causative factor in his ED and hypogonadism conditions. Dr. Tillett remarked that the longer an individual is taking opioid medications, the greater the effect on erectile and testicular function. He

determined that reducing Claimant's opioid medication now would not likely have much impact on his ED and testosterone function. Furthermore, Dr. Grossman explained that Claimant had hypogonadism or reduced testosterone as a result of "sustained action oral opioids" that subsequently caused his ED. Moreover, Dr. Augspurger remarked that low testosterone levels may be attributed to narcotic use. He reasoned that, if Claimant's ED was related to narcotic use, the ED would be "indirectly related" to his industrial lower back injury.

10. As found, Dr. Tillett also recommended additional diagnostic testing for Claimant's hypogonadism condition. He explained that hypogonadism therapy can produce benefits such as increased sexual desire, libido, energy and lean muscle mass while also providing a general sense of well-being. The therapy can also cause improvements in emotional/psychologic parameters, lipid profiles/cholesterol levels and ED. Thus, beginning testosterone treatment could help decrease Claimant's depression while increasing his energy and level of functioning.

11. As found, in contrast, Dr. Lambden maintained that Claimant should be gradually tapered from opioid medications. Dr. Lambden concluded that Claimant's ED is a multifactorial problem not likely caused by opioid use, borderline low testosterone levels or surgery because his symptoms preceded his opioid use and surgery. He reasoned that Claimant's use of opioids as a result of his June 27, 2005 industrial injury did not cause his ED and Cialis should be discontinued. Furthermore, Dr. Lambden noted that Claimant was not having sufficient depressive symptoms to warrant continuing Sertraline in light of its negative effect on ED. He summarized that, once the case has been closed and Claimant has adjusted to living in Mali, his depression symptoms should resolve without medication. However, the persuasive evidence reveals that Claimant began suffering from constant back pain, depression and ED as a result of his June 22, 2005 industrial injury. The record and medical opinions of Drs. Kawasaki, Hawkins and Tillett reflect that Claimant's pain medications, psychotropic prescriptions and ED medications have not only reduced his pain but also maximized his level of function over an extended period of time consistent with the Division of Workers' Compensation *Medical Treatment Guidelines (Guidelines)*. Moreover, the testosterone therapy recommended by Dr. Tillett will likely decrease Claimant's depression while improving his level of functioning. Accordingly, Claimant shall receive reasonable, necessary and related medical maintenance benefits designed to relieve the effects of his June 27, 2005 industrial injury or prevent further deterioration of his condition.

ORDER

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

1. Claimant shall receive specifically delineated reasonable, necessary and related medical maintenance benefits as prescribed by Drs. Kawasaki and Tillett. The medical maintenance medications that Claimant shall receive include: (1) 100 milligrams of Sertraline (an anti-anxiety medication for panic disorders); (2) Bupropion

(an anti-depressant medication for major depressive disorders); (3) Ibuprofen (an anti-inflammatory medication for pain); (4) Lyrica, 75 milligrams (a neuropathic pain medication); (5) Oxycodone, 10 milligrams every six hours (a narcotic medication for pain); (6) Cialis 10 milligrams (for ED); and (7) Temazepam (for sleep).. Claimant shall also receive the additional testosterone therapy recommended by Dr. Tillett. Respondents shall be financially responsible for the preceding medical maintenance benefits.

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

If you are a party 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 certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at <http://www.colorado.gov/dpa/oac/forms-WC.htm>.*

DATED: March 5, 2019.

DIGITAL SIGNATURE:


Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

ISSUES

- Did Respondent prove a basis to withdraw its admission of liability?
- Did Respondent overcome the DIME's determination Claimant is not at MMI by clear and convincing evidence?

FINDINGS OF FACT

Pre-Existing Condition

1. Claimant has a history of low back pain dating to a work-related injury on October 13, 1992. Imaging studies showed Grade 1 spondylolisthesis and a "mild" disc bulge at L5-S1, with no nerve root or cord impingement. An EMG in November 1992 showed "minor" bilateral S1 radiculopathy. Dr. Daniel Olson, who served as the primary ATP, placed Claimant at MMI as of August 10, 1993. Claimant underwent a DIME on August 25, 1994 with Dr. Velma Campbell, who affirmed MMI and provided 13% whole person rating for the lumbar spine. There is no record of ongoing treatment after the claim concluded.

2. Claimant started working for Employer in the maintenance department in 1993, and has worked in this capacity for Employer since then.

3. On January 19, 1997, Claimant sustained a work-related injury when he fell through a ceiling in an office building. Claimant complained cervical, thoracic, and lumbar pain, with pain radiating into his legs. He received conservative treatment and was placed at MMI with no additional impairment, no future medical recommendations, and no permanent restrictions.

4. Claimant continued to work full duty for Employer after the 1997 incident.

5. In October 2006, Claimant suffered another flare of his low back pain while working. He was performing computer work when he noticed pain in his back and radicular type symptoms in his left leg. Claimant had a brief course of conservative treatment and was released after three weeks with no impairment, physical restrictions, or future treatment recommendations.

6. On January 9, 2016, Claimant aggravated his back when he slipped on ice and fell directly on his back. He was evaluated at the Parkview Medical Center emergency department. Claimant disclosed his history of low back pain and noted an acute onset of spasms due to the fall. Examination of the back and lower extremities was unremarkable, except some midline tenderness of the low back. X-rays showed no fracture or other acute structural injury. Claimant was given a nonspecific diagnosis of "back pain" and released with instructions to follow up with his primary care physician.

7. Per the ER instructions, Claimant followed up with his PCP, Dr. Bradley Smith a few days later. Dr. Smith prescribed a muscle relaxer and referred Claimant to massage and physical therapy. Claimant went to PT at the Parkview Medical Center Outpatient Rehabilitation Center from January 25, 2016 to March 22, 2016. The discharge note indicates Claimant was “no longer having any pain,” and “feels like a new man.” Claimant saw Dr. Smith again a month later for an unrelated medical problem, but the report contains no mention of any ongoing back symptoms. The records corroborate Claimant’s testimony that the symptoms resolved.

8. At hearing, Claimant testified that between 1992 and 2016 his low back flared episodically, but these flares were generally brief, rarely required any medical treatment, and he always returned to full activity. This ALJ finds Claimant to be credible in this regard. Furthermore, Claimant’s testimony is supported by the medical records and his ability to work full duty during those years.

Claimant’s injury and course of treatment

9. Claimant’s current claim arose out of landscaping work he performed on July 21, 2016, spraying trees with the assistance of several inmates. To accomplish the task, Claimant drove a “sand rail” vehicle outfitted with a tank and sprayer. He drove the sand rail over uneven and bumpy terrain throughout his shift, including over curbs and through swales and “trenches.” The vehicle had very limited suspension, and the rough ride caused significant jarring to his body throughout the day. It also vibrated badly while the engine was running.

10. Claimant credibly testified the activity bothered his back during the shift. He recalled several instances where he felt a jolt of pain when hitting a bump or driving through a trench. He explained the pain was “deep inside . . . under my belly button and went to my back.” By the end of his shift, Claimant felt pain “deep” in his abdomen and his low back and spasms in his back muscles. He also felt nauseous and wondered if he had caught a stomach illness that was bothering one of the inmates that day.

11. Claimant’s symptoms worsened on the drive home. He laid down on the floor when he got home, hoping to alleviate the pain. The pain kept getting worse, so he called a supervisor and reported he was going to see a doctor.

12. Claimant was seen at the Southern Colorado Clinic urgent care facility later that day. The history is described as:

This is a 56-year-old male who presents with mid abdominal pain. The symptoms began today while he was driving “a cart” spraying trees today at his work at DOC. On a scale of mild to severe, the intensity is described as moderate-severe. Pain is constant and worsened in severity since onset this afternoon.

13. On examination, his abdomen was slightly distended with diffuse tenderness and guarding on palpation of the epigastric region. No back examination was performed. The urgent care physician diagnosed abdominal pain of “unclear” etiology.

Due to the severity of symptoms, she directed him to the emergency room. The report concludes with the comment, “he was claiming this was a work-related issue but I don’t see any association with his work today driving a cart.”

14. Claimant left the urgent care clinic and went to Parkview Hospital. The emergency department was very busy, and after waiting more than an hour to be seen Claimant felt a bit better and went home to rest.

15. The next day Claimant was still in pain. He worked part of his shift — running the sand rail again — and the pain continued to intensify. He asked his supervisor to send him to a doctor, and was referred to CCOM.

16. Claimant saw PA-C Steven Quackenbush at CCOM on July 22, 2016. On the intake form, Claimant described “lower back pain, mid back pain,” which he attributed to “spraying trees in a Go Cart bouncing and turning” the day before. Claimant related his prior history of back problems, but stated, “He feels that the back pain he developed on 07/21/2016 is ‘different’ from his usual back pain symptoms.” Claimant also reported a “stinging” pain in his left foot, which was “new” since the work incident. On examination, Claimant walked with an “obvious antalgic gait.” Palpation revealed paralumbar and parathoracic muscular tenderness, mild left SI joint tenderness, and mild diffuse periumbilical muscular tenderness. Mr. Quackenbush diagnosed a low back muscular strain and opined,

Acute findings are consistent with history and/or work-related mechanism of injury. Any chronic findings from known chronic back pain from 1997 injury are not work-related The patient has chronic back pain and may be treated back to baseline only.

17. Mr. Quackenbush imposed a five-pound lifting restriction, prescribed muscle relaxers and ibuprofen, and asked Claimant to return in three days.

18. Claimant returned to CCOM on July 25, 2016. He was somewhat better but still had aching and spasms in his low back and SI area with some radicular pain to the left knee. Physical examination showed persistent paralumbar and parathoracic muscular tenderness and left SI joint tenderness. Mr. Quackenbush maintained the 5-pound lifting restriction and referred Claimant to physical therapy.

19. On August 2, 2016, Mr. Quackenbush added tramadol for pain and ordered a lumbar MRI “to help sort out acute from chronic.”

20. On August 10, 2016, Mr. Quackenbush noted Claimant remained symptomatic with ongoing “spasms” and some radicular symptoms. Claimant said physical therapy was not helping, so Mr. Quackenbush referred him to a chiropractor. Claimant subsequently had several chiropractic sessions, which were somewhat helpful.

21. Claimant had the lumbar MRI on August 17, 2016. The most significant findings were at L5-S1, including anterolisthesis and pars defects, severe foraminal narrowing (worsen toward the left), and a left lateral disc herniation.

22. Dr. Daniel Olson took over Claimant's care on August 31, 2016. Dr. Olson noted Claimant's symptoms began "after using an all-terrain vehicle up and down some slopes spraying trees. It is a somewhat odd presentation in that he noticed discomfort in his abdomen first, then lower back pain." Claimant told Dr. Olson "while he was in physical therapy [he felt] like his spine shifted and since then he has noticed increasing thoracic pain and even muscle spasms on the left side of his anterior neck." Claimant's pain diagram reflected pain in the neck, mid-thoracic and lumbar areas, and some numbness in his left foot. On examination, Dr. Olson appreciated asymmetry of the left anterior neck musculature compared to the right, and thoracic pain on palpation with spasm. Dr. Olson liberalized Claimant's work restrictions to 10 pounds lifting and referred him for a psychiatric evaluation.

23. Claimant saw Dr. Dwight Leggett, a physical medicine and rehabilitation specialist, on September 26, 2016. Claimant described the history as

On [July 21, 2016], he states that he was given a cart to drive around to monitor inmates. He reports that the cart had minimal suspension and he had to drive over variable surfaces. This was quite "jarring." Soon after, he began to have pain in the low back as well as in his stomach muscles. He was evaluated by Mr. Quackenbush on 7/22/2016. He was diagnosed with a low back strain which was felt to be different from his chronic low back issues.

24. Claimant's primary area of concern was his low back, with constant stabbing, pinching, and sharp pain. He also reported intermittent pain, numbness, and tingling in the left leg. His symptoms were aggravated by prolonged standing and static postures. Claimant described muscle tension and twitching on the left side of his neck and stated, "He believes that this began on the same day as his workman's compensation claim, and has been worsening with time. This was especially true after his physical therapy visits, which seemed to intensify the spasms." Claimant also reported spasms in the abdominal muscles. Claimant told Dr. Leggett about his preinjury back problems, but was "quite specific that his current pain is very different in character from his previous back pain."

25. Dr. Leggett documented by far the most thorough physical examination performed up to that time. He noted significant myofascial tightness and tenderness in the low back with multiple palpable trigger points, and moderate tenderness in the left greater than right SI joints. He also documented significant myofascial tightness at the insertion of the abdominal muscles below the ribs. Cervical examination showed significant tension, primarily involving the left sternocleidomastoid muscle, which produced "noticeable asymmetry and muscle tension." Dr. Leggett opined Claimant's primary issue was his low back pain, mainly involving the L5-S1 facet joints. He recommended facet joint injections and a steroid injection into the pars region. He suggested a lumbar ESI if the facet injections did not help. Dr. Leggett also referenced "irritability" in the left rib/abdominal region, and opined "this will improve once we get the low back region under control." He suggested additional chiropractic treatment, with more focus on manual manipulation. Regarding the neck pain, Dr. Leggett stated, "at this point,

we have been asked to address the low back region, and any additional treatment to the neck will be left at your discretion, Dr. Olson.”

26. Dr. Olson reviewed Dr. Leggett’s report on October 13, 2016, and agreed with the recommendations.

27. On October 20, 2016, Claimant reported the chiropractic treatment was helpful, particularly regarding his neck spasms. He was still waiting for the facet injections to be approved.

28. Dr. Leggett reevaluated Claimant on December 5, 2016. The facet injections had been denied by a peer review due to “incomplete documentation,” which Dr. Leggett could not understand given the thorough examination and detailed discussion documented after the initial visit. Claimant reported the chiropractic treatment was helpful but only giving short-term relief. Claimant was “extremely frustrated with his ongoing pain.” Dr. Leggett noted the initial referral was limited to the low back, but he had now been authorized to look at the cervical region. Examination of his back revealed significant myofascial tenderness and palpable trigger points. Clinical findings regarding the neck were worse than at the previous evaluation. Dr. Leggett reiterated his recommendation for bilateral L5 S1 facet joint injections, and recommended trigger point injections for both cervical and lumbar myofascial pain. Depending on Claimant’s response to the trigger point injections, he would consider an occipital nerve block or Botox injections for the neck. Dr. Leggett noted many months have passed since Claimant’s injury with “minimal” treatment and opined “it is important that we be more aggressive with his treatment. I would like to prevent his acute pain from becoming chronic in nature.”

29. Claimant underwent the L5 S1 facet blocks with Dr. Scheper on January 10, 2017. He followed up with Dr. Leggett on January 25, and reported approximately one week of significant pain reduction and increased function. Dr. Leggett considered it a positive diagnostic response, which “confirms that we are targeting the right pain generation.” He recommended bilateral medial branch blocks, and possible rhizotomy. Dr. Leggett noted the trigger point injections had been denied.

30. Dr. Sparr performed electrodiagnostic testing on February 8, 2017, which showed no evidence of lumbosacral radiculopathy, sciatic, or distal compression neuropathy.

31. On March 15, 2017, Dr. Leggett noted the medial branch blocks had been denied. Dr. Leggett was frustrated by the ongoing difficulty obtaining authorization for treatment, which he believed was impeding Claimant’s recovery. He could not understand why the blocks had been denied given the extensive and thorough documentation in his previous reports. Dr. Leggett further explained,

On exam, there continue to be multiple areas of myofascial pain generation with clear trigger points and associated twitch responses. In the past, trigger point injections have been requested and denied. Similar was noted for the request for massage treatments.

He has received authorization for chiropractic treatments, which were beneficial. Unfortunately, he has completed this course of treatment. I believe that the overall effect of the chiropractic treatment, while helpful, was not nearly as impactful as coordinating additional treatments. [Claimant's] pain has been going on for months, with his care being sporadic at best. We are having extreme difficulty with any sort of recommended treatment being approved. When a form of treatment is approved, it takes a significant amount of time for this to be completed. With the multiple regions of pain generation and the worsening nature of his pain, a multifactorial approach to his care is required. This is also been instructed by insurance, selecting only part of the recommended course of medical treatment. As discussed in the past, it seems of the insurance company is directing his medical care.

Despite the above issues, I will continue to move forward with [Claimant's] best interest in mind. With this, I will again request trigger point injections and massage.

For the ongoing neck pain, there seems to be an evolving spasticity. This is not surprising in that no treatment has been approved to target this region. . . . Botox injections may be needed, as previously discussed.

I will have him return to clinic as soon as some form of treatment is authorized. Despite the disruption in his care, I will do my best to move forward with any possible treatment that I can.

32. The medial branch blocks were ultimately completed on April 4, 2017. Claimant returned to Dr. Leggett the next day to discuss his response. Almost immediately after the injections, Claimant developed severe flare of pain and muscle spasm and multiple areas including his abdomen, low back, and neck. Dr. Leggett had a lengthy discussion with Claimant, but Claimant could not separate his low back pain from the increased pain and other areas of his body. Dr. Leggett opined, "With this, I am unable to identify any specific diagnostic improvement that would support the need for radiofrequency ablation." Dr. Leggett noted his of the recommendations remained denied. He stated,

At this point, authorizations have been quite sporadic, and no specific treatment plan has been followed. I am running out of options

Highest concern right now is the increasing left a cervical tension, which is evolving into spasticity. There seems to be a developing and increasing cervical dystonia. [Ideally], trigger point injections would be the first line to target this in coordination with manual treatments. However, this has been denied. Therefore, I will request authorization for Botox injections.

33. Claimant later declined Botox due to fear of possible complications and side effects.

34. On April 14, 2017, Dr. Olson noted he was “struggling” with Claimant’s symptom complex, as “nothing really seems to make sense.”

35. Claimant underwent cervical and thoracic MRIs on May 13, 2017. They showed diffuse degenerative changes and multiple bulging discs, but no obvious structural instability or compromise of the spinal cord or spinal nerve roots.

36. Claimant transferred his care to CCOM’s Canon City clinic in May 2017 and started seeing Dr. Thomas Centi. Commencing on May 30, 2017, Dr. Centi issued a series of reports allegedly documenting essentially normal physical examinations of all areas involved in Claimant’s claim, including no pain with palpation or movement of his cervical, thoracic, or lumbar areas and normal range of motion. These cloned examination notes are inconsistent with the accompanying pain diagrams and Dr. Leggett’s detailed clinical findings. Dr. Centi also repeatedly alleged Claimant had described his symptoms as “minimal” and “improving,” which is also belied by the pain diagrams and Dr. Leggett’s records. The ALJ finds Dr. Centi’s records inaccurate and unreliable and declines to give them substantial weight. The ALJ has given far greater weight to Claimant’s pain diagrams and Dr. Leggett’s thorough reports.

37. Dr. Leggett last saw Claimant on June 16, 2017. He had recently spoken with Dr. Centi who was under the mistaken impression Claimant only drove the sand rail “on a completely level surface” on the date of injury. Dr. Leggett was concerned about the persistent and progressive nature of Claimant’s symptoms and suggested additional workup to investigate potential diffuse neurological issues such as ALS or muscle related dystrophy. He recommended a dexamethasone steroid burst to help with any inflammatory-related pain. He concluded,

At this point, I do not have any other options to offer [Claimant]. We have tried some interventional procedures which did not provide the anticipated benefit. There are some procedures that he is not comfortable moving forward with. Other procedures have been denied. . . . I encouraged him to follow-up with [Dr. Centi] to see how the steroid burst performed. If there are any other treatment options that are available that I can assist with, I would be more than happy to do so.

38. Dr. Centi placed Claimant at MMI with no impairment and no permanent restrictions on July 20, 2017. Dr. Centi’s report contains no significant discussion or analysis of MMI, which is surprising given the complex nature of Claimant’s condition and his course of care.

39. Respondent filed a Final Admission of Liability (FAL) on August 28, 2017 based on Dr. Centi’s MMI report. Despite Dr. Centi’s recommendation for refills of Mobic, Robaxin, and Ultram, the FAL denied medical benefits after MMI.

40. Claimant timely objected to the FAL and requested a DIME.

41. Claimant saw Dr. Miguel Castrejon for the DIME on November 15, 2017. Claimant’s gait was slow and unsteady, favoring the left leg. Cervical range of motion was

reduced, with “visible spasm” of the left sternocleidomastoid muscle, and scattered trigger points with muscle hypertonicity and spasm. Dr. Castrejon also appreciated hypertonicity and spasm of the thoracic and lumbar musculature. Sensation was decreased in an S1 distribution on the left. Gastrocnemius strength was 4/5 with “evident” atrophy. Dr. Castrejon diagnosed cervical spine “dystonic features,” thoracic sprain, lumbar strain/sprain with facetitis, aggravation of pre-existing spondylolisthesis at L5-S1, and left S1 radiculopathy. He opined these diagnoses were causally related to Claimant’s work activity on July 21, 2016. Regarding the cervical spine, he opined, “the presence of a recent traumatic event (the activity of July 21, 2016 in combination with an apparent injury during participation in physical therapy) argues toward the cervical spine as being considered industrial in nature.” Dr. Castrejon further commented that Dr. Centi’s “template examination” reports made him wonder “whether he ever reviewed Dr. Olson’s report of April 14, 2017 and respectfully question whether he examined the same individual that I, Dr. Olson and Dr. Olson’s PA examined.”

42. Dr. Castrejon determined Claimant is not at MMI. He recommended flexion and extension x-rays, a neurosurgical consultation, repeat electrodiagnostic testing, and consideration of left L5 and S1 nerve root blocks. He also recommended a psychological evaluation to help Claimant manage his chronic pain.

43. On February 2, 2018, Claimant completed an annual refresher Defensive Tactics and Pressure Points Control Tactics course, required of all employees to work around inmates. Mr. James Holcomb has taught the course for the past 10 years. Mr. Holcomb testified the PPCT testing is physically demanding and demonstrated several tactics during the hearing. Some tactics and techniques require the ability to freely turn one’s neck and twist at the waist. Others require bending at the waist and kneeling to take physical control of an inmate on the floor. Mr. Holcomb explained, “I don’t expect anyone to be an MMA fighter,” and tells the participants “when you take this class, just do the best you can.” Mr. Holcomb certified Claimant proficient after completing the refresher course in February 2018. Claimant also passed the course in approximately January or February 2017.

44. Before completing the course, Claimant completed a form on which he referenced “back and neck problems” as conditions that “may impede participation in this program.” Mr. Holcomb admitted he did not specifically recall the refresher session Claimant attended in February 2018, and his testimony merely described the techniques he teaches generally.

45. Claimant testified he struggled with the refresher course and could not complete few tactics. He recalled the 2018 course was “gentler” than some previous courses, and not as strenuous as those Mr. Holcomb described generally.

46. Dr. Allison Fall performed an IME for Respondent on March 15, 2018. She disagreed with Dr. Castrejon’s opinion Claimant is not at MMI. She opined his physical examination findings were nonphysiologic and self-limited. In contrast to examinations by Dr. Leggett and Dr. Castrejon, Dr. Fall stated there was no acute spasm on palpation of

Claimant's neck. Dr. Fall thought Claimant's presentation was exaggerated and nonsensical, and none of his ongoing complaints were related to his work.

47. Dr. Michael Rauzzino performed an IME for Respondent on April 3, 2018. His conclusions echoed those reached by Dr. Fall, namely that Claimant did not injure his back or neck at work on July 21, 2016, and requires no further treatment in relation to any work exposure. Specifically, Dr. Rauzzino opined,

[Claimant's] vague and diffuse complaints have morphed over the course of his claim. There is nothing in the records to suggest that he sustained a specific injury as a result of riding in the sand rail or as a result of his treatment such that he would have sustained injury to the cervical spine, specifically dystonia or cervical facetogenic disease for which treatment has been proposed.

48. Dr. Rauzzino testified for Respondent in an evidentiary deposition on June 4, 2018. His testimony tracked the opinions expressed in his IME report. Dr. Rauzzino testified Claimant does not have cervical dystonia¹ based on his presentation and the mechanism of injury. Dr. Rauzzino opined it was not medically probable Claimant developed cervical dystonia because of any activity in therapy. Dr. Rauzzino reviewed Claimant's August 2016 lumbar MRI and identified no acute lumbar spine injury. He opined Claimant's MRI findings are consistent with a chronic disk bulge with no evidence of acute annular tear or hemorrhage to suggest any acute process.

49. Dr. Castrejon testified in an evidentiary deposition on September 26, 2018. He reviewed additional medical records before the deposition, including Dr. Rauzzino's and Dr. Fall's IME reports. Dr. Castrejon admitted he had not known about Claimant's participation in the PPCT refresher course, and would have doubted he could complete such a program. Nonetheless, none of the additional information convinced Dr. Castrejon to change his opinions regarding injury-related body parts or MMI.

50. Dr. Fall testified for Respondent in a post-hearing deposition on December 18, 2018, consistent with the opinions expressed in her IME report. She testified Claimant's presentation at Dr. Castrejon's DIME and her IME were incompatible with her general understanding of the defensive tactics in the PPCT course. Dr. Fall reiterated her opinion Claimant's presentation is "exaggerated" and "does not make physiologic sense." She maintained that Claimant is at MMI and requires no further treatment for any work-related condition.

51. Claimant's testimony regarding the onset and progression of symptoms in relation to his work is credible and persuasive.

¹ The ALJ notes Dr. Castrejon did not specifically diagnose cervical dystonia, but rather diagnosed "dystonic features."

52. Respondent failed to prove a basis to withdraw its admission of liability. The preponderance of persuasive evidence shows Claimant suffered a compensable injury on July 21, 2016.

53. Respondent failed to overcome the DIME's determination Claimant is not at MMI by clear and convincing evidence. Respondent failed to overcome the DIME's causation determination regarding Claimant's cervical spine. The contrary opinions of Dr. Fall and Dr. Rauzzino amount to "mere differences of medical opinion," which are insufficient to overcome the DIME.

CONCLUSIONS OF LAW

A. Withdrawal of admissions

By filing an admission of liability, the Respondent "admitted that the claimant sustained the burden of proving entitlement to benefits." *City of Brighton v. Rodriguez*, 318 P.3d 496, 507 (Colo. 2014). If the respondents seek to withdraw the admission of liability, they must prove by a preponderance of the evidence that the claimant suffered no compensable injury. See § 8-43-201(1) ("a party seeking to modify an issue determined by a general or final admission ... shall bear the burden of proof for any such modification."). Under *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000), the respondents may withdraw an admission of liability even after a claimant has gone through the DIME process. But to ensure that a request to withdraw an admission is not merely a "tactical" pretext to avoid the heightened burden of proof regarding DIMEs, the respondents must prove the claimant suffered no compensable injury in the first instance. *Id.* Once the claimant crosses the threshold for compensability, determinations of MMI are driven by ATPs and the DIME process.

The existence of a pre-existing condition does not disqualify a claim for compensation if an industrial injury aggravates, accelerates, or combines with a pre-existing condition to produce disability or a need for treatment. *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 sufficient for an award of medical benefits if it caused the claimant to need treatment he would not otherwise have required. *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).

Even a “minor strain” or a “temporary exacerbation” of a pre-existing condition can be a sufficient basis for a compensable claim if it was caused by a claimant’s work activities and caused him to seek medical treatment. *E.g.*, *Garcia v. Express Personnel*, W.C. No. 4-587-458 (August 24, 2004); *Conry v. City of Aurora*, W.C. No. 4-195-130 (April 17, 1996).

As found, Respondents failed to prove a basis for withdrawing the admission of liability. The persuasive evidence shows Claimant more likely than not suffered at least soft tissue strains and a symptomatic aggravation of his pre-existing condition as a proximate result of his work activities on July 21, 2016. The symptoms reasonably caused a need for treatment and limitations that impeded his ability to perform his regular work. Although Claimant had prior back problems, they were tolerable and well managed before July 21, 2016. The January 2016 slip and fall temporarily aggravated Claimant’s back but he recovered well after two months of therapy. Claimant’s statement that his symptoms after July 21, 2016 differed greatly from before the accident is credible and supported by the medical records. The fact that Claimant’s symptoms may have expanded and intensified since the original injury does not change the ALJ’s conclusion he suffered a compensable injury in the first instance.

B. Overcoming the DIME

“Maximum Medical Improvement” (MMI) is defined as the point when any medically determinable physical or mental impairment as a result of the industrial injury has become stable, and no further treatment is reasonably expected to improve the condition. Section 8-40-201(11.5). The DIME’s determination regarding MMI is binding unless overcome by clear and convincing evidence. Section 8-42-107(8)(b) and (c); *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). In determining whether a claimant is at MMI, the DIME “inherently” must decide whether further treatment is causally related to the industrial injury, and the DIME’s determination that a particular condition is or is not related to the industrial injury is binding unless overcome by clear and convincing evidence. *Egan v. Industrial Claim Appeals Office*, 971 P.2d 664 (Colo. App. 1998). Clear and convincing evidence must be “unmistakable and free from serious or substantial doubt.” *Leming v. Industrial Claim Appeals Office*, 62 P.3d 1015 (Colo. App. 2002). The party challenging a DIME’s conclusions must demonstrate it is “highly probable” that the MMI finding is incorrect. *Qual-Med*, 961 P.2d at 592; *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A “mere difference of medical opinion” does not constitute clear and convincing evidence that the DIME is incorrect. *E.g.*, *Gutierrez v. Startek USA, Inc.*, W.C. No. 4-842-550-01 (March 18, 2016).

As found, Respondent failed to overcome Dr. Castrejon's MMI opinion. Reasonable physicians can disagree on whether Claimant's ongoing back and neck symptoms are causally related to his work on July 21, 2016. In his report and deposition testimony, Dr. Castrejon provided well-reasoned and thorough explanations for his opinions and conclusions. Dr. Castrejon considered Claimant credible. Dr. Leggett also believed Claimant's complaints were genuine and the lion's share of his symptoms relate to the admitted injury. Additionally, Dr. Leggett noted at least some of the worsening over time is attributable to delays in authorization and denial of some requested treatment. The record shows Claimant experienced the onset of low back and mid back pain shortly after operating the sand rail on July 21, 2016. Claimant has consistently attributed his symptoms to that activity. He has consistently stated his symptoms after July 21, 2016 were substantially different than his previous back problems. Claimant's physical condition as depicted in the medical records after July 21, 2016 appears significantly worse than before the injury. Dr. Castrejon synthesized all the available information, which led him to conclude Claimant's current back symptoms are more likely than not injury-related. Dr. Fall and Dr. Rauzzino's contrary opinions are amount to "mere differences of opinion," and do not persuade the ALJ to overturn the DIME.

Respondent's most compelling evidence is the testimony of James Holcomb. At first blush, Claimant's completion of the defensive tactics refresher course in 2018 appears inconsistent with his reported symptoms and limitations. Mr. Holcomb appeared sincere and the ALJ has no reason to doubt the general descriptions he provided of the physical maneuvers involved. But it requires supposition to connect the dots between Mr. Holcomb's general demonstration of tactics and Claimant's *actual performance* in the course. Mr. Holcomb testified he does not "expect anyone to be an MMA fighter" and tells the participants to "do the best they can." It seems reasonable to infer a wide range of proficiency among DOC employees, many of whom probably complete the course without looking like the second coming of Bruce Lee. Moreover, Mr. Holcomb admitted he had no specific recollection of Claimant's refresher training, so he cannot directly contradict Claimant's testimony of how he managed to get through the course despite his pain and limitations. The ALJ is also mindful that Dr. Leggett and Dr. Castrejon documented objective clinical findings to corroborate Claimant's reported symptoms, including muscle spasm and trigger points. Respondent's primary argument is Claimant's completion of the refresher course "is inconsistent with an ongoing need for medical care and permanent impairment." The ALJ is not persuaded to draw that inference, particularly in the context of a clear and convincing evidence burden.

Regarding the neck, Claimant asserts he injured his neck in physical therapy prescribed for his compensable injury. He told multiple providers the same thing since August 2016. Dr. Castrejon was persuaded by Claimant's assertion and incorporated it into his MMI determination. As a result, Respondent must prove a negative, *i.e.*, that Claimant did not injure his neck, by clear and convincing evidence. While there is room for legitimate disagreement on this point, Respondent's evidence does not rise to the level of clear and convincing.

Nor does the ALJ find clear and convincing evidence to overcome Dr. Castrejon's recommendations for further evaluations and treatment. Several of Dr. Castrejon's

recommendations are diagnostic in nature, which seems reasonable given the challenging and complex nature of Claimant's presentation. Diagnostic procedures are a legitimate basis to forestall MMI when such procedures have a reasonable prospect of diagnosing or defining the claimant's condition so as to suggest a course of further treatment. *Soto v. Corrections Corp. of America*, W.C. No. 4-813-582 (October 27, 2011). The ALJ concludes that standard is satisfied here.

Additionally, the ALJ sees no persuasive evidence to contradict Dr. Castrejon's opinion that Claimant would benefit from a psychological assessment and possible counseling. The Chronic Pain MTGs provide,

All patients who are diagnosed as having chronic pain should be referred for a psychosocial evaluation, as well as concomitant interdisciplinary rehabilitation treatment. This referral should be performed in a way so as to not imply that the patient's claims are invalid or that the patient is malingering or mentally ill. Even in cases where no diagnosable mental condition is present, these evaluations can identify social, cultural, coping, and other variables that may be influencing the patient's recovery process and may be amenable to various treatments including behavioral therapy. As pain is understood to be a biocide Co. social phenomenon, these evaluations should be regarded as an integral part of the assessment of chronic pain conditions.²

Finally, Respondent's argument the ALJ has no authority to order treatment recommended a non-ATP (the DIME) is unpersuasive for several reasons. First, the ALJ is not ordering any specific treatment. The sole issues for determination are (1) Respondent's request to withdraw the GAL, and (2) Respondent's attempt to overcome the DIME regarding MMI. Claimant has not requested the ALJ to award any specific treatment. Second, Respondent's argument would mean a DIME could never make treatment recommendations, which would eviscerate the ability to declare a claimant not at MMI. The DIME's role is not to simply choose between treatment recommendations made by ATPs. Rather, the DIME gives an independent opinion regarding any treatment he or she believes is necessary to bring the claimant to MMI. It is then incumbent on ATPs to implement those recommendations, or for the parties to otherwise find a way to resolve the matter. The possibility that a claimant may be whipsawed between the DIME and a recalcitrant ATP, while unfortunate, is simply an inherent feature of this process. *Williams v. Kunau*, 147 P.3d 33 (Colo. 2006).

ORDER

It is therefore ordered that:

1. Respondent's request to withdraw its admission of liability is denied and dismissed.

² Rule 17, Exhibit 9, § (F)(2).

2. Respondent's request to overcome the DIME regarding MMI is denied and dismissed.

3. 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: March 5, 2019

s/Patrick C.H. Spencer II

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

ISSUES

- Whether Claimant has established by a preponderance of the evidence that he sustained an injury in the course and scope of his employment on July 13, 2017.
- Whether Claimant has established by a preponderance of the evidence that he is entitled to medical benefits because of a work-related injury.

FINDINGS OF FACT

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

1. Employer is a framing and welding company owned by Michael Dunlap. Claimant and Mr. Dunlap are first cousins. After Claimant took welding classes, he began working for Employer's welding company in May 2017 as its sole employee.

2. On July 13, 2017, Claimant was driving a three-ton company truck when a small passenger sedan hit it from behind. The other driver was at fault and the responding officer issued him a citation. Claimant testified that there was damage to the rear trailer hitch and the electrical trailer plug-in, and that he took it to a shop for repair. However, Mr. Dunlap testified that he inspected the truck at the scene of the accident and that it sustained no damage. He also testified that he was unaware of any repair work performed on the truck. Photographs of the truck admitted as exhibit J show no discernable damage.

3. At the scene, Claimant told Mr. Dunlap that he was not injured, and he denied medical care. However, Claimant testified that he later began experiencing symptoms.

4. That evening Claimant sought medical attention at the emergency department of Boulder Community Hospital. Records of the visit provide:

- Claimant complained of pain in his left neck and left shoulder, "no other symptoms."
- Claimant told his treating physician that his symptoms developed throughout his neck and upper back, primarily on the left side.
- Claimant reported no neurologic symptoms.

5. Claimant testified that the records were incorrect because he did not have left-sided symptoms. He later testified that he initially had pain in both of his shoulders.

6. The emergency room provider diagnosed Claimant with an acute cervical sprain and dispensed a muscle relaxant and ibuprofen.

7. On July 21, 2017, Claimant returned to the emergency department of

Boulder Community Hospital complaining of headache, ringing in his ears, left lateral neck pain, and numbness of the left hand. Claimant's testimony did not relate his headaches or the ringing in his ears as ongoing symptoms due to his work-related injury. The record details the neurological examination of Claimant's left fingers and his left hand. It also details the musculoskeletal examination, which found "vague left-sided paraspinal tenderness on palpation, which is mild extending down into his left trapezius."

8. Claimant testified that the July 21, 2017 medical record was also incorrect because he did not have left-sided symptoms.

9. Claimant initially testified that his current symptoms were numbness in three fingers of his right hand, burning extending from his right forearm through his right elbow into his right shoulder and the right side of his neck. Claimant further testified that all these symptoms had been present since he began experiencing symptoms on July 13, 2017.

10. Claimant sought medical treatment for an unrelated incident on August 17, 2017, after falling and striking his right elbow on a rock. The physician performed a comprehensive examination of twelve systems, including the neurological and musculoskeletal systems that he noted were negative except for Claimant's severely swollen right elbow. Claimant initially testified that the provider examined only his right elbow. Later, he testified that a normal examination occurred regarding other body parts. Claimant further testified that he was experiencing tingling in his right hand and fingers on August 17, 2017. However, the record does not support his claim.

11. Dr. Hattem, Respondent's expert witness and former emergency medicine practitioner, testified that performing a neck examination is a precautionary measure and standard practice for any person who reports falling.

12. Claimant returned to Boulder Community Health on August 20, 2017, to follow up regarding his right elbow. The physician did not record Claimant reporting any symptoms related to the car accident. The physician performed another review of symptoms noting only right arm swelling and pain. However, the provider specifically noted, "Neck is supple and non-tender." The medical record contradicts Claimant's testimony that no provider examined his neck when he treated for his elbow.

13. In early spring of 2018, Claimant began receiving invoices for his July 2017 emergency room visits.¹

14. On April 25, 2018, Claimant reported his July 13, 2017 work injury. Employer filed a first report of injury that day, and provided Claimant with a designated provider list.

15. On April 30, 2018, Claimant sought treatment at U.S. Healthworks where Peter Mars, M.D. evaluated him. Claimant reported a 261-day history of right-sided neck

¹ Neither party explained why the at-fault driver's auto insurance did not cover Claimant's treatment.

pain and tingling in his right index and middle fingers. Claimant reported that with heavy activity he experienced burning pain down his posterior right arm to the elbow and that his fourth and fifth digits experienced infrequent numbness and tingling. Claimant did not report right or left shoulder pain, or left neck pain. In the eight months since Claimant had last treated, his reported symptoms migrated from the left side to the right side of his body.

16. On June 28, 2018, Dr. Shoemaker reviewed Dr. Mars' May 30, 2018 medical record, examined Claimant, and determined that Claimant's current symptoms were work related. Nothing in Dr. Shoemaker's notes indicates that Dr. Shoemaker reviewed any other records, specifically the July and August of 2017 Boulder Community Health records.

17. On August 14, 2018, Dr. Shoemaker conducted an EMG study of Claimant's right arm. An EMG provides objective evidence of radiculopathy if it is present. Claimant exhibited a C8 distribution of chronic/remote radiculopathy, but at C6-7, the test exhibited normal results.

18. Claimant has a broad-based disc herniation at C6-7, for which Dr. Gerlach offered surgery. Insurer denied the surgical request.

19. Dr. Long-Miller placed Claimant at MMI.

20. Dr. Hattem testified the Medical Treatment Guidelines consider whiplash an unlikely cause of disc herniation. Additionally, Dr. Hattem testified that Claimant reported left-sided radicular symptoms eight days after the accident.

21. Dr. Hattem relied on the Medical Treatment Guidelines which provide:

- No evidence relates degenerative disc disease related to whiplash or to non-radicular neck pain.
- Whiplash is probably an uncommon cause of cervical disc herniation.
- Early and reproducible signs of radiculopathy should support a potential causal connection between whiplash and cervical disc herniation. Claimant's initial assessment did not include any immediate or reproducible radicular symptoms.

22. Dr. Hattem testified that Claimant initially reported left-sided pain, but that when he evaluated Claimant, Claimant reported right-sided pain. Dr. Hattem explained that while errors regarding the side of pain do occur, it was unlikely the references to left-sided symptoms were in error because they repeated throughout the July 13 and July 21 medical records in both the physician's and nurse's notes. Dr. Hattem concluded that Claimant's right-sided symptoms had not occurred at that time. The fact that Claimant's current symptoms are contralateral to those he reported on the date of and one week following the car accident indicate that Claimant's current symptoms are unrelated to the accident. Further, Dr. Hattem testified that medical providers examined Claimant twice

in August 2017 and both reviews of symptoms and examinations were negative for neck symptoms.

23. Dr. Hattem was unsure if Dr. Shoemaker and the other authorized treating physicians were aware of the eight-month gap in Claimant's treatment. As a former occupational medical provider, he opined that unless a physician receives a specific prior medical record with a request to review it, physicians typically treat and test based solely on the history obtained from the patient.

24. Dr. Hattem testified that even if there had been radiculopathy at C6-7, the symptoms still would have been on the right side while Claimant's initial complaints were left-sided.

25. Dr. Hattem persuasively testified that any injury from the accident would have been minor and unlikely to produce neck pain, based on his review of the police report and Claimant's description of the accident. Dr. Hattem testified that Claimant's evaluations in August establish that his symptoms had resolved in one month. Therefore, Claimant's herniation at C6-7 disc does not relate to the July 13, 2017 accident.

26. Dr. Hattem testified that no objective evidence supported Claimant's claim for benefits in this case. Dr. Hattem concluded that Claimant's neck pain and decreased range of motion related to cervical degenerative disc disease rather than an acute work injury.

27. Claimant treated through November 19, 2018, reporting constant pain in the right side of his neck, right trapezius, and right shoulder radiating to the right upper arm, forearm, and hand.

28. On December 18, 2017, Michael Dunlap provided Claimant with a notice of layoff, terminating Claimant's employment on December 22, 2017. Mr. Dunlap testified that financial constraints caused Claimant's termination and that Claimant was Employer's highest paid employee. After terminating Claimant, Employer closed its welding shop and consolidated its limited welding work at the framing business location.

29. The ALJ finds it unlikely that the hospital records erred in describing Claimant's symptoms, especially given the consistent and detailed descriptions of left-sided symptoms and examinations.

30. The ALJ finds Claimant to be a poor historian with respect to his symptoms and medical treatment.

31. The ALJ finds that Claimant sustained a work-related injury on July 13, 2017 consisting of an acute cervical strain.

32. The ALJ finds that that injury resolved on its own sometime before August 17, 2017.

33. The ALJ finds Dr. Hattem's opinions and analysis to be well founded and

persuasive.

34. The ALJ finds that Claimant has not met his burden of proving by a preponderance of the evidence that he sustained a right-sided work injury.

CONCLUSIONS OF LAW

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

For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. C.R.S. § 8-41-301(1)(c). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.*, 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the ALJ. *Faulkner*, 12 P.3d at 846. A compensable injury is an injury which "arises out of" and "in the course of" employment. See C.R.S. § 8-41-301(1)(b); *Price v. Industrial Claim Appeals*, 919 P.2d 207 (Colo. 2012).

In deciding whether the claimant has met his burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to testimony, and draw plausible inferences from the evidence." See *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002).

Credibility is a significant consideration when determining compensability. In assessing credibility, the ALJ should consider, among other things, the consistency or inconsistency of the witness' testimony and actions; the reasonableness or unreasonableness of the testimony; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936).

In establishing causation, a claimant must show that the industrial injury bears a direct causal relationship between the precipitating event and the resulting disability. Respondents are liable for medical treatment that is reasonably necessary to cure and/or relieve an injured worker from the effects of an industrial injury. § 8-42-101(1)(a), C.R.S. The claimant must prove a causal nexus between the claimed disability, need for medical treatment, and the work related injury. *Singleton*, 961 P.2d 571 (Colo. App. 1998). The question of whether the claimant has met the burden to establish the requisite causal connection and whether the medical treatment sought is reasonably necessary is one of fact for the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner*, 12 P.3d 844 (Colo. App. 2000).

Claimant has failed to meet his burden to establish the requisite causal connection between the July 13, 2017 accident and medical treatment for his right-sided symptoms.

Claimant originally reported only left-sided symptoms on July 13 and 21, 2017. Furthermore, August 17 and 20, 2017 medical records indicate that no further neck, shoulder, or arm symptoms were present. Claimant's extensive testing and treatment in 2018 indicates that there is a herniated disc at C6-7, but such disc herniation is degenerative in nature. An EMG concluded that Claimant did not have right-sided radicular symptoms due to a C6-7 disc herniation. Claimant's temporary left-sided symptoms resolved within one month and his right-sided symptoms are not related to the July 13, 2017, accident.

Claimant failed to meet his burden to prove by a preponderance of the evidence that he suffered an injury other than an acute left-sided cervical strain proximately caused by and arising out of the course and scope of his employment. Claimant's testimony during the hearing was self-contradictory, inconsistent with medical records, and inconsistent with the more credible testimony of Mr. Dunlap and Dr. Hattem. Two medical records indicate that immediately following the accident, Claimant was experiencing left-sided symptoms in his neck, shoulder, and, eventually, hand. Two additional medical records indicate an absence of those same symptoms one month after the accident. Nine months after the date of injury, Claimant reported new symptoms in the opposite side of his body despite seeking no additional treatment during the interim. Then, from April 2018 through November 2018, Claimant's symptoms evolved from being intermittent to constant. This again conflicted with Claimant's testimony that his symptoms had been constant since they first began.

ORDER

IT IS THEREFORE, ORDERED THAT:

- A. Claimant has failed to prove that he sustained a right-sided injury in the course and scope of his employment on July 13, 2017.
- B. Claimant's claim for benefits is therefore denied and dismissed.

DATED this 4th day of March, 2019.

/s/ Kimberly Turnbow
Kimberly B. Turnbow
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, Colorado, 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. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://colorado.gov/dpa/oac/forms-WC.htm>.**

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 5-067-897-001**

ISSUE

1. A determination of Claimant's Average Weekly Wage (AWW).
2. Whether Claimant is entitled to receive increased Temporary Partial Disability (TPD) and Temporary Total Disability (TTD) benefits based on a higher AWW.

STIPULATION

The parties agreed that Claimant's admitted AWW of \$1,190.06 from Employer is not in dispute.

FINDINGS OF FACT

1. Employer is a rehabilitation facility that provides in-patient medical services to acutely injured and ill individuals. On December 5, 2017 Employer hired Claimant to work as an overnight Registered Nurse (RN). Employer's HR Director Rae Roberts testified that Claimant was hired to perform full-time employment consisting of three to four twelve-hour overnight RN shifts per week. Ms. Roberts explained that Claimant's position as an overnight RN included not only caring for patients but also supervising other employees.

2. Employer hired Claimant with the expectation that she would be available seven days each week. Claimant only limited her availability by requesting to have off every other weekend. Ms. Roberts explained that Employer's staffing needs changed weekly and monthly based on the number of patients who were at the facility and the acuity level of each patient. Because of the changing staffing needs, Employer did not offer Claimant a permanent, fixed schedule.

3. After Claimant secured a position with Employer, she tendered her written resignation with previous Employer Avamere on December 6, 2017. Claimant's resignation letter reflects that she ceased employment with Avamere because her new job with Employer offered an increased salary and a shorter commute.

4. Claimant explained that she had worked for Avamere since approximately 2012 as an RN performing overnight shifts. Similar to Employer, Avamere provides in-patient rehabilitation services to individuals. Claimant noted that the patients at Employer's facility tend to be more acutely ill or injured than the patients at Avamere. Otherwise, Claimant's job duties for Employer and Avamere were fairly similar.

5. Director of Nursing at Avamere Daniella Johnson, RN testified that when Claimant tendered her resignation on December 6, 2017 Avamere asked her to work on a PRN or "as needed" basis. Ms. Johnson remarked that nurses who are employed on a

PRN basis are expected to work at least one shift each month. The PRN shifts would be scheduled when Avamere required additional coverage and Claimant was available.

6. During January 2018 Claimant worked full-time for Employer. She specifically worked three to four twelve-hour shifts per week.

7. Ms. Johnson testified that in the first week or two of January 2018 she offered Claimant a full-time position at Avamere involving three shifts per week with a pay raise of \$4.00-\$5.00 per hour to match her pay rate from Employer. Claimant did not immediately accept the offer because she wanted to discuss the matter with her family.

8. On January 21, 2018 Claimant suffered injuries to her hip while working for Employer. She specifically slipped and fell on ice. Physicians assigned Claimant work restrictions. Claimant received Temporary Total Disability (TTD) benefits from Employer because it was unable to accommodate her restrictions. Claimant noted that Avamere was also unable to accommodate her work restrictions and she was placed on a leave of absence.

9. Ms. Johnson testified that Claimant contacted her and advised that she wanted to accept the full-time position at Avamere at the higher wage rate. However, she had just been injured in a slip and fall accident while working for Employer. Claimant agreed that she did not accept the offer to return to work full-time at the higher pay rate at Avamere prior to sustaining her work-related injuries on January 21, 2018.

10. Claimant explained that she never performed any PRN shifts at Avamere in January 2018 because they conflicted with her work schedule for Employer. She noted, and Ms. Johnson agreed, that her schedule with Employer received priority and any Avamere shifts would be scheduled around her work for Employer. Ms. Johnson confirmed that Avamere offered Claimant PRN shifts in January 2018 but Claimant was unavailable and did not work any shifts. She remarked that Avamere offers a flexible PRN schedule that could accommodate Claimant's full-time position with Employer.

11. Subsequent to her industrial injury while working for Employer, Claimant attended meetings at Avamere. The meetings permitted Claimant to remain current on her training requirements. Avamere paid Claimant for attending the meetings.

12. Claimant's rate of pay from Avamere for the period January 22, 2018 through August 15, 2018 was \$30.40 per hour. Beginning August 16, 2018 Claimant's pay rate from Avamere increased to \$34.00 each hour.

13. Claimant's 2017 W-2 Wage and Tax Statement from Avamere reflects that she earned total wages of \$63,639.80 or an AWW of \$1,223.04. Prior to December 2017 Claimant routinely worked three to five twelve-hour shifts per week at Avamere and did not have concurrent employment. She seeks to increase the admitted AWW of \$1,190.06 by adding her AWW from Avamere. Claimant thus seeks a total AWW of \$2,413.10.

14. Claimant's request to increase her base AWW from Employer by adding her AWW from Avamere in 2017 does not fairly approximate her wage loss or diminished

earning capacity at around the time of her Industrial injuries on January 21, 2018. Her wages from Avamere in 2017 do not reflect earnings as a result of concurrent employment. Claimant acknowledged that her 2017 wages from Avamere include weeks in which she worked five twelve-hour shifts. Working five twelve-hour overnight shifts each week at Avamere is incompatible with Employer's requirement of completing at least three twelve-hour overnight shifts each week.

15. Nevertheless, Claimant is entitled to an increase in her AWW as a result of concurrent employment with Avamere. Initially, Claimant credibly explained that she worked three to five twelve-hour shifts each week at Avamere and her employment with Employer involved similar job duties. Moreover, Claimant is required to work at least three twelve-hour shifts each week with Employer. She specifically worked three to four twelve-hour shifts per week for Employer during January 2018 but did not engage in concurrent work for Avamere during the time period.

16. Based on Claimant's credible testimony and employment records, she typically worked four twelve hour shifts or 48 hours per week at Avamere. Claimant continues employment with Avamere but is currently on a leave of absence status. She has attended paid meetings at Avamere to remain current on her training requirements. Claimant is thus concurrently employed by Employer and Avamere.

17. Because Claimant is required to work at least three twelve-hour shifts each week for Employer, adding an additional twelve-hour shift each week at Avamere accurately reflects her wage loss and diminished earning capacity. Claimant's rate of pay from Avamere beginning January 22, 2018 was \$30.40 per hour. One twelve-hour shift per week times \$30.40 yields an AWW from concurrent employment with Avamere of \$364.80. Adding \$364.80 to Claimant's admitted AWW with Employer of \$1,190.06 yields a total AWW of \$1554.86. A total AWW based on Claimant's work for Employer and concurrent employment with Avamere constitutes a fair approximation of her wage loss and diminished earning capacity as a result of her January 21, 2018 industrial injuries. Accordingly, Claimant is entitled to receive increased TPD and TTD benefits based on her higher total AWW of \$1554.86.

CONCLUSIONS OF LAW

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

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

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

4. Section 8-42-102(2), C.R.S. requires the Judge to determine a claimant's AWW based on her earnings at the time of injury. The Judge must calculate the money rate at which services are paid to the claimant under the contract of hire in force at the time of injury. *Pizza Hut v. ICAO*, 18 P.3d 867, 869 (Colo. App. 2001). However, §8-42-102(3), C.R.S. authorizes a Judge to exercise discretionary authority to calculate an AWW in another manner if the prescribed methods will not fairly calculate the AWW based on the particular circumstances. *Campbell v. IBM Corp.*, 867 P.2d 77, 82 (Colo. App. 1993). The overall objective in calculating an AWW is to arrive at a fair approximation of a claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997). Therefore, §8-42-102(3), C.R.S. grants an ALJ substantial discretion to modify the AWW if the statutorily prescribed method will not fairly compute a claimant's wages based on the particular circumstances of the case. *In Re Broomfield*, W.C. No. 4-651-471 (ICAP, Mar. 5, 2007).

5. When a worker is concurrently employed the ALJ may, in order to achieve fairness, include all wages in the computation of the AWW. *Broadmoor Hotel and Continental Ins. Co. v. Industrial Claim Appeals Office*, 939 P.2d 460 (Colo. App. 1996); *Guerrero Barrio v. GCA Services Group, Inc.*, W.C. No. 4-813-965 (ICAP, July 28, 2010); see *Miranda v. ISS Prudential Services, Inc. and/or Denver Public Schools*, W.C. Nos. 3-833-976, 3-908-234 and 4-105-113 (Feb. 28, 1994) (where the claimant holds concurrent employment at the time of the injury, the ALJ has discretion to calculate the AWW to include the total income from the multiple employers). However, there is no mandate that wages from concurrent employment must be included in the AWW. *Coleman v. National Produce Service*, W.C. No. 4-601-676 (ICAP, July 12, 2005); *Yankee v. Flagship International*, W.C. No. 3-862-644 (ICAP, Dec. 7, 1988).

6. As found, Claimant's request to increase her base AWW from Employer by adding her AWW from Avamere in 2017 does not fairly approximate her wage loss or diminished earning capacity at around the time of her Industrial injuries on January 21, 2018. Her wages from Avamere in 2017 do not reflect earnings as a result of concurrent employment. Claimant acknowledged that her 2017 wages from Avamere include weeks in which she worked five twelve-hour shifts. Working five twelve-hour overnight shifts

each week at Avamere is incompatible with Employer's requirement of completing at least three twelve-hour overnight shifts each week.

7. As found, nevertheless, Claimant is entitled to an increase in her AWW as a result of concurrent employment with Avamere. Initially, Claimant credibly explained that she worked three to five twelve-hour shifts each week at Avamere and her employment with Employer involved similar job duties. Moreover, Claimant is required to work at least three twelve-hour shifts each week with Employer. She specifically worked three to four twelve-hour shifts per week for Employer during January 2018 but did not engage in concurrent work for Avamere during the time period.

8. As found, based on Claimant's credible testimony and employment records, she typically worked four twelve hour shifts or 48 hours per week at Avamere. Claimant continues employment with Avamere but is currently on a leave of absence status. She has attended paid meetings at Avamere to remain current on her training requirements. Claimant is thus concurrently employed by Employer and Avamere.

9. As found, because Claimant is required to work at least three twelve-hour shifts each week for Employer, adding an additional twelve-hour shift each week at Avamere accurately reflects her wage loss and diminished earning capacity. Claimant's rate of pay from Avamere beginning January 22, 2018 was \$30.40 per hour. One twelve-hour shift per week times \$30.40 yields an AWW from concurrent employment with Avamere of \$364.80. Adding \$364.80 to Claimant's admitted AWW with Employer of \$1,190.06 yields a total AWW of \$1554.86. A total AWW based on Claimant's work for Employer and concurrent employment with Avamere constitutes a fair approximation of her wage loss and diminished earning capacity as a result of her January 21, 2018 industrial injuries. Accordingly, Claimant is entitled to receive increased TPD and TTD benefits based on her higher total AWW of \$1554.86.

ORDER

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

1. Claimant earned an AWW of \$1554.86.
2. Claimant is entitled to receive increased TPD and TTD benefits based on her higher total AWW of \$1554.86.
3. Any issues not resolved in this Order are reserved for future determination.

If you are a party 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 certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it

within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at <http://www.colorado.gov/dpa/oac/forms-WC.htm>.*

DATED: March 7, 2019.

DIGITAL SIGNATURE:


Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-791-506-001**

ISSUES

- Did Claimant prove his claim should be reopened for further medical treatment as recommended by Dr. Miguel Castrejon?
- Did Respondent prove no further treatment is reasonably necessary or causally related to Claimant's June 9, 2008 admitted injury?

FINDINGS OF FACT

1. Claimant suffered an admitted neck injury on June 9, 2008. He was moving bleachers with three coworkers and felt a "strain sensation" in the left side of his neck. He was diagnosed with a left cervical and trapezius strain. A cervical MRI showed chronic multilevel degenerative changes, but no acute pathology. Claimant was prescribed conservative care, including therapy, muscle relaxers, and Biofreeze. In April 2009, he underwent diagnostic facet medial branch blocks at C4-5, C5-6, and C6-7, with no benefit.

2. Claimant's ATP, Dr. Richard Nanes, put him at MMI on April 28, 2009 with a 14% whole person rating. Dr. Nanes noted Claimant's condition was "pretty much unchanged" with "no response to all of our treatments." Claimant was released to work without restrictions. The only maintenance recommendations were to finish a few remaining sessions of physical therapy and a final refill of Biofreeze.

3. Thereafter, Claimant received no treatment for his neck for more than four years.

4. Claimant saw Dr. Jenks on August 8, 2013 for a DIME. Dr. Jenks assigned a 10% whole person cervical spine rating. The rating was lower than Dr. Nanes' rating because Claimant's range of motion had improved in the interim. Dr. Jenks opined, "He does not need any maintenance care."

5. Respondent filed an FAL admitting to Dr. Jenks' 10% rating and denying medical benefits after MMI. Claimant timely objected to the FAL.

6. Claimant saw Dr. Miguel Castrejon for an IME at his counsel's request on January 15, 2014. Dr. Castrejon recommended additional treatment including C3-4, C4-5, and C5-6 facet blocks and medial branch blocks, possible rhizotomy, a left greater occipital nerve block, trigger point injections, physical therapy, and a psychological evaluation.

7. Dr. Carlos Cebrian performed an IME for Respondent in July 2014. Dr. Cebrian's report was not entered into evidence, but its general content can be gleaned from other records. Dr. Cebrian disagreed with Dr. Castrejon's recommendations and opined no further treatment was required on a work-related basis.

8. The parties subsequently reached a stipulation on November 20, 2014, which provides, “Respondent agrees to admit to reasonable, necessary, and related maintenance medical treatment as related to this June 9, 2008 workers’ compensation claim. Furthermore, the parties agreed to authorize a facet injection as long as this injection continues to be recommended by the new authorized treating physician, Dr. Michael Sparr.” The stipulation closed the claim as to all other issues.

9. Claimant received treatment from Dr. Sparr from December 10, 2014 to February 3, 2016. Dr. Sparr provided no detailed causation analysis and simply noted he had been authorized to provide ongoing treatment for Claimant’s neck symptoms. Dr. Sparr found no reliable indication for facet injections. He provided multiple trigger point injections followed immediately by chiropractic treatment. Claimant reported short-term relief, but no lasting benefit. On February 3, 2016, Dr. Sparr released Claimant to a self-directed stretching and home exercise program. On May 17, 2017, Dr. Sparr reiterated that no further active treatment was reasonably necessary.

10. Dr. Castrejon re-evaluated Claimant on November 1, 2018. His opinions and recommendations remained essentially unchanged from his original evaluation.

11. Dr. Cebrian performed another IME on September 26, 2018. Dr. Cebrian maintained his opinion Claimant requires no further treatment in relation to his June 2008 injury.

12. Dr. Castrejon and Dr. Cebrian testified consistent with the opinions expressed in their reports.

13. Dr. Cebrian’s causation opinions are credible and more persuasive than those offered by Dr. Castrejon.

14. Respondent proved by a preponderance of the evidence Claimant requires no further treatment causally related to the June 2008 injury.

CONCLUSIONS OF LAW

Claimant requests that his claim be “reopened” for further treatment. But the medical portion of Claimant’s claim remains open pursuant to the parties’ stipulation. Therefore, reopening is moot.

Respondent seeks to withdraw its “admission” for medical treatment after MMI on the theory that no further care is reasonably necessary or causally related to the June 2008 admitted injury. Although Respondent has covered maintenance care under a stipulation rather than a formal admission, the analysis is the same. Even where the respondents admit liability for medical benefits after MMI, they retain the right to challenge the compensability, reasonableness, and necessity of specific treatment. *Hanna v. Print Expeditors Inc.*, 77 P.3d 863 (Colo. App. 2003). Usually, the claimant must prove entitlement to disputed medical benefits by a preponderance of the evidence. *Ford v. Regional Transportation District*, W.C. No. 4-309-217 (February 12, 2009). But the Act was amended in 2009 to place the burden of proof on the party seeking to modify an

issue determined by a previous admission or order. Where the respondents' seek to terminate all previously admitted maintenance benefits, the respondents must prove treatment is no longer reasonably necessary or causally related to the injury. Section 8-43-201(1); *Salisbury v. Prowers County School District RE2*, W.C. No. 7-702-144 (June 5, 2013); *Dunn v. St. Mary Corwin Hospital*, W.C. No. 4-754-838 (October 1, 2013).

Respondent proved there is no causal connection between any ongoing need for treatment and the 2008 admitted injury. Dr. Cebrian's causation opinions are credible and persuasive. Claimant's injury involved no significant trauma and caused no identifiable objective change to his cervical spine. The ALJ sees no persuasive connection between Claimant's current symptoms and a minor strain nearly 11 years ago. Given the pre-existing degenerative changes shown on imaging studies, the minor nature of the original incident, the lengthy interval since the accident, and the expected, natural progression of Claimant's underlying condition over time, the ALJ is persuaded the 2008 accidental injury is not the proximate cause of any current need for treatment. Claimant's current need for treatment is due to the natural progression of his personal medical condition, without contribution from the work accident.

ORDER

It is therefore ordered that:

1. Respondent's request to terminate Claimant's medical benefits is granted. Claimant's request for further medical treatment related to the June 9, 2008 injury 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: March 8, 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
WORKERS' COMPENSATION NO. WC 5-052-120-002**

ISSUES

1. Whether Respondents have established that Claimant was responsible for the termination of his employment on October 19, 2018 based on his voluntary resignation and thus is not entitled to temporary total disability (TTD) benefits after that date.

FINDINGS OF FACT

1. Claimant is a 50 year old male who was employed by Employer as a dishwasher.

2. On July 17, 2017, while working, Claimant sustained a compensable injury to his right eye. On that date, a co-worker dropped a plate and a shard of the broken plate penetrated the Claimant's right eye causing him eventually to lose almost all sight in his right eye.

3. Claimant underwent extensive treatment for his injury and M. Susan Zickenfoose, M.D. became one of his authorized treating providers. In September of 2018, Dr. Zickenfoose noted that the duration of Claimant's condition was probably life and that he may never regain full vision in his right eye and may need injections in his eye for the rest of his life. Dr. Zickenfoose noted that Claimant was unable to be around heat and steam as it caused right eye irritation. She also noted that Claimant needed another surgery on his right eye. Dr. Zickenfoose noted that Claimant had not been completely incapacitated due to his injury, but that he had been incapacitated for multiple short periods of time due to medical treatment and recovery. Dr. Zickenfoose noted that Claimant would need to be off work for the new surgery and for visits with his eye doctor. See Exhibit J.

4. Claimant was scheduled for an additional surgery on October 8, 2018. Claimant worked on Friday October 5, 2018, his last scheduled day of work before surgery.

5. On October 8, 2018, Claimant underwent surgery that included a vitrectomy of the right eye. Claimant's diagnoses included epiretinal membrane, right and aphakia of the right eye. See Exhibits 2, K.

6. The aftercare instructions for Claimant following surgery included wearing his eye patch/shield the first night, positioning himself to avoid lying flat on his back, lifting of more than 10 pounds for 1 week, and no bending, stooping, or straining for one week. Claimant was scheduled for follow up visits. See Exhibit 1.

7. On October 13, 2018, Claimant went to the emergency room due to a headache and pain in his right eye. He was ultimately discharged with instructions to follow up the next day.

8. On October 14, 2018, Claimant called UC Health to report that he was not sure if he could make it to his follow up appointment due to weather and the cost of a taxi. Claimant reported that his eye felt better and that he didn't know if he needed to come in. Claimant was encouraged to come in due to potential pressure that could be high and put him at risk for vision loss. Claimant reported that he would come in and have his son bring him. See Exhibit 3.

9. On October 14, 2018, Claimant was evaluated at UC Health by Marisa Lau, M.D. Claimant reported that following his right eye surgery he had some delay in using eye drops due to difficulty getting medications because he was going through workers' compensation. Claimant also reported that he had stopped taking a different eye drop because he did not recall being told to continue those drops. Claimant reported that the day prior he had an acute right sided headache and that he went to the emergency department. Dr. Lau recommended Claimant continue the eye drop regimen for his right eye including five different types of drops. Dr. Lau emphasized the importance of compliance with the eye drop regimen. Her diagnosis noted ruptured globe of right eye with a retinal detachment surgery. See Exhibit 3.

10. On October 15, 2018, M. Susan Zickenfoose, M.D. evaluated Claimant. Dr. Zickenfoose noted that Claimant underwent eye surgery on October 8, 2018 and that he then had increased eye pain on October 13, 2018 and had to go to the emergency room where they found that the pressure in Claimant's eye was increased. Dr. Zickenfoose noted that Claimant could not work until he was rechecked by an eye doctor and by her and noted his work status as unable to work from October 15 through October 24, 2018. She scheduled Claimant for a return evaluation on October 24, 2018. See Exhibit 4.

11. Claimant did not go to the scheduled return evaluation. Claimant did not return to work for Employer. Claimant, without notifying his Employer or physicians, moved to Texas where he thought his finances would be in better shape since he owns a home in Texas.

12. On October 19, 2018, Claimant's counsel sent a letter to Respondents' counsel. The letter indicated that Claimant owned a home in Texas and had advised their office that day that he was moving to Texas and would need a change of physician immediately. Claimant's counsel noted that his staff would cancel all future appointments set in Denver. Claimant's counsel also indicated that Claimant had to treat urgently over the last weekend due to complications following surgery and that there was the potential Claimant would need treatment very soon. See Exhibit H.

13. On October 29, 2018, Claimant sent a fax to Employer indicating that he was resigning because he had moved to Texas. Claimant listed his resignation date as October 19, 2018. Claimant noted that he had surgery on October 8, 2018 and was in

pain since. Claimant noted he had been hospitalized on October 13, 2018 and that after he was released he saw other doctors. Claimant reported that he had moved to Texas on October 19. See Exhibits 5, H.

14. On October 30, 2018, Respondents filed a Petition to Modify, Terminate, or Suspend Compensation requesting to terminate TTD benefits from October 19, 2018 to ongoing. Respondents indicated that Claimant had been working for Employer within his restrictions but that he had voluntarily moved to Texas and voluntarily terminated his position with Employer as of October 19, 2018. See Exhibit C.

15. On October 31, 2018, Respondents filed an Amended General Admission of Liability noting temporary total disability benefits were admitted from October 8, 2018 thru ongoing. Respondents admitted for reasonable and necessary medical treatment to the right eye and noted that Claimant had been out of work since undergoing an eye surgery on October 8, 2018. See Exhibit B.

16. On November 6, 2018, Claimant objected to the Petition to Modify, Terminate, or Suspend Compensation. Claimant noted that he remained on restrictions while awaiting Respondents designation of a provider in Texas and argued that temporary benefits must continue until terminated according to Rule 6. See Exhibit D.

17. In early November, 2018 Claimant began treatment in Texas.

18. On November 6, 2018, Claimant was evaluated by Marc Ellman, M.D. and Ahmed Sollman, M.D. in Texas. Dr. Ellman filled out a Texas Workers' Compensation Work Status Report indicating that Claimant was still prevented from returning to work as of the date of injury July 17, 2017. Claimant was expected to be prevented from returning to work through the time of recommendation from a primary care physician/retina specialist. Claimant reported to Dr. Sollman that about a year ago, a piece of glass went into his right eye and that he had multiple eye surgeries. Claimant reported that he had recently moved to Texas, had constant headaches, and sees floaters in his right eye. Claimant reported that his vision was blurry and that he had stains in the right eye that would multiply or decrease throughout the day. Claimant requested a second opinion on the vision in his right eye and reported he wanted to be able to get at least 25-30% of his vision back. The plan was to get a baseline FP/MOCT/RNFL done and to repeat the MOCT at the next visit. Dr. Sollman noted that if the MOCT was not better at the next visit, they would refer Claimant to a retina specialist. See Exhibits 6, 7, L.

19. On November 12, 2018, Claimant was evaluated by Dr. Sollman and Dr. Ellman. Claimant was referred to SWRC for re-evaluation in 6 weeks. Dr. Ellman filled out another Texas Workers' Compensation Work Status Report indicating that Claimant was still prevented from returning to work as of the date of the injury and was expected to continue through "per PCP." See Exhibits 8, 9, L.

20. On December 6, 2018, Manouchehr Refaeian, M.D. evaluated Claimant. Claimant reported that while he was at work, a piece of glass went into his right eye and

that he was 90% blind due to his injury. Claimant reported that he had multiple surgeries to his right eye with the last one being in October of 2018. Claimant reported blurry vision and poor visual acuity in his right eye. Dr. Refaeian planned a follow up in one month and told Claimant to return if the problem worsened. Dr. Refaeian noted that Claimant could perform light duty work status with no driving. He noted that Claimant could return to work with a restriction of no driving/operating heavy equipment. Dr. Refaeian noted that since moving to Texas, Claimant had only been seen by general physicians for his eye, which was not sufficient given Claimant's ongoing and very complicated issues. Dr. Refaeian requested that a retinal specialist see Claimant. See Exhibits 10, 11, M.

21. Prior to his injury, Claimant had worked for Employer for approximately 2.5 years as a dishwasher/utility worker. Claimant was a great employee and hard worker.

22. Throughout Claimant's treatment for this injury, Employer honored Claimant's work restrictions and found jobs he could do within his restrictions. They accommodated him by having him bus tables instead of being on dishwashing duties, and put him into a "utility position." Employer had a policy of always trying to accommodate work restrictions. In September of 2018, they provided Claimant an offer of utility worker without dishwashing to accommodate his restriction from working around steam. See Exhibit I.

23. After his October 8, 2018 surgery, Claimant decided to move to Texas where he owned a home due to his perceived financial stress. Claimant was aware that while receiving temporary total disability (TTD) benefits he would not get his entire salary replaced and Claimant was living on a tight budget. Claimant decided, for personal financial reasons that living in a home he owned without a mortgage in Texas would be a better decision for him.

24. Following his injury and during periods where he was not earning 100% of his normal pre-injury wages, Claimant was able to make ends meet but lived on a very limited budget. Claimant had visited food banks on occasion. Claimant felt embarrassed about this because he had never before needed assistance and had always worked multiple jobs. After his October 8, 2018 surgery, and due to his financial situation, Claimant called his son and asked his son to come get him and drive him to Texas.

25. Once in Texas, Claimant submitted his resignation letter to Employer noting that he had moved to Texas.

26. If Claimant had stayed in Colorado, Employer would have continued to employ Claimant. Employer would have continued to accommodate Claimant's restrictions as they had done throughout the claim from July of 2017 through October of 2018. Employer would have worked with Claimant to accommodate him, since Claimant was a great and valued employee.

27. On December 28, 2018, Claimant signed an affidavit comparing his expenses while living in Texas to his expenses while living in Colorado. The expenses,

overall, were very similar except in Texas Claimant pays \$0 in rent as he owns a home outright while in Colorado he paid \$800 per month in rent. See Exhibits 13, N.

28. Claimant testified at hearing. Claimant testified that after his October 8, 2018 surgery he couldn't return to work. Claimant testified that on October 13, 2018 he went to the emergency room because of the terrible pain in his eye. Claimant testified that he moved to Texas on October 19, 2018 and that he decided to move because he knew his wages would drop if he wasn't working and knew that he would have financial problems and stress if he stayed in Colorado. Claimant testified that after his injury he was under financial stress with time off work and wage replacement not covering his full wages. Claimant testified that he had to go to a food bank for food and was ashamed. Claimant testified that he felt like there was no way out if he stayed in Colorado and that he didn't want to have to go to a food bank again. Claimant testified that he is still restricted from driving and that there are not many businesses near his home with the closest one being five miles away. Claimant testified that there is no public transportation and that an Uber ride costs \$45-50 roundtrip. Claimant testified that he enjoyed his job with Employer and only resigned because of the money issues.

29. Claimant testified that the last day he worked was October 5th and that although Employer knew he had surgery coming up, he did not have any conversations with Employer about returning to work after his surgery. This is not credible.

30. Neil Davis, Claimant's direct supervisor while employed with Employer, testified at hearing. Mr. Davis believed Claimant planned to return to work after the October 8, 2018 surgery. Mr. Davis was unaware that Claimant was moving to Texas. Mr. Davis was shocked by Claimant's resignation and surprised that Claimant didn't call him directly or tell him. Mr. Davis had thought that he would be getting a doctor's note to look at for restrictions so that he could continue to accommodate Claimant after the surgery and was shocked to see a resignation letter in his box at work. Mr. Davis testified that he wanted Claimant to return to work after the October 8, 2018 surgery because Claimant was a good employee and a hard worker. Mr. Davis is credible.

31. Jennifer Davidson, Employer's executive director, also testified at hearing. She also testified that Claimant was a good employee. Ms. Davidson testified that after the injury, Claimant was on and off work restrictions while going through treatment and that Employer accommodated all the restrictions Claimant had completely. Ms. Davidson testified that Employer has a policy to always accommodate work restrictions. She testified that they were always glad when Claimant was at work. Claimant never asked Ms. Davidson for more hours or for a raise and did not mention financial problems to her. Claimant did not tell Ms. Davidson that he planned to move to Texas. On October 5, 2018, Ms. Davidson saw Claimant at work and wished him luck with his October 8, 2018 surgery. Ms. Davidson told Claimant to let her know when he was released by the doctor to return to work. Ms. Davidson testified that she was waiting for doctor's orders to know when Claimant could return after October 8, 2018 and what restrictions he would have. Instead, she testified that she received a faxed resignation letter from Claimant. Ms. Davidson also was surprised by the resignation. Ms. Davidson is credible.

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. *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 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).

Termination of Employment

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*. 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*.

Claimant’s wage loss from October 8, 2018 through December 6, 2018 was due to Claimant’s work related injury, surgery, and inability to work following surgery. Claimant was on “no work” restrictions during this period following his October 8, 2018 surgery. However, on December 6, 2018, Claimant was released to light duty work. If Claimant had stayed in Colorado, Employer would have accommodated Claimant’s work restrictions as they had repeatedly done throughout the claim. Claimant thus would have been able to return to his normal full time schedule with Employer under his work restrictions of no driving or operating heavy equipment. Claimant would have resumed earning his normal full wages on December 7, 2018. However, Claimant’s resignation and his voluntary decision to resign his employment with Employer and move to Texas prevented him from resuming his job and returning to his normal full wages. Thus, the cause of Claimant’s wage loss beginning December 7, 2018 was Claimant’s voluntary decision to quit his job. Claimant was responsible for the termination of his employment. Respondents have established by a preponderance of the evidence that any wage loss after December 6, 2018 is due to the termination of Claimant’s employment for which Claimant was responsible. Respondents have established that they are entitled to terminate TTD benefits as of December 7, 2018.

Respondents’ argument that TTD benefits should be terminated as of the date of Claimant’s resignation, October 19, 2018, is not persuasive. The wage loss that is the consequence of Claimant’s voluntary resignation did not begin until December 7, 2018. Prior to December 7, 2018, Claimant’s wage loss was due to his “no work” restrictions from his medical providers. The wage loss attributable to the termination of employment did not begin until December 7, 2018.

Claimant’s arguments, overall, are not found persuasive. Although Claimant was living on a very tight budget, Claimant was not compelled to resign because of his injury. The undersigned realizes that Claimant barely could meet his monthly expenses while receiving TTD, but Claimant was able to do so. Claimant was an excellent worker and Respondents had repeatedly accommodated any restrictions that Claimant had following his injury. Respondents would have continued to do so after the October 8, 2018 surgery and when Claimant was released to light duty work on December 6, 2018. If not for his

resignation, Claimant could have returned to his normal wages and normal work hours on December 7, 2018. Claimant prevented this opportunity by voluntarily resigning and moving to Texas. Any wage loss December 7, 2018 and ongoing is due to Claimant's voluntary decision to resign and move out of state. This decision was not compelled by Respondents and was not compelled by the injury but was a subjective decision made by Claimant. Claimant owned a home without mortgage in Texas. While it is understandable that Claimant would want to move and would subjectively decide that he was sick of living check to check in Colorado, this was a subjective personal choice made by Claimant and was not compelled by the injury.

ORDER

It is therefore ordered that:

1. Claimant was responsible for the termination of his employment with Employer.
2. Claimant is entitled to TTD benefits from October 8, 2018 through December 6, 2018. His wage loss during this time was due to his work related surgery and recovery from surgery.
3. Respondents have established that Claimant is not entitled to TTD benefits from December 7, 2018 and ongoing as the wage loss beginning December 7, 2018 was due to Claimant's termination of employment.
4. 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: March 8, 2019

/s/ Michelle E. Jones

Michelle E. Jones
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, CO 80203

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 5-068-026-001**

ISSUES

I. Whether Claimant established by a preponderance of the evidence that he suffered compensable injuries to his back, head and hands in addition to an aggravation of his pre-existing PTSD on January 15, 2018.

II. If Claimant established that he suffered compensable injuries, whether he also established that he is entitled to reasonable, necessary, and related medical treatment.

III. If Claimant established that he sustained compensable injuries, whether he also established that he is entitled to temporary total disability benefits extending from January 15, 2018 through April 24, 2015

IV. Whether Respondents' established by a preponderance of the evidence that Claimant is responsible for his separation from employment thereby precluding his entitlement to TTD benefits.

FINDINGS OF FACT

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

1. Claimant alleges injuries as a result of being assaulted while in the course and scope of his employment on January 15, 2018. Claimant was the Director of Dining Services for Respondent-Employer. Claimant began working for Respondent-Employer on August 14, 2017. His employment with Respondent-Employer ended on January 19, 2018. As director of dining services, Claimant's duties, included, cooking, ordering food, managing kitchen staff, maintaining sanitation standards, and assist in the purchasing of food supplies.

2. Prior to the alleged January 15, 2018 assault, Claimant caught a subordinate cook (Nick) stealing t-shirts out of his office. Claimant testified that based upon his job description, he thought he had authority to terminate Nick. Claimant testified that he discussed the situation with Chris Wilson and Wendy Voong, co-workers associated with Respondent-Employer's Human Resources Department. Ms. Voong conducted an investigation into the incident and spoke directly to Nick.

According to Claimant, Nick admitted taking the shirts during his conversation with Ms. Voong prompting Claimant to terminate him. Per Claimant, Nick then spoke to Mr. Gardner, Respondent-Employer's Executive Director who agreed to investigate the matter further. Ultimately, Mr. Gardner agreed to back Nick and reinstate him to his position.

3. Regarding this situation, Mr. Gardner testified that on January 11, 2018, he held a meeting with Claimant and Ms. Voong to discuss Claimant's decision to terminate Nick. Ms. Voong testified that Claimant was very upset at the meeting and was raising his voice. The ALJ infers from the evidence presented, that Claimant was upset about Nick's decision to discuss the situation with Mr. Gardner and more importantly, Mr. Gardener's decision to investigate the matter further. At the end of this meeting, Mr. Gardner asked Claimant to attend a follow-up meeting on January 12, 2018 with he and Nick to discuss the termination decision further. Claimant did not show for the meeting.

4. On January 13, 2018, Claimant, having not attended the January 12th meeting, emailed Mr. Gardner informing him that there were two cooks coming to interview for the vacant cook position the following Monday. Mr. Gardner responded that same day that he was reassessing Nick's termination and to wait on filling the position. He also requested that they discuss the matter on the following Monday. Claimant testified he felt undermined by Mr. Gardner and that he was angry with him for overriding his decision to terminate Nick. Accordingly, he sent a responsive email informing Mr. Gardner that he would "make it easy" on him by resigning on Monday so he could bring Nick back. Claimant specifically indicated to Mr. Gardner that he would prepare his letter of resignation on Monday. Claimant copied Emily Clark with his email response to Mr. Gardner. He also explained his anger/frustration with Mr. Gardner and informed her of his intent to resign.

5. Mr. Gardner responded to Claimant later on January 13, 2018, acknowledging his contributions to kitchen and explaining that Nick's firing was still in investigation so as to mitigate "possible unemployment" consequences. His email response also documented his hope that Claimant might reconsider his decision to resign. Mr. Gardner testified that he never received any indication from Claimant that he intended to withdraw his decision to resign.

6. Ms. Voong testified that the proper procedure to terminate an employee is for the supervisor to discuss the termination with the Executive Director and then obtain the necessary paperwork documenting the termination from Ms. Voong. Before going to Mr. Gardner to discuss Nick's termination, Claimant went to Ms. Voong to secure the paperwork necessary to document and support Nick's termination. Voong testified that she believed that Claimant told her Mr. Gardner had approved the termination when he

requested the termination paperwork; although, it later was made clear that Mr. Gardner had not approved Nick's firing.

7. On January 14, 2018, Claimant sent an email to Mr. Gardner explaining that he was leaving for Arizona on January 22 and returning on January 27, 2018. Mr. Gardner responded to the email by indicating: "Will, I just remembered that our CCA audit will start on the 22nd and go through the 24th. I believe one of the sections of the audit will be on dietary. We need to come up with a plan on who will represent the kitchen those days. Perhaps Emily or Nicole. Let me know who will be covering the kitchen". Despite testifying that Respondent-Employer's policy requires 30 days advanced notice for requesting time off, Mr. Gardner did not mention the above referenced policy in his email response to Claimant nor did he indicate that Claimant was not approved for leave. Indeed, as far as Mr. Gardner knew, Claimant was going to resign on Monday, January 15, 2018.

8. On January 15, 2018, Ms. Clark responded to Claimant's January 13, 2018 email regarding the circumstances surrounding Nick's termination. She asked if Claimant really intended to resign. Claimant immediately responded that he was not going to resign deciding instead to "do his job". He also took the opportunity to question Mr. Gardner's leadership noting that if "Mark wants to go against his Directors and not back us then I will start looking for something one day".

9. Ms. Clark testified that she was not Claimant's supervisor and had a limited role in the hiring and disciplinary process for Respondent-Employer. She testified she did not have authority to terminate anyone. She also testified that she was not the proper person to whom Claimant should have send his email rescinding his decision to resign his employment. Rather, Ms. Clark testified that if Claimant had decided to rescind his resignation, he needed to inform Mr. Gardner. As noted above, Mr. Gardner testified that Claimant never informed him he had changed his mind regarding his decision to resign his position with Respondent-Employer.

10. Claimant reported to work as scheduled on Monday, January 15, 2018. He testified that on January 15, 2018, at approximately 8:30 a.m. he went out to an outdoor freezer where food items are stored to do inventory and complete a food order. Claimant testified that he noticed the freezer door and back gate were partially open. According to Claimant, as he looked into the open freezer, a large man rushed out and struck him on the left forehead, knocking his glasses from his face and to the ground. Claimant testified that he fell backwards landing on the palms of his hands and buttocks as the assailant fled. He reported having abrasions resulting in a small amount of blood coming from his right hand. Claimant testified that he got up and went back inside and called Mr. Gardner to report the assault.

11. Mr. Gardner testified that he received a call from Claimant stating that he had just been hit. Mr. Gardner testified that he found Claimant calm and collected, sitting on the stairs inside the back door of the building where just outside the freezer in question is located. Mr. Gardner testified that Claimant told him he went outside to check the food truck delivery and was punched by someone when he looked into the freezer.

12. Mr. Gardner testified that he did not observe any cuts on or bleeding coming from Claimant and his glasses appeared intact. He admitted during cross examination that he did not look at Claimant's hands, but added that Claimant did not complain about injuries and did not request medical attention or that the police be called. He also questioned Claimant's report that he was going to check the food truck delivery, testifying that food trucks deliver food on Tuesdays and Fridays. The ALJ takes judicial notice that January 15, 2018 was a Monday. Moreover, the evidence presented, supports a finding that a food delivery was made on January 16, 2018 for an order placed January 15, 2018.¹

13. Based upon the evidence presented, including Mr. Gardner's testimony that, as part of his duties, Claimant would have to go to the outside freezer to take inventory coupled with the invoice indicating that a food order was placed on January 15, 2018, the ALJ finds it reasonable to infer that Claimant had gone out to the freezer to check, i.e. inventory the food delivery from the previous Friday and order additional food items for delivery on January 16, 2018. Nonetheless, this evidence, without more is insufficient to support a finding that Claimant was assaulted as he prepared to take inventory.

14. Ms. Voong testified that Mr. Gardner came to her office and told her to call 911 to report the assault. Ms. Voong testified that Claimant then came into her office wearing his white chef's coat. According to Ms. Voong, the back of Claimant's coat was wrinkled²; however, she observed no cuts, redness or abrasions about Claimant's person. Ms. Voong testified that Claimant was not acting anxious. The police were summoned and according to Ms. Voong, arrived about 10 minutes after she called 911. Ms. Voong also testified that she completed an Employer's First Report of Injury and a statement regarding the circumstances surrounding the assault on January 15, 2018. However, on cross examination Ms. Voong admitted that the statement she insisted she wrote on the day of the assault included events which occurred on subsequent days,

¹ Claimant would reference the January 16, 2018 delivery to Dr. Peterson during a visit later the same day.

² Mr. Gardner testified on cross examination that he did not specifically look at the back of Claimant's coat after the assault was reported to him.

leading the ALJ to find that she probably did not write her statement on January 15, 2018 as claimed.

15. Officer Cory May with the Colorado Springs Police Department investigated this incident. Officer May obtained a statement from Claimant during which he reported that he had gone out to the “refrigerated lockers” to get some items for the kitchen when he noticed the locker door was open. According to Claimant’s statement, he did not think much about the door being open because another member of the kitchen staff was retrieving items from the locker during the same timeframe. Claimant reported that he went into the refrigerator and was “immediately punched in the left eye”. Claimant reported that he fell on his back and his glasses went “flying” off his head. Officer May took digital photographs of Claimant. He testified that he observed redness above the left eye but admitted during cross examination that he did not know what caused the redness. He also testified that Claimant’s glasses may have been scratched when they impacted the ground. The ALJ scrutinized the photographs taken by Officer May. Based upon that review, the ALJ is unable to discern any observable redness, swelling, bruising, bleeding, or abrasions to the head or hands. Nevertheless, the pictures support Ms. Voong’s testimony that Claimant’s white coat appeared wrinkled at the time the pictures were taken. Furthermore, the coat appears slightly dirty at the bottom as if the fabric made contact with the ground. While this constitutes some evidence that Claimant, at some point, made contact with the ground, it is not, alone conclusive evidence that Claimant was assaulted and then fell to the ground. Without more, the ALJ finds it equally plausible that the wrinkles and dirt located on the bottom of Claimant’s chef’s coat may have been caused by sitting on the steps where Mr. Gardner testified he found Claimant.

16. Claimant testified that there were several prior incidents involving transients loitering around the outdoor refrigerators. He testified to prior break-ins of the refrigerators noting further that safety measures, including the installation of flood lights, fencing and sirens, had been taken to help make the area more secure.³ While Respondent-Employer undertook efforts to make the area safe for its employees, the area could not be locked off completely per the report of Officer May due to fire code restrictions. The evidence presented persuades the ALJ that thieves were able to access the freezers and the same probably occurred on January 15, 2018. Because the area was not secure and the refrigerators had been discovered and plundered before, the ALJ also finds the potential for a confrontation ending in an assault by a would be thief probable.

³ Mr. Gardner confirmed Claimant’s testimony in this regard noting that individuals would access the area of the freezer through an unlocked gate and would then proceed to cut the lock on the freezer in an effort to steal food items.

17. Claimant was evaluated by Dr. Peterson at Concentra the same day of the alleged assault, on January 15, 2018. Dr. Peterson noted under "History of Present Illness" that Claimant was hit with a fist in the left forehead by a vagrant. Dr. Peterson noted tenderness over the left frontal area of the head, but it was atraumatic with no masses, swelling, or hematoma. A small superficial abrasion on the heel of the right hand was noted as were subjective reports of burning pain in the low back between the shoulder blades. Palpation of the thoracic and lumbar spine revealed subjective reports of tenderness but without objective evidence of muscle spasm. Straight leg raise testing was negative, strength was normal and Claimant's reflexes in the upper and lower extremities were symmetric and his sensation to light touch was intact. Claimant was assessed with a contusion of the scalp, lumbosacral strain, thoracic strain, abrasion of the right hand and anxiety caused by "assault by bodily force". As for treatment, Dr. Peterson recommended Advil or Tylenol, rest and an ice pack.

18. Ms. Clark testified that she spoke to Claimant after the alleged incident. Ms. Clark testified that Claimant explained that he thought he heard a delivery truck pull up at the back door, so he went outside to check it. Ms. Clark testified that this was odd because delivery trucks do not come on Mondays but arrive on Tuesdays. Ms. Clark also testified that there were several concrete block walls between the kitchen and the outside making it very difficult to hear a delivery truck arrive.

19. On January 16, 2018, Claimant was reevaluated by Dr. Peterson. During this encounter Claimant reported that he had returned to work but felt incapable of handling food deliveries. Palpation of the back reveals left-sided muscle spasm and Claimant demonstrated limited and painful range of motion, for which Dr. Peterson prescribed Cyclobenzaprine, a muscle relaxant. Claimant also reported sleeping poorly the night before his appointment secondary to nightmares he attributed to a "flare up" of his chronic PTSD prompting him to call a counselor through his employee assistance program (EAP). According to Dr. Peterson's note, Claimant's PTSD was "rendering him a bit non-functional". While the pain between Claimant's shoulder blades had resolved, he reported persistent back pain. Dr. Peterson recommended physical therapy for the back pain, referred Claimant to Dr. Gary Neuger or Dr. Herman Staudenmayer for "assistance in dealing with an acute anxiety reaction to the assault" and excused Claimant from work for two days.

20. On January 18, 2018 Claimant followed up with Dr. Peterson for continued low back pain. Claimant told Dr. Peterson that he was planning on flying to Arizona to see his son. Physical examination on this date, revealed tenderness over left frontal area, tenderness upon palpation of the left QL areas. Dr. Peterson also found persistent restricted range of motion with left-sided muscle spasms. Dr. Peterson noted Claimant appeared agitated, angry, anxious, depressed, dysphoric, fearful, frightened, in pain, and tearful. On this date, Dr. Peterson gave Claimant

work restrictions of lifting up to 10 pounds occasionally, push/pull up to 15 pounds occasionally, bending occasionally, engage in activities requiring trunk rotation occasionally, and change positions periodically to relieve discomfort.

21. On January 19, 2018, Respondent-Employer terminated Claimant's employment. On this date, Claimant met with Mr. Gardner and Ms. Wilson to discuss his job separation. During the January 19, 2018 meeting, Mr. Gardner informed Claimant that Respondent had elected to accept his resignation as tendered on January 13, 2018. Following this meeting, Mr. Gardner authored a post discharge letter which was sent to Claimant wherein he explained that the decision to accept Claimant's resignation was based upon the following performance issues:

- Failure to follow the chain of command by contacting Mr. Gardner's supervisor concerning a pay raise,
- Improper termination of the dietary employee without performing a complete and thorough investigation of the facts surrounding the misconduct along with refusing to meet with Mr. Gardner and the HR/payroll representative regarding the termination and then becoming angry, argumentative, and tendering his resignation when requested to attend the meeting,
- Providing less than thirty (30) days formal notice to take time off with an audit pending; and
- Undermining a work place investigation concerning sexual harassment by intimidating and making remarks to subordinates.⁴

22. Mr. Gardner testified that he reported to work at approximately 7:45 on Monday, January 15, 2018. He testified that he was unaware and surprised that Claimant had begun his shift Monday morning testifying that he felt that Claimant had decided to resign since he had not heard from him in response to the email message he sent Claimant on January 13, 2018 requesting that they discuss matters concerning Nick's termination and his (Claimant's) decision to tender his resignation. Absent a response, Mr. Gardner testified that he understood Claimant to have resigned. Claimant suggested that Mr. Gardner knew that Claimant had not resigned because he did not come looking for him upon arrival to work and he knew that someone had to get breakfast ready for the facilities residents. Mr. Gardner testified that he did not look for

⁴ While employed by Respondent-Employer in December of 2017, an anonymous complaint was received alleging that Claimant was sexually harassing co-workers. Ms. Wilson was involved in investigating the sexual harassment allegations. According to Mr. Gardner, while the matter was being investigated, Claimant became very upset and impeded the investigation through inappropriate behavior and comments.

Claimant because he had a meeting and knew that the kitchen staff could prepare the residents breakfast in Claimant's absence.

23. Claimant was reevaluated by Dr. Peterson on February 8, 2018. On this date, Claimant told Dr. Peterson that his low back pain continues but he was having nightmares again which wakes him up at night leading to drowsiness. Dr. Peterson prescribed diazepam and referred Claimant for an MRI and to Dr. Kenneth Finn or Dr. Tim Sandell for consideration of injection therapy for facet syndrome. Dr. Peterson also referred Claimant to Dr. Gary Neuger or Dr. Herman Staudenmayer for acute exacerbation of pre-existing PTSD. Claimant's work restriction remained unchanged from his prior visit with Dr. Peterson.

24. Dr. Peterson's office note of February 23, 2018 reflects that Claimant had plateaued with physical therapy. He recommended further care to include an MRI and a consult with pain management. Dr. Peterson noted that the MRI and referrals to physiatry had been denied. Dr. Peterson continued the same restrictions as given on prior visits.

25. Claimant was last seen by Dr. Peterson on March 21, 2018. Dr. Peterson noted that there were no significant changes since the last visit and the Insurer had denied all referrals. Upon physical examination, Dr. Peterson found significant tenderness at L4-5 facets with less tenderness at the SI joint. Dr. Peterson also found more pain with extension/rotation vs. flexion along with a positive Patrick's test on the left. Dr. Peterson noted that Claimant did not wish to take the diazepam due to addiction concerns. Because of this, Dr. Peterson prescribed Doxepin and Terazosin to help with nightmares and insomnia. Dr. Peterson continued the same restrictions as given on prior visits. Claimant has not returned to Dr. Peterson due to the claim being denied.

26. At Respondent's request, Claimant was evaluated by Dr. Kathleen D'Angelo on April 30, 2018. Claimant gave Dr. D'Angelo a history of going to the freezers out back and noticing the back gate and freezer door were open. The history further reveals that when Claimant stuck his head around the door, an unidentified person hit him in the head, knocking him to the ground. Claimant denied being hit with a fist but could not identify the object with which he was hit. Claimant told Dr. D'Angelo that he had a lump on his head, both his hands were scraped up and he had a cut on one hand as a result of the fall. Dr. D'Angelo testified that she reviewed the police photos and did not see any lumps, redness, or abrasions. Dr.

D'Angelo testified that the face and scalp are very vascular which causes quick swelling, ecchymosis, or bleeding with head contusions if struck.

27. Similar to Dr. Peterson's initial report, Dr. D'Angelo noted a lack of muscle spasms in Claimant's low back. She explained this was very significant because the lack of spasm did not correlate with Claimant's lumbar spine range of motion. Dr. D'Angelo explained that it was unusual to not have muscular hypertonicity, (spasm), when a patient has a lumbar strain because it is almost involuntary. D'Angelo testified that it was extraordinarily unusual to have a patient complain of severe pain, have restricted range of motion and not have muscle spasm. Dr. D'Angelo raised concerns regarding the assault itself. In support of her concern, Dr. D'Angelo pointed to the inconsistencies in Claimant's history concerning the mechanism of injury (MOI) in this case, including the "Employer Incident Report" and the history initially given to Dr. Peterson of being hit on the left side of the forehead and what she perceived to be the absence of any visible signs consistent with an assault present in the police photographs.

28. During his independent medical examination (IME), Claimant reported, to Dr. D'Angelo, a history of significant emotional trauma he had experienced, including a tumultuous childhood, a prior assault in 2003/2004, and, most significantly, his daughter's murder in 2007. Claimant reported that since his January 15, 2018 assault, he was afraid to go outside and was isolating himself. According to Dr. D'Angelo, Claimant reported that he was too afraid to go bowling with his friends, an activity he previously enjoyed doing. Dr. D'Angelo was very concerned with Claimant's mental health and recommended further psychological evaluation following her IME.

29. Ultimately, Dr. D'Angelo opined that Claimant was at MMI for claim related diagnoses of head contusion, lumbar myofascial irritation, thoracic myofascial irritation. She deferred regarding the possible aggravation of pre-existing PTSD, which she noted she would opine upon after reviewing a psychiatric assessment by Dr. Carbaugh.

30. Claimant underwent an independent medical examination with Dr. Robert Kleinman on May 30, 2018. Claimant reported to Dr. Kleinman that he was hit by an object that was in the hand of the assailant. Dr. Kleinman noted that Claimant had a long history of trauma which caused posttraumatic stress disorder, major depressive episodes, persistent depressive disorder and maladaptive personality traits. Dr. Kleinman opined that Claimant's posttraumatic stress disorder was caused by his childhood trauma and neglect and permanently aggravated by the violent murder of his

daughter. Dr. Kleinman also opined that Claimant had been persistently depressed with several episodes of major depression which again was permanently aggravated by the death of his daughter.

31. Dr. Kleinman opined that there was no indication that Claimant's psychological symptoms were any worse after the alleged assault on January 15, 2018. Dr. Kleinman opined that Claimant's PTSD was at baseline and that his depression was not exacerbated or aggravated by the January 15, 2018 incident. Dr. Kleinman opined that Claimant had persistent maladaptive personality traits evidenced by six failed marriages and inconsistent work history. The MMPI 2 indicated a chronic and pervasive pattern of psychological problems. Dr. Kleinman ultimately opined that Claimant did not have a psychiatric diagnosis caused by the January 15, 2018, incident. However, Dr. Kleinman said that "taken at face value" the January 15, 2018 incident might have caused a brief temporary exacerbation of Claimant's PTSD symptoms for a few days.

32. Respondents performed a social media search wherein Facebook photographs were discovered of Claimant vacationing in Honduras. During his testimony, Claimant admitted that he took a trip to Honduras from March 23 through March 30, 2018. He testified that he travelled with his best friend for her 50th birthday. According to Claimant, he flew from Denver to Honduras with a stop in Miami and Cayman. Claimant testified that he spent time with his friend's family, relaxing and cooking out. Photographs posted to Facebook show Claimant socializing, wading/swimming, and dancing. Claimant appears relaxed and generally in good spirits in the posted pictures. Claimant reported that none of his activities while on vacation resulted in a violation of his physical restrictions, except perhaps "lifting a piece of luggage".

33. Dr. Kleinman reviewed the aforementioned photos and provided an addendum IME report on July 13, 2018. Dr. Kleinman noted that Claimant underreported his activities of daily living and attempted to appear worse than he was. Dr. Kleinman opined that Claimant's version of events cannot be accepted at face value and he could not be relied upon to provide an accurate history, noting further that the fact that "Mr. McElroy is willing to misrepresent himself regarding his mental health issues, activities of daily living, interpersonal relationships, and impairment, indicates that [he] might also misrepresent himself regarding how the alleged incident occurred".

34. Dr. D'Angelo also reviewed the social media photographs and altered her opinion. One of the Facebook photographs shows Claimant underwater bent over. Dr. D'Angelo explained that Claimant's position in the photo contradicts his reported symptoms of pain in the trapezius muscles and numbness down his left lower extremity.

Dr. D'Angelo explained that bending forward, as in the pictures, would cause dural stretch and worsen Claimant's lower extremity numbness. Dr. D'Angelo also noted that flexion of the trunk and extension of the head at the neck is a tough maneuver for the trapezius muscle and Claimant did not appear uncomfortable in the photographs. Dr. D'Angelo also noted that the photographs of Claimant dancing showed him in various positions that Claimant previously reported as being difficult. Finally, Claimant's dancing, smiling, and socializing were psychologically very different than he reported his functioning to be during his IME with Dr. D'Angelo.

35. Dr. D'Angelo agreed with Dr. Kleinman, that Claimant's reliability regarding the assault was questionable specifically agreeing that he might misrepresent how the alleged incident occurred. She testified that it would be "really hard to believe" given everything involved in the case, that Claimant suffered a physical or mental injury assuming that the assault occurred. Nonetheless, she admitted that the mechanism of injury as described by Claimant can cause a low back injury and that if the assault occurred, her diagnosis would be lumbosacral myofascial irritation and thoracic myofascial irritation. Finally, Dr. D'Angelo testified that she disagreed with Dr. Peterson that more care was needed in this case.

CONCLUSIONS OF LAW

Based upon the evidence presented, including the deposition testimony of Emily Clark and Dr. D'Angelo, the ALJ draws the following conclusions of law:

Generally

A. 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).

Claimant's Credibility

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. While there are inconsistencies in Claimant's reporting concerning how the alleged assault occurred in this case, the ALJ concludes, as noted at paragraph 13 of the above findings of fact, that Claimant probably had gone out to the freezer to check, i.e. inventory the food delivery from the previous Friday and order additional food items for delivery on January 16, 2018. Consequently, the ALJ concludes that Claimant had the occasion to be in and around the area of the outdoor freezer on January 15, 2018. Moreover, as found above, the evidence presented, including Claimant's testimony, convinces the ALJ that he probably encountered a would be thief who rushed him and struck him in the head causing him to fall to the ground on his outstretched arms/hands and buttocks. This most accurately explains the wrinkles and dirt on Claimant's coat and small abrasion on the right hand. While Claimant varied on whether he was hit in the head by a fist or an object, the ALJ notes that Officer May observed redness over the left eye and Dr. Peterson documented tenderness over this area, leading the ALJ to conclude that Claimant was probably hit by something as the assailant was attempting to flee the scene. Accordingly, the ALJ finds Claimant's testimony regarding the events surrounding this assault credible. Dr. D'Angelo and Dr. Kleinman's contrary inferences/suggestions are not persuasive.

Compensability

C. A "compensable injury" is one which requires medical treatment or causes disability. *Romero v. Industrial Commission*, 632 P.2d 1052 (Colo. App. 1981); *Aragon v. CHIMR, et al.*, W.C. No. 4-543-782 (ICAO, Sept. 24, 2004); *H & H Warehouse v. Vicory*, 805 P.2d 1167, 1169 (Colo. App. 1990). No benefits flow to the victim of an industrial accident unless the accident results in a compensable "injury." *Romero*, supra; § 8-41-301, C.R.S. To sustain his burden of proof concerning compensability, Claimant must establish that the condition for which he seeks benefits was proximately caused by an "injury" arising out of and in the course of employment. *Loofbourrow v. Industrial Claim Appeals Office*, 321 P.3d 548 (Colo. App. 2011), *aff'd Harman-Bergstedt, Inc. v. Loofbourrow*, 320 P.3d 327 (Colo. 2014); *Section 8-41-301(l)(b)*, C.R.S.

D. The phrases "arising out of" and "in the course of" are not synonymous and a claimant must meet both requirements for the injury to be compensable. *Younger v. City and County of Denver*, 810 P.2d 647, 649 (Colo. 1991); *In re Question Submitted by U.S. Court of Appeals*, 759 P.2d 17, 20 (Colo. 1988). The latter requirement refers to the time, place, and circumstances under which a work-related injury occurs. *Popovich v. Irlanda*, 811 P.2d 379, 381 (Colo. 1991). An injury occurs in the course and scope of employment when it takes place within the time and place limits of the employment

relationship and during an activity connected with the employee's job-related functions. *In re Question Submitted by U.S. Court of Appeals, supra; Deterts v. Times Publ'g Co.*, 38 Colo. App. 48, 51, 552 P.2d 1033, 1036 (1976). Here, the ALJ determines that Claimant has produced sufficient evidence to support a conclusion that the assault and subsequent injuries to his head, back and hands occurred in the scope of employment, specifically while he was taking inventory of food stocks and completing an order for subsequent delivery as part of his duties as the Dining Services Director for Respondent-Employer. As found, the totality of the evidence, including the prior break-ins of the onsite freezers and Mr. Gardner's testimony that Claimant did have to complete inventory of the outside freezers coupled with the objective evidence, i.e. Claimant's dirty/wrinkled uniform, the redness over the left eye observed by Officer May and the scrape on Claimant's right hand is more persuasive than an assault occurred than is Dr. D'Angelo speculation that Claimant fabricated the incident.

E. While Claimant established that he was injured in the course and scope of his employment, it is also necessary to address whether his symptoms/injury arose out of that employment before his injury can be determined to be compensable. The term "arises out of" refers to the origin or cause of an injury. *Deterts v. Times Publ'g Co. supra*. There must be a causal connection between the injury and the work conditions for the injury to arise out of the employment. *Younger v. City and County of Denver, supra*. An injury "arises out of" employment when it has its origin in an employee's work-related functions and is sufficiently related to those functions to be considered part of the employee's employment contract. *Popovich v. Irlanda supra*.

F. There is no presumption that an injury, which occurs in the course of employment, also arises out of the employment. *Finn v. Industrial Commission*, 165 Colo. 106, 437 P.2d 542 (1968). The determination of whether there is a sufficient "nexus" or causal relationship between a claimant's employment and the injury is one of fact and one that the ALJ must determine based on the totality of the circumstances. *In Re Question Submitted by the United States Court of Appeals*, 759 P.2d 17 (Colo. 1988); *Moorhead Machinery & Boiler Co. v. Del Valle*, 934 P.2d 861 (Colo.App. 1996). As found, the totality of the evidence presented, including the observations of Officer May and the medical reports of Dr. Peterson persuade the ALJ that the assault involved in this case probably resulted in acute soft tissue injuries to the head and right hand as well as a lumbosacral strain. Indeed, Dr. D'Angelo testified that assuming the assault to have occurred, she would diagnose Claimant with lumbosacral and thoracic myofascial irritation. While not a strain, the ALJ finds myofascial irritation a recognized diagnosis and treatable condition. Accordingly, the ALJ concludes that Claimant has proven he suffered compensable injuries to his head, right hand and low back. Nonetheless, the ALJ finds Claimant's testimony regarding the effects this encounter had on his psyche highly suspect. Here, the totality of the evidence presented, persuades the ALJ that Claimant probably over-reported his alleged psychological injuries and failed to report

important functional abilities to both Dr. D'Angelo and Dr. Kleinman. Without question, Claimant reported that his mental state was so impaired and he was so paralyzed by fear after this incident that he was isolating himself and rarely left the house. Indeed, Claimant reported that he no longer socialized, participated in bowling or went to movies. Dr. Kleinman and Dr. D'Angelo took Claimant's reports at face value and provided opinions consistent with this stated functional capacity. Dr. D'Angelo testified that she was so concerned about the state of Claimant's mental health that but for his comments about never committing suicide, she had considered placing him on a 72-hour psychiatric hold.

G. Claimant's reported psychological symptoms and functional capacity stand in stark contrast to his demonstrated psychological capabilities. Despite reporting significantly impaired psychological functioning, Claimant was able to travel to both Arizona and Honduras after the attack. Claimant failed to report to either Dr. D'Angelo or Dr. Kleinman that he was capable of traveling long distances and in the case of Honduras, if current events are to be credited, to a country plagued by substantial violence. The Facebook photos introduced into evidence demonstrate Claimant to be dancing, swimming, socializing and enjoying himself. Such evidence strongly belies Claimant's testimony suggesting that he was a virtual shut in following this attack. To be sure, the photographic evidence posted to Facebook lead Dr. Kleinman, an expert in psychiatry, to opine that Claimant was misrepresenting his mental functioning. Based upon the evidence presented, the ALJ credits the opinions of Dr. Kleinman to conclude that Claimant's mental health conditions are probably emanating from his pre-existing PTSD and persistent maladaptive personality traits without contribution from his January 15, 2018 assault as originally expressed by Dr. Kleinman following his May 30, 2018 psychiatric IME. As Claimant's psychological/psychiatric conditions did not arise from his work related assault, they are not compensable.

Medical Benefits

H. Once a claimant has established the compensable nature of his/her work injury, he/she is entitled to a general award of medical benefits and respondents are liable to provide all reasonable, necessary, and related 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 his/her need for medical treatment. *Merriman v. Indus. Comm'n*, 210 P.2d 448 (Colo. 1949); *Standard Metals Corp. v. Ball*, 172 Colo. 510, 474 P.2d 622 (1970); § 8-41-301(1)(c), C.R.S. 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, supra*.

I. 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). The question of whether a particular medical treatment is reasonably necessary to cure and relieve a claimant from the effects of the injury is a question of fact. *City & County of Denver v. Industrial Commission*, 682 P.2d 513 (Colo.App. 1984). As found here, Claimant has proven by a preponderance of the evidence that he sustained acute soft tissue injuries to his head, right hand and low back after being assaulted on January 15, 2018. The evidence presented convinces the ALJ that these compensable “injuries” are the proximate cause of Claimant’s need for medical treatment including his visits to Dr. Peterson. Moreover, the totality of the evidence presented establishes that the care received was reasonable and necessary in light of the MOI and the acute nature of Claimant’s symptoms. While the aforementioned conditions can be fairly traced to Claimant’s assault, his claimed psychological symptoms cannot. Here, the evidence presented persuades the ALJ that Claimant’s current psychological symptoms flow naturally from his non-work related PTSD and persistent maladaptive personality traits driven and reinforced by his chaotic upbringing and the tragic murder of his daughter. As Claimant’s current need for psychological treatment is not proximately related to his January 15, 2018 work related assault, Respondents are not obligated to provide and pay for it.

Claimant’s Separation from Employment & Entitlement to TTD

J. As Claimant’s injury was after July 1, 1999, sections 8-42-105(4) and 8-42-103(1)(g), C.R.S. apply regarding her entitlement to TTD benefits. These identical provisions state, “In cases where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury.” *Colorado Springs Disposal d/b/a Bestway Disposal v. Industrial Claim Appeals Office*, 58 P.3d 1061 (Colo. App. 2002). Simply put, if the claimant is responsible for his/her termination of employment, he/she is not entitled to recover temporary disability benefits for wage loss. *Padilla v. Digital Equipment Corp.*, 902 P.2d 414, 416 (Colo. App. 1994). Respondents shoulder the burden of proving by a preponderance of the evidence that Claimant was responsible for the termination. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 20 P. 3d 1209 (Colo. App. 2000).

K. The concept of "responsibility" is similar to the concept of "fault" under the previous version of the statute. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). "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). An employee is "responsible" if the employee precipitated the employment termination by a volitional act that an employee would reasonably expect to result in the loss of employment. *Patchek v. Colorado Department of Public Safety*, W.C. No. 4-432-301 (September 27, 2001). "Fault" does not require "willful intent" on the part of the Claimant. *Richards v. Winter Park Recreational Association*, 919 P.2d 933 (Colo. App. 1996) (unemployment insurance); *Harrison v. Dunmire Property Management, Inc.*, W.C. no. 4-676-410 (ICAO, April 9, 2008).

M. In this case, the record evidence demonstrates that prior to January 15, 2018, Claimant was considered an excellent employee. He was given a raise approximately three months after he was hired. Respondent-Employer's email reflects that Claimant was receiving accolades for saving money and for helping out when and where needed. No credible evidence was presented that Claimant had been counseled or disciplined for his job performance prior to his reporting the work related assault. From the evidence presented, Claimant was terminated on January 19, 2018 for failure to follow the chain of command, improper termination of a dietary employee and unprofessional conduct, providing late notice to take time off, and undermining a workplace investigation.

N. The failure to follow the chain of command concerns an email Claimant sent to Mr. Gardner's supervisor, David Jorgenson, regarding a pay raise on January 12, 2018. The email response from Mr. Jorgenson simply indicated that the workplace culture allows employees to reach out to each other concerning work issues but any pay raise issues needs to be addressed with Mr. Gardner. There was no indication in Mr. Jorgenson's email to Claimant that the email to Mr. Jorgenson was in any way improper. In fact, Mr. Gardner testified that employees can go over their supervisor's head without fear of termination. There was no credible evidence that sending the email to Mr. Jorgenson was in anyway improper until Claimant was terminated on January 19, 2018.

O. Concerning the late notice to take time off from work, Claimant emailed Mr. Gardner on January 14, 2018 of his intent to go to Arizona on January 22, 2018 to spend time with his family on the anniversary of his daughter's murder. Mr. Gardner responded back simply indicating that a plan needs to be devised as to

who will represent the kitchen for an upcoming audit. In this same email, Mr. Gardner suggested that Claimant contact Emily Clark or Nicole as to coverage for the audit. There was no indication in this email exchange that Claimant was violating any rules or doing anything improper by asking for the time off. In fact, there was never an indication from Mr. Gardner that asking for the time off was problematic until after Claimant reported his work assault and injury.

P. Regarding the work place investigation, Claimant credibly testified that he did not intimidate or harass any of his subordinates or anyone else concerning the investigation and that it was his subordinates who came to him with information concerning the investigation. There was no credible evidence presented that the investigation was in any way hampered by Claimant. Moreover, there was no credible evidence presented that reflects that Claimant was disciplined for any alleged interference with the investigation.

Q. Insofar as the termination of the dietary employee Claimant admits that he did indeed terminate one of his subordinates for what Claimant thought was theft of company property. Claimant testified that he thought he had the authority to terminate an employee under his supervision without conferring with Mr. Gardner. This view is supported by the job duty description for the dining director which allows for termination of employees when necessary so long as he documents and coordinates the termination with the personnel director and/or administrator. Claimant reasonably thought Wendy Voong was the personnel director as she was the only human resources employee in the facility where Claimant worked. Mr. Gardner testified that he is both the director of the facility where Claimant worked and also the personnel director. However, when pressed, Mr. Gardner admitted that the job description for the dining services director is out of date as there is no personnel director at the facility where Claimant was injured.

R. Based on a totality of the circumstances presented, the ALJ concludes that the explanations articulated for "accepting" Claimant's resignation in Respondent-Employer's January 19, 2018 letter were pre-textual in nature and designed to cloak their real intention in separating Claimant from his employment. In this case, the evidence supports that Claimant was a valued employee up until the date he was he reported that he was assaulted. Moreover, while Claimant attempted to resign his position via email on January 13, 2018, Mr. Gardner did not accept the resignation. In fact, in response to Claimant's email, Mr. Gardner emailed Claimant indicating that he had been a good employee, was an asset to the team, and asking if he and Claimant could discuss the matter further on January 15, 2018 in the hopes that Claimant might change his mind. Had Respondent-Employer clearly accepted

Claimant's resignation on January 13, 2018 the analysis on this point would be different. Instead, the evidence reflects that Claimant was lead to believe he was still Respondent-Employer's Director of Dining Services. Moreover, the evidence presented persuades the ALJ that Claimant had changed his mind concerning resigning and Mr. Gardner knew or should have known about this fact. This evidence is reflected by Claimant's email to Ms. Clark that he was not going to resign. Moreover, Claimant emailed Mr. Gardner on January 14, indicating that he was going to take time off to go Arizona providing constructive notice to Mr. Gardner that he did not intend to resign. In addition, Claimant showed up for his regular shift on the morning of January 15, 2018 without preparing a resignation letter as he informed Mr. Gardner he intended to do. If Mr. Gardner felt that Claimant had resigned as he testified, the ALJ finds it unpersuasive he would not take it upon himself to clarify with Claimant his intentions before he allowed him into the building to start working. Based upon the evidence presented, the ALJ finds that Respondents failed to establish that Claimant voluntarily terminated his employment in this case or was terminated for cause.

ORDER

It is therefore ordered that:

1. Claimant has proven by a preponderance of the evidence that he sustained a compensable injury to his head, right hand and low back as a consequence of being assaulted in the course and scope of his work on January 15, 2018.

2. Respondents shall pay for all medical expenses, pursuant to the Workers' Compensation Medical Benefits Fee Schedule, to cure and relieve Claimant from the effects of his head, right hand and low back injuries, including, but not limited to the care provided by Dr. Peterson.

3. Claimant has failed to prove, by a preponderance of the evidence that his psychological symptoms and need for mental health treatment are causally related to his January 15, 2018 work related assault.

4. Respondents have failed to establish, by a preponderance of the evidence, that Claimant is responsible for his termination of employment.

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: March 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 her scheduled impairment rating should be converted to a whole person impairment rating.

FINDINGS OF FACT

1. The claimant suffered an admitted injury to her left shoulder on November 18, 2015. The injury occurred when the claimant was reaching overhead for a box, and a box on top of that box slipped and fell. The claimant testified that she attempted to catch the falling box with her left hand. However, as the box fell the claimant's left hand also moved downward, resulting in pain in the claimant's left shoulder.

2. During her claim, the claimant's authorized treating provider (ATP) has been Work Partners where she primarily treated with Erica Herrera, PA, but was also seen by Dr. Lori Fay.

3. Ultimately, the claimant was diagnosed with a left torn rotator cuff. On March 10, 2016, Dr. Mark Luker performed a rotator cuff repair.

4. The claimant testified that following her March 10, 2016 surgery she experienced low back pain while in physical therapy. The claimant also testified that she reported this low back pain to her chiropractor as well as to Dr. Fay and Ms. Herrera.

5. On January 27, 2017 Dr. Peter Millett performed a reverse shoulder arthroplasty. Thereafter, the claimant began a course of physical therapy. When she first began physical therapy, the claimant reported low back pain. However, on February 8, 2017, the claimant reported to Dr. Fay that her low back pain had resolved.

6. Thereafter, the claimant was seen by Dr. Millet on May 4, 2017. At that time, the claimant reported a "clunking" sensation in her left shoulder. Dr. Millett indicated this would improve with strengthening. On that date, Dr. Millet discharged the claimant from his care and instructed her to follow-up in one year.

7. On August 10, 2017, the claimant returned to Dr. Millett and reported continued popping and clunking in her left shoulder. Based upon these complaints, Dr. Millett referred Claimant for computerized tomography (CT) scan of her left shoulder.

8. On September 18, 2017, the CT scan showed an “uncomplicated left shoulder reverse arthroplasty.” On November 9, 2017, Dr. Millet informed the claimant that she could return to normal activities.

9. On January 12, 2018, Dr. Fay placed the claimant at maximum medical improvement (MMI). At that time Dr. Fay assessed a permanent impairment rating of 44% for the claimant’s left upper extremity (which equates to a 26% whole person impairment). At that time, Dr. Fay assessed permanent work restrictions including no lifting, repetitive lifting, carrying, pushing, or pulling over 20 pounds. In addition, no reaching overhead with her left upper extremity or reaching away from her body with her left upper extremity.

10. On February 15, 2018, the respondent filed a Final Admission of Liability (FAL) admitting for the MMI date and permanent impairment rating as assessed by Dr. Fay. The claimant objected to the FAL and proceeded to the Division sponsored independent medical examination (DIME) process.

11. On July 9, 2018, the claimant attended a DIME with Dr. Douglas Scott. As part of the DIME process, Dr. Scott reviewed the claimant’s medical records, obtained a history from the claimant and completed a physical examination. Dr. Scott agreed that the claimant was properly placed at MMI on January 12, 2018. Dr. Scott assessed a permanent impairment rating of 41% for the claimant’s left upper extremity. Dr. Scott also agreed with the permanent work restrictions assigned by Dr. Fay.

12. Following the DIME, the Division asked Dr. Scott to review the issue of apportionment given the claimant’s **prior** injury to her left shoulder.

13. The claimant suffered a prior work related injury to her left shoulder on February 27, 2006. Dr. Scott performed a DIME for that injury on August 27, 2010. At that time, Dr. Scott assessed a permanent impairment rating of 15% for the claimant’s left upper extremity.

14. On August 29, 2018, Dr. Scott issued an addendum to his July 9, 2018 DIME report with consideration of apportionment of the claimant’s 2006 injury and related impairment. Dr. Scott subtracted 15% from the 44% assessment for the 2010 impairment rating. This resulted in a permanent impairment rating of 29% for the claimant’s left upper extremity (which would equate to a 17% whole person impairment) for the November 18, 2015 work injury.

15. On September 18, 2018, the respondent filed a FAL admitting for the 29% permanent impairment rating for the claimant’s left upper extremity.

16. On November 14, 2018, the claimant attended an independent medical examination (IME) with Dr. Allison Fall. In connection with the IME, Dr. Fall reviewed the claimant’s medical records, obtained a history from the claimant and completed a physical examination. In her IME report, Dr. Fall opined that the claimant’s injury was to her left shoulder. Dr. Fall specifically diagnosed the claimant with a left shoulder rotator

cuff tear “acute on chronic”, status post rotator cuff repair with subsequent re-tear and a reverse total shoulder arthroplasty. Dr. Fall agreed that the claimant reached MMI on January 12, 2018 and opined that the claimant’s permanent impairment was appropriately determined to be a left upper extremity impairment. Dr. Fall’s testimony at hearing was consistent with her written report. Dr. Fall credibly testified that the claimant’s loss of function is only to her left shoulder. Dr. Fall also testified that the claimant’s complaints of pain throughout her body are likely related to the claimant’s inflammatory arthritis, and not related to the claimant’s left shoulder injury.

17. The claimant testified that as a result of her left shoulder injury, she has pain into her left trapezius and into her neck. The claimant also testified that the pain travels down into her ribcage and is particularly painful when she coughs. The claimant further testified that she has pain into her low back, hip, and knees. The claimant testified that she leans to the left when she walks. It is the claimant’s belief that these symptoms are related to her left shoulder injury.

18. The ALJ credits the medical records and the opinions of Dr. Fall and finds that the permanent impairment rating was appropriately assessed for the claimant’s left upper extremity, and there is no functional impairment beyond the claimant’s left shoulder. Therefore, the ALJ finds that the claimant has failed to demonstrate that it is more likely than not that she has suffered any functional impairment that is not contained on the schedule. Therefore, the ALJ declines to convert the claimant’s scheduled left upper extremity impairment rating to a full person impairment.

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

contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2015).

3. The question of whether the claimant has sustained an “injury” which is on or off the schedule of impairment depends on whether the claimant has sustained a “functional impairment” to a part of the body that is not contained on the schedule. *Strauch v. PSL Swedish Health Care System*, 917 P.2d 366 (Colo. App. 1996). Functional impairment need not take any particular impairment. Discomfort which interferes with the claimant’s ability to use a portion of his body may be considered “impairment.” *Mader v. Popejoy Construction Company, Inc.*, W.C. No. 4-198-489, (ICAO August 9, 1996). Pain and discomfort which limits a claimant’s ability to use a portion of his body may be considered a “functional impairment” for determining whether an injury is on or off the schedule. See, e.g., *Beck v. Mile Hi Express Inc.*, W.C. No. 4-238-483 (ICAO February 11, 1997).

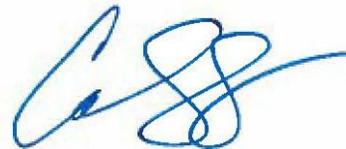
4. It is the claimant’s burden of proof by a preponderance of the evidence to establish both that he suffered a permanent impairment and that the permanent impairment is either contained on the schedule set forth at subsection (2) or not on the schedule specified in subsection (2). Further, it is the claimant’s burden to prove by a preponderance of the evidence the extent of the permanent impairment.

5. As found, the claimant has failed to demonstrate by a preponderance of the evidence that she has suffered any functional impairment that is not contained on the schedule. Therefore, claimant’s request to convert her scheduled impairment rating to a whole person impairment is denied. As found, the medical records and the opinions of Dr. Fall are credible and persuasive.

ORDER

It is therefore ordered that the claimant’s request to convert her scheduled impairment to a whole person impairment is denied and dismissed.

Dated March 12, 2018



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. Has Claimant shown, by a preponderance of the evidence, that the second bilateral L3, L4, L5 radiofrequency neurotomy ("RFN") as recommended by Dr. Malinky, is reasonable, necessary, and related to her work injury of November 12, 2016?

FINDINGS OF FACT

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

1. Claimant is a 68-year-old personal care provider who has been employed by Employer since October 2015. (Ex. C, p. 12). On November 12, 2016, a special-needs patient assaulted Claimant while at work, causing injuries to her left shoulder, right hip, abdomen, chest, neck, and back. Employer was notified of a work injury, paramedics were called, and Claimant was transported to Memorial Hospital Emergency Room.
2. Upon examination and imaging in the ER, Claimant was diagnosed with an L-1 compression fracture, generalized abdominal pain, left shoulder pain, and myalgias. (Ex. S). She initially complained of pain primarily in her left hip with lesser pain in her back. Claimant was noted to have diabetes, pre-existing severe left glenohumeral joint osteoarthritis, and severe left C4-5 facet osteoarthritis with related grade 1 anterolisthesis. Claimant told providers in the ER that her assailant kicked her in the chest, abdomen, shoulder, and hip. *Id.* at 249. Physical examination did not reveal evidence of contusions to claimant's spine.
3. On November 16, 2016, Claimant returned Memorial ER complaining of 10/10 pain with urinary incontinence since her work injury (4 days prior). (Ex. S, p. 261) Claimant indicated that she had had incontinence while in the ER on November 12, 2016, but thought it had been due to the pain she was experiencing. Claimant was deemed non-surgical, as her compression fracture did not result in cord compromise or cauda equina syndrome. Her providers were unsure as to the source of her incontinence. Physical examination of Claimant's spine revealed minimal tenderness to palpation and "no evidence of contusion, edema, or erythema." Claimant was admitted to inpatient care for continued observation. She was discharged on November 22, 2016, referred to undergo physical therapy, and recommended to follow up with her neurosurgeon in 3 to 4 weeks.
4. On November 22, 2016, Claimant presented to Dr. Cynthia Lund with complaints, in part, of severe mid-back pain and urinary incontinence. Because of the compression fracture along with complaints of urinary incontinence, Claimant was immediately admitted to Memorial Hospital for further evaluation (Ex. 3, pp. 18-19). Claimant was

discharged from Memorial Hospital on November 28, 2018 with diagnoses of L1 compression fracture, L5-S1 neuroforaminal narrowing, bowel and bladder incontinence of uncertain etiology, diabetes mellitus, rheumatoid arthritis, and recent emotional trauma. Upon discharge Claimant was advised to follow up with a neurosurgeon and to consult with a social worker for the emotional trauma

5. Claimant was transferred from Memorial Hospital to Health South Rehabilitation where she was treated up through December 14, 2016. According to the records, Claimant was experiencing low back pain for which she received Fentanyl along with Meloxicam. Upon discharge from Health South Claimant was ambulating over 300 feet with a quad cane and was able to ascend and descend multiple stairs. Claimant was discharged home with home healthcare services and a prescription for Fentanyl patch and Oxycodone/Oxy-IR 5 mg per 6 hours (Ex. O, pp. 163-170).
6. Claimant was seen on December 16, 2016 by Dr. Lund with complaints of severe mid back pain and severe left shoulder pain. Claimant advised Dr. Lund she was unable to walk unassisted, had incontinence of urine, had generalized pain, and was lightheaded. Dr. Lund advised Claimant to continue using a back brace, continue the Fentanyl patch and Oxycodone. Dr. Lund also referred Claimant to a psychologist and a urologist (Ex. 3, p. 24).
7. Claimant returned to Dr. Lund on January 7, 2017 with ongoing complaints of mid back pain at a 9/10 level. On this date, Claimant was still wearing a back brace. Dr. Lund recommended Claimant should walk and try to move about more. Dr. Lund indicated that Claimant was to wean down off Norco and Valium and that there will be no further refill of Fentanyl patches (Ex. 3, p.30).
8. Claimant was re-evaluated on January 20, 2017 by Dr. Lund. It was noted that Claimant was still experiencing severe mid-back pain and severe left shoulder pain at a 10/10 level. Dr. Lund prescribed Norco, and referred Claimant to physical therapy (Ex. 3, pp. 36-37).
9. Claimant was seen by Dr. Lund on February 3, 2017 with continued back pain at a 10/10 level. Dr. Lund noted that Claimant was off the Fentanyl patch and was only taking Norco twice daily. Dr. Lund noted that Claimant was wearing her back brace and therefore no range of motion testing was done. Dr. Lund diagnosed Claimant with multiple injuries due to the assault including an L1 vertebral fracture and situational depression. Dr. Lund recommended Claimant continue her home exercises and to continue treating with Dr. Beaver and Staudenmayer for depression (Ex. 3, p. 39).
10. On January 24, 2017, Dr. Steven Hake reviewed Claimant's lumbar films and concluded that her L1 compression fracture was stable. He was unable to explain Claimant's urinary incontinence from a spinal perspective despite "extensive work-up." (Ex. BB, p. 661).

11. Claimant was seen by Dr. Lund on February 3, 2017 with continued back pain at a 10/10 level. Dr. Lund noted that Claimant was off the Fentanyl patch and was only taking Norco twice daily. Dr. Lund noted that Claimant was wearing her back brace and therefore no range of motion testing was done. Dr. Lund diagnosed Claimant with multiple injuries due to the assault including an L1 vertebral fracture and situational depression. Dr. Lund recommended Claimant continue her home exercises and to continue treating with Dr. Beaver and Staudenmayer for depression. (Ex. 3, p. 39)
12. On February 21, 2017, Claimant returned to her rheumatologist, Dr. Michael Sayers, DO, for evaluation of her RA. Her work injuries were discussed at this time. (Ex. 6, Ex. L). Claimant's medications included: amitriptyline HCL 50 MG tablet 1 tablet orally once a day, levothyroxine sodium 75 MCG capsule 1 capsule on an empty stomach in the morning orally once a day, meloxicam 15 MG tablet 1 tablet orally once a day, paroxetine HCL ER 12.5 MG Tablet extended release 24 hour 1 tablet in the morning orally once a day, myrbetriq 50 MB tablet extended release 24 hour tablet orally once a day, prednisone 1 mg 1 MG tablet delayed release 2 tablets orally once a day, vitamin D-3 1- unit capsule 1 capsule orally twice a week, methotrexate sodium 50 MG/2ML solution .8 ml injection once a week, Enbrel sureclick 1 ml 50 MG/ML solution autoinjector 1 ml subcutaneous once a week, and voltaren 1% gel transdermal. *Id.*, at p 122.
13. Claimant was seen by Dr. Vernon Maas at UC Health for follow-up on March 23, 2018. At this time Claimant was experiencing low back, right hip, and right sided pain at an 8/10 level. Claimant indicated that she is no better than how she felt at her last examination. Dr. Maas noted that Claimant was tender to palpation over bilateral lower thoracic and lumbar region with spasms present. Dr. Maas diagnosed multiple injuries due to assault including L1 vertebral fracture and situational depression. Dr. Maas recommended continued use of the walker as needed, continued use of Paxil and Norco, and to follow up with Dr. Lund (Claimant's Submissions- Bate #s 0047-0049).
14. Dr. Lund's office notes of April 14, 2017 indicated that Claimant lost her balance on April 12 and fell down some steps on April 9. As a result, Claimant's left side was hurting. On this date Claimant's pain was worse at a 9/10 level. Dr. Lund noted that a recent MRI showed that Claimant's L1 fracture was stable at 25 percent. Dr. Lund continued Claimant's same medication and made multiple referrals to a variety of physicians including Dr. Willman for pain management. (Claimant's Submissions, Bate #s 0050-0052).
15. During Claimant's April 18, 2017 neurosurgical examination, Dr. Thompson noted claimant's L1 compression fracture to be almost completely healed. Claimant was noted to have "spondylolysis at L5 with grade 1 spondylolisthesis at this level with bilateral lateral recess and neural foraminal stenosis. There is also a disk bulging at L4-5 with lateral recess stenosis. Unfortunately, **she continues to have low back pain and right radicular leg pain**" (Ex.BB, p. 668) (emphasis added).

16. Claimant reported for initial examination at Interventional Pain Management on May 3, 2017, where she was examined by Dr. Bertram Willman. (Ex. P, p. 175). Claimant complained of pain in her face, bilateral cervical spine, bilateral shoulders, thoracic spine, lower back, SI joint, bilateral hands, and bilateral feet. She had tenderness over her old L1 compression fracture and lower lumbar pain over her L5. Claimant's Norco was replaced with tramadol 50 3 times a day, she was continued on Robaxin 500 4 times a day, and Neurontin 300 3 times a day was initiated to help with her neuropathic pain. Dr. Willman believed Claimant's pain might have been emanating from her L5 foraminal stenosis, or from her L1 compression fracture. He believed she might benefit from L5-S1 transforaminal injection and a medical branch block *at the L1 level*, and bilateral SI joint injections. (Ex.8 pp. 319-320).
17. On May 4, 2017, Claimant received a L5-S1 caudal epidural steroid injection ("ESI") from Dr. Martin Verhey. It was noted that she complained of lumbar radiculopathy. (Ex. N, p. 161). On May 5, 2017, Claimant returned to Dr. Lund. According to the notes of this date, Claimant had received an L5 ESI and was still experiencing 9/10 low back pain. This same note indicates that Claimant was now using a cane at home and a walker out of the home. Dr. Lund also noted that Claimant was seeing Dr. Staudenmayer with good results. Under "Treatment Plan", Dr. Lund wrote that Claimant was improving but continues to have low back pain. Furthermore, Dr. Lund wrote that Claimant was to follow up with Dr. Thompson in a month regarding her back brace and Dr. Verhey for a possible second ESI (Ex. 3, pp. 53-55).
18. On May 17, 2017 Claimant returned for psychological counseling with Dr. Staudenmayer. Claimant described the incident to Dr. Staudenmayer and reported an increase in her back pain after visualizing the assault. (Ex. Z, p. 605).
19. Claimant was seen by Dr. Willman on May 30, 2017. Dr. Willman's note of this date indicates that Claimant's recent injection under Dr. Verhey provided some benefit for 6 days. Claimant's main complaints on this date were low back and bilateral hip pain. Dr. Willman noted that by history and exam Claimant had not only spinal stenosis at L4-5 and L5-S1 but also bilateral SI joint irritation with inflammation. Dr. Willman deferred any procedures until Claimant was seen by her neurosurgeon Dr. Thompson (Ex. 8, pp. 319-321).
20. An office note from Dr. Lund dated July 14, 2017 indicated that Claimant had fallen in the bathtub due to lack of a handrail for support. Dr. Lund recommended that Claimant continue in her back brace, and follow up with her specialists. (Ex. 3, pp. 59-61).
21. During her July 28, 2017 follow up appointment with Dr. Willman, Claimant indicated that her tramadol prescription was not strong enough. (Ex. P, p. 179). Dr. Willman replaced her tramadol with a prescription for Norco. Claimant was referred to undergo L3-5 medial branch blocks.
22. On August 7, 2017, Claimant returned to see Dr. Willman at Interventional Pain Management for examination, with continued complaints of chronic low back pain. (Ex.

P. p. 181). After speaking with Claimant, Dr. Willman performed medial branch blocks (“MBB”) on Claimant’s L2-L3, L3-L4, L4-L5 bilaterally. No pre-VAS scores were identified. No post-VAS scores were notated. Claimant was not given a pain diary. She was recommended to follow up in a few weeks for post-MBB evaluation.

23. Claimant returned for physical therapy on August 9, 2017 (2 days after her MMB) where she complained of pain of 8.5-9. (Ex. W, p. 500). No significant reduction in her pain was reported. Claimant was discharged from care as she no longer wished to participate in physical therapy.
24. MRI results obtained on August 22, 2017 revealed no significant change of Claimant’s L1 compression deformity of persistent bone marrow edema, no significant change of anterolisthesis of her L5 on S1, no significant change of lumbar spondylosis with mild to moderate L4-5 and L5-S1 spinal canal stenosis, and no significant change of her severe bilateral L5-S1 foraminal stenosis. (Ex. DD, p. 98).
25. On October 16, 2017 Claimant reported for physical therapy at Amazing Care. (Ex. K, p.113). Claimant reported 9/10 pain. However, her therapist noted that despite her high reported pain level, she moved and functioned like someone with a lower pain level. Claimant did not make any facial grimaces and picked up her granddaughter without issue. (Ex. K, p.114).
26. On October 18, 2017 Claimant returned for examination with her occupational therapist. Claimant reported that she “is more fearful and that she did not know how to report it, so she feels that it is severe pain.” Her therapist noted claimant’s current report of 9-10/10 pain, “although facial expressions do not correlate with such levels.” She reported a minimum Pain of 8/10 with a maximum of 10/10. (Ex. K, p. 118).
27. On October 23, 2017, Claimant returned to Interventional Pain Management for post L3-L5 MBB examination. Dr. Willman had left the practice, and Dr. Malinky took over her care. Dr. Malinky noted “pt here for f/u L3-5 MBB, 60-70% relief, pt would like to discuss another injection pt has been in a full body brace up until 2 weeks ago, denies fever/chills s/s infection pain level 8-9/10” (Ex. P, p. 184). She was given a refill on her narcotic medications, gabapentin, and muscle relaxer and referred to undergo L3-L5 RFTCs. Under Review of Systems, he noted: Psychiatric: depression and anxiety. (Ex. P, p. 184)
28. On November 27, 2017, Claimant returned to Dr. Malinky for examination. (Ex. P, p.187). Dr. Malinky now reported that Claimant had experienced greater than 70% reduction in pain from the single set of bilateral medial branch blocks, and that **she had no history of any radicular symptoms** (despite her prior complaints of right leg radiculopathy during her April 18, 2017 neurosurgical evaluation). Dr. Malinky opined the MRI and physical exam suggested facet related pain. Dr. Malinky, without obtaining prior authorization, administered L3-S1 radiofrequency nerve ablations. (Ex. P, p. 188). No Visual Analog Scale (“VAS”) pain scores were identified. No post-VAS scores were notated. Claimant was not given a pain diary. *Id.*

29. On December 20, 2017, Claimant returned to UC Health Physical Therapy with current complaints of 8/10 pain. (Ex. W, p. 501). Claimant noted 8/10 was the minimum amount of pain she felt at the time.
30. On January 3, 2018 Claimant returned to physical therapy noting 6/10 for current pain complaints but noted she had been in 9/10 pain within the last 24 hours. (Ex. W, p. 507). Claimant's physical therapist made a note of Claimant's "high subjective pain levels."
31. Claimant returned to her physical therapist at UC Health on January 10, 2018. She complained of 8/10 pain currently with a minimum of 7/10 and maximum of 10/10. (Ex. W. p. 509)
32. On January 12, 2018 Claimant reported her current pain level as 7/10 with a maximum of 10/10 pain in the last 24 hours. Her therapist continued to note Claimant's 'high levels of subjective pain'. (Ex. W, p. 511).
33. On January 17, 2018 Claimant reported for physical therapy at UC Health. (Ex. W, p. 512). She noted that she had seen her pain management physician yesterday, and was concerned with the lowering of her Norco medication. She was encouraged to address her concern at her next pain management appointment on March 7, 2018. She reported 8/10 pain currently with a minimum of 8/10 and maximum of 10/10.
34. On January 19, 2018 Claimant complained of 8-9/10 pain in the past 24 hours. (Ex. W, p. 517). Claimant was noted to have lower left leg weakness which was presenting claimant with difficulties ascending stairs. Likewise, on January 26, 2018 Claimant reported minimum pain levels as 8/10. *Id* at 522.
35. Claimant attended additional physical therapy appointments on January 31, February 7, and February 21, 2018 with no mention of any pain complaints at the level of 2-3/10. (Ex. W, pp. 523-529).
36. On March 7, 2018 (3 months and 8 days after the 1st RFN procedure) Claimant returned to Dr. Malinky with complaints of 8/10 pain and requests to increase her narcotic pain medications after they had been decreased less than a month prior. (Ex. P, p.193). Dr. Malinky requested repeat medial branch blocks (not repeat RFN) and increased her pain medications. (Ex. G, p. 61).
37. On March 13, 2018, Dr. Joseph Fillmore completed a physician advisor review regarding the request for repeat medial branch blocks. (Ex. J, p. 109). He did not believe there was any medical indication for repeat medial branch blocks at the same level as previously performed as Claimant's complaints remained the same and records did not show functional improvement.

38. Dr. Malinky wrote a letter on March 21, 2018, now requesting Respondents grant the request for bilateral L3-5 radiofrequency nerve ablation. (Ex. P, p. 196). He acknowledged his failure to follow the guidelines regarding the requirement for 2 diagnostic medical branch blocks prior to proceeding to radiofrequency nerve ablation, but argued for a second RFN due to claimant's reported "70% relief for five months", and increased physical activity and quality of life after the first RFN. There is no evidence in the records suggesting that Dr. Malinky had actually reviewed any of Claimant's other medical records at this time.
39. On March 22, 2018, Dr. Fillmore conducted his second physician advisor review based the appeal received from Dr. Malinky. (Ex. J, p. 110). It was noted that Dr. Malinky was now requesting a repeat radiofrequency neurotomy, as Claimant had "70% improvement with both medial branch blocks and prior radiofrequency neurotomy." Dr. Fillmore could not find indications or documentation of functional improvement, and recommended denying the procedure.
40. Claimant's ATP care was transferred to Dr. Autumn Dean on or about April 13, 2018. (Ex. BB, p. 708). During her appointment on that date, Claimant noted that she was nearly complete with physical therapy and had 9 sessions of massage therapy left. Claimant's PTSD was stable at the time. MMI was pending her upcoming IME.
41. On April 16, 2018, Dr. Eric Ridings completed his IME of claimant. It was his opinion that there were no anatomical findings which would support her claim of urinary incontinence. Instead, he believed the cause to be emanating from Claimant's severe somatic and psychological distress and recommended a complete review of claimant's prior medical and psychological history. He also believed claimant's facet arthritis and spondylolisthesis were not related to this claim. and that the previously administered diagnostic tests were not within the medical treatment guidelines. Dr. Ridings believed Claimant had attained MMI for her physical conditions, but recommended the she undergo a psychiatric evaluation to determine what, if any, psychiatric diagnosis should be included as part of her work-injury.
42. After receiving Dr. Ridings IME report, Dr. Dean wrote a letter on May 18, 2018, stating that she agreed with Dr. Ridings assessment, and recommended Claimant undergo a psychiatric assessment. (Ex. BB, p. 712). She deferred determination of MMI until psychiatric evaluation was completed.
43. Dr. Stephan Moe conducted a psychiatric IME of Claimant on July 16, 2018. (Ex. H). Dr. Moe opined that the Claimant's "physical symptoms have been influenced by psychological factors," and that her subjective reports of pain were not in alignment with objective data. Dr. Moe opined that emotional distress, that which follows a traumatic incident in particular, is associated with greater and more severe physical symptoms, a process called somatic amplification. He concluded that psychological factors undoubtedly had a very significant influence on her post-injury medical history, and that Claimant was likely suffering from conversion disorder as she had many medically unexplained symptoms. *Id.* He recommended tending to Claimant's psychological

conditions in order for her to reach MMI.

44. Dr. Moe testified at hearing that Claimant had significant somatic overlay to her physical conditions. Claimant scored the highest possible score on the GAD-7, to measure her symptoms of anxiety disorders, scored 8/9 symptoms on her PHQ-9, indicating a significant level of depression, and had 16/20 symptoms on the PCL-5, indicating severe PTSD symptoms. Dr. Moe agreed that Claimant had severe psychological overlay in her symptoms that significantly influenced her descriptions of pain. He cautioned against proceeding with invasive treatment techniques without first thoroughly reviewing her psychiatric conditions. He also cautioned against undue reliance on claimant's subjective description of pain and recommended objective confirmation.
45. Dr. Moe testified that as a rule, individuals with high amounts of psychological overlay are not good candidates for invasive procedures. He opined that an individual's psychological condition should first be addressed prior to any invasive procedures, including RRN nerve ablation, and that all safeguards should have absolutely been taken in this instance. Dr. Moe believed any 'dismissive attitudes' toward Claimant's psychological condition and its effects should be reconsidered. He was very concerned that Dr. Malinky was giving excessive weight to Claimant's subjective descriptions of pain.
46. Dr. Ridings testified via deposition on January 23, 2019. It was his opinion that the repeat L3-L5 RFN procedure was not reasonable, necessary, or related to her November 12, 2016 injury. Dr. Ridings reviewed Claimant's medical records from her work injury in addition to records from before the injury. He testified that there was no objective evidence showing an injury to Claimant's L3-L5, and that her L1 compression fracture had healed, having no effect on her L3-L5. It was his opinion that the medical treatment guidelines were used to rule out false positives - "the placebo effect"- and that the Guidelines should have been followed in Claimant's case due to a multitude of red flags.
47. Based on his review of the records, he believed Claimant had a negative diagnostic response to the medial branch blocks and a negative diagnostic response to the RFN procedure. According to Dr. Ridings, those negative diagnostic responses provided evidence which showed Claimant's pain generator to be coming from somewhere other than her L3-L5 facet joints. He believed there was substantial literature showing that if there is psychological overlay to the severity of the patient's pain complaints, that unless that was effectively treated, the results of interventional procedures would be much worse. He strongly believed Claimant needed no further physical intervention and instead, suggested that her psychological issues be addressed.
48. Christopher Malinky, M.D. testified by deposition as an expert in anesthesia and pain management. Dr. Malinky testified that the majority of his practice involves treating patients who suffer from chronic and acute low back issues. Dr. Malinky testified that he first evaluated Claimant on October 23, 2017 as a transfer patient from Dr. Willman who had recently left the practice. Dr. Malinky testified that he was seeing Claimant for

reevaluation following a diagnostic medial branch block done on August 7, 2017.

49. Dr. Malinky reported that Claimant had a 60 to 70 percent relief from that medial branch block which tells him, as a pain management doctor, that the L3-L5 levels are the pain generators. Dr. Malinky testified that based on the results of the August 7, 2017 diagnostic block he recommended a radiofrequency neurotomy to achieve the same amount of relief but lasting for six to eight months to avoid ongoing/escalating narcotics and to increase function. He testified that on November 27, 2017 (the date of the RFN procedure), he spent "a couple minutes" with Claimant face-to-face about her existing pain complaints, since he had already seen her at the October 23, 2017 consult.
50. According to Dr. Malinky, after the November 27, 2017 neurotomy was done Claimant reported a 75 to 80 percent reduction in low back pain and that her pain level in the low back was a 2-3/10 and a 9/10 for other parts of her body. Dr. Malinky opined that a 75 to 80 percent pain relief and a concomitant reduction in narcotic usage, as well as the ability to participate in physical therapy would be a good result.
51. Dr. Malinky testified that at Claimant's next visit with him, she was complaining of more pain in her low back with a corresponding decrease in her ability to perform her activities of daily living, both of which indicated that the effects of the radiofrequency neurotomy was wearing off. Dr. Malinky testified that Claimant received only four to five months of pain relief as opposed to the preferred six to eight months. However, Dr. Malinky went on to explain that everyone's nerves regenerate at a different rate and the nerve may not have been completely ablated, so as to achieve a more lasting result. Ultimately, Dr. Malinky opined that a four to five-month duration in pain relief was meaningful improvement and a repeat neurotomy can last even longer.
52. Dr. Malinky testified that as of March 7, 2018, Claimant would benefit from a repeat radiofrequency neurotomy. Dr. Malinky testified that he was aware that the D.O.W.C. Treatment Guidelines (Guidelines) for the low back require that two MBBs be done with good results before the radiofrequency neurotomy is performed and that Claimant had only had one medial branch block before. However, Dr. Malinky went on to explain that since Claimant already had a medial branch block followed by a successful neurotomy that the chances of having a false positive are low. Therefore, Dr. Malinky felt that this was justification for deviating from the Guidelines. Dr. Malinky further testified that he uses psychological screenings with some patients who will be undergoing radiofrequency neurotomies. However, in Claimant's case, he did not feel it was necessary.
53. Dr. Malinky also testified concerning the discrepancies in the pain levels noted in the physical therapy records and his own treatment notes. He stated that when he asks a patient concerning pain levels that he gets really specific about what exactly hurts and how much it hurts. Dr. Malinky further testified that in many instances the patient is going to concentrate on what hurts the most. In addition, Dr. Malinky said it also depends on how and when the question is asked regarding pain levels e.g. before or after therapy. On cross examination, Dr. Malinky was queried concerning pain scales

and the psychological status of a patient who is a potential candidate for a neurotomy. Dr. Malinky testified that pain is subjective and you can't rely on it alone for determining whether or not a neurotomy is appropriate. Rather, a physician has to look at the whole picture which includes talking to the patient, examining them, looking at their imaging, and how they respond to treatment.

54. Dr. Malinky testified that he had not reviewed any of Claimant's prior medical records upon examining her for the first time. He testified that a Rhizotomy procedure should give a patient 75%-80% pain relief for 6-9 months. Dr. Malinky believed that Claimant had pain relief for 4 months from her initial RFN. He testified that he believed the rhizotomy had 'worked', because Claimant was now able to engage in physical therapy and reduced her Norco prescription.
55. He further acknowledged that there was no evidence of any acute injury to Claimant's L3-L5 region, but there was evidence of degenerative changes. He had not read any of Claimant's medical records, either from within his own office, or from outside. He had not read any of Dr. Staudenmeyer's records.
56. He further admitted that he cannot recall if he ever gave Claimant a pain diary, nor if he ever used any VAS pain charts. Instead, he relied exclusively upon Claimant's self-reported characterization of a 60-70% improvement in pain from the date of service (August 7, 2017), until her follow up appointment on 10/23/2017. Based upon this one appointment, he then determined to perform the RFA, which occurred on 11/27/2017.
57. Dr. Malinky further acknowledged that the Guidelines required him to perform two MBBs, but he went straight to the first RFA after one MBB. When asked why this occurred, Dr. Malinky replied: "I don't know. I think, probably it was a mistake and miscommunication."
58. Claimant testified at hearing on October 30, 2018. Claimant alleged that all treatment modalities gave her benefit. She confirmed her pre-existing diagnosis of fibromyalgia and rheumatoid arthritis, which presented her with whole body aching pains.
59. Claimant remembered receiving some benefit from the ESI she received in early May 2017. Claimant alleged she had 3 months of relief from the first Rhizotomy. Claimant testified that she could feel the difference when the injections were wearing off; however, she reported pain levels which mirrored those prior to the medial branch block or RFN procedure. She confirmed she had not had a pain free day since the incident, and denied that she ever reported a 2-3/10 pain to any provider. She confirmed the pain levels had never been lower than a 6-6.5/10 since her injury, and that improvement in her pain from the injections only ever reduced her pain to a 6-6.5/10.

CONCLUSIONS OF LAW

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

Generally

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. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

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

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

Medical Benefits, Generally

4. Respondents are liable for authorized medical treatment that is reasonably necessary to cure and/or relieve an injured worker from the effects of the industrial injury. § 8-42-101(1)(a), C.R.S. An admission of liability does not amount to an admission that all subsequent medical treatment is causally related to the industrial injury or that all subsequent treatment is reasonably necessary. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). Respondent retains the right to challenge the cause of the need for continuing treatment and the reasonable necessity of specific treatment. *Hanna v. Print Expeditors, Inc.*, 77 P.3d 863 (Colo. App. 2003).

5. The Claimant must prove a causal nexus between the claimed disability and need for medical treatment and the work related injury. *Singleton v. Kenya Corp.*, 961 P.2d 571 (Colo. App. 1998).

Medical Treatment Guidelines, Generally

6. The Director of the Division of Workers' Compensation (Division)

promulgated the “medical treatment guidelines and utilization standards.” *City of Manassa v. Ruff* 235 P.3d 1051 (Colo. 2010). The Division's medical treatment guidelines were established by the Director pursuant to an express grant of statutory authority. Section 8-42-101(3.5)(a)(II), C.R.S. The Division's medical treatment guidelines are regarded as the accepted professional standards for care under the Workers' Compensation Act (Act). *Rook v. Industrial Claim Appeals Office* 111 P.3d 549 (Colo. App. 2005). The guidelines are to be used by health care practitioners when furnishing medical aid under the Act. Section 8-42-101(3)(b), C.R.S.; *Hall v. Industrial Claim Appeals Office* 74 P.3d 459 (Colo. App. 2003).

7. An ALJ should consider the Guidelines in deciding whether a certain medical treatment is reasonable and necessary for the Claimant's condition. *Deets v. Multimedia Audio Visual*, W. C. No. 4-327-591 (March 18, 2005), *aff'd Deets v. Industrial Claim Appeals Office No. 05CA0719* (Colo. App. May 17, 2007) (not selected for publication); See *Eldi v. Montgomery Ward* W. C. No. 3-757-021 (October 30, 1998) (medical treatment guidelines are a reasonable source for identifying the diagnostic criteria).

8. While it is appropriate for an ALJ to consider the Guidelines in deciding whether a certain medical treatment is reasonable and necessary for the claimant's condition, See *Deets v. Multimedia Audio Visual*, W. C. No.4-327-591 (March 18, 2005) (medical treatment guidelines are a reasonable source for identifying the diagnostic criteria), the ALJ's consideration of the Guidelines may include deviations from them where there is evidence justifying the deviations. *Logiudice v. Siemens Westinghouse*, W.C. No. 4-665-873 (January 25, 2011).

Medical Treatment Guidelines, Rule 17, Exhibit 1, (E) (2) (b) (vi) B)

B) Medial Branch Blocks: These are generally accepted diagnostic injections, used to determine whether a patient is a candidate for radiofrequency medial branch neurotomy (also known as facet rhizotomy).

It is obligatory that sufficient data be accumulated by the examiner performing this procedure such that the diagnostic value of the procedure is evident to other reviewers. This entails documentation of patient response regarding the degree and type of response to specific symptoms. As recommended by the ISIS guidelines, the **examiner should identify three or four measurable physical functions, which are currently impaired and can be objectively reassessed 30 minutes or more after the injection.** A successful block requires documentation of positive functional changes **by trained medical personnel experienced in measuring range of motion or assessing activity performance.** *The evaluator should be acquainted with the patient, in order to determine pre and post values, and preferably unaffiliated with the injectionist's office.* Qualified evaluators include nurses, physician assistants, medical assistants, therapists, or noninjectionist physicians. To be successful the results should occur within the expected time frame and there

should be pain relief of *approximately 80% demonstrated by pre and post Visual Analog Scale (VAS) scores*. Examples of functional changes may include sitting, walking, and lifting. *Additionally, a prospective patient **completed pain diary must be recorded** as part of the medical record that documents response hourly for a minimum requirement of the first 8 hours post injection or until the block has clearly worn off and preferably for the week following an injection*. The diary results should be compared to the expected duration of the local anesthetic phase of the procedure. Responses must be identified as to specific body part (e.g., low back, leg pain). The practitioner must identify the local anesthetic used and the expected duration of response for diagnostic purposes. The success rate of radiofrequency neurotomy is likely to decrease with lesser percentages of pain relief from a branch block.

A separate comparative block on a different date should be performed to confirm the level of involvement. A comparative block uses anesthetics of varying lengths of activity. Medial Branch blocks are probably not helpful to determine the likelihood of success for spinal fusion.

It is essential that only light sedation be used for diagnostic trials in order to avoid having the sedation interfere with the patient's ability to interpret pain relief from the injection itself. Many patients may not need any medication. For those requiring anxiolytics, short acting agents, such as midazolam, may be used. As with all patients, the pain diary and functional testing post injection must be rigorously adhered to in order to correctly interpret the results of the diagnostic injection.

Needle Placement: Multi-planar fluoroscopic imaging is required for all medial branch blocks injections. Injection of contrast dye to assure correct needle placement is required to verify the flow of medication. Permanent images are required to verify needle placement.

Indications: All injections should be preceded by an MRI or a CT scan. Individuals should have met all of the following indications:

- Physical exam findings consistent with facet origin pain, and
- At least 3 months of pain, unresponsive to 6-8 weeks of conservative therapies, including manual therapy, and
- *A psychosocial screening (e.g., thorough psychosocial history, screening questionnaire) with treatment as appropriate.*

⊞ Frequency and Maximum Duration: May be repeated once for comparative blocks. Limited to 2 anatomic facet levels or 3 medial branch levels. (emphasis added).

Medical Treatment Guidelines, Rule 17, Exhibit 1, (F) (4) (e)

e. Radio Frequency (RF) Denervation - Medial Branch Neurotomy/Facet Rhizotomy:

i. Description -- A procedure designed to denervate the facet joint by ablating the corresponding sensory medial branches. Continuous percutaneous radiofrequency is the method generally used. Pulsed radiofrequency should not be used as it may result in incomplete denervation. Cooled radiofrequency is generally not recommended due to current lack of evidence.

There is good evidence in the lumbar spine that *carefully selected patients* who had 80% relief with medial branch controlled blinded blocks and then had RF neurotomy will have improved pain relief over 6 months and decreased impairment compared to those than those who had sham procedures. *Generally pain relief lasts 7-9 months and repeat radiofrequency neurotomy can be successful and last longer.* RF neurotomy is the procedure of choice over alcohol, phenol, or cryoablation. Precise positioning of the probe using fluoroscopic guidance is required because the maximum effective diameter of the device is a 5x8 millimeter oval. Permanent images should be recorded to verify placement of the device.

ii. Needle Placement: Multi-planar fluoroscopic imaging is required for all injections. Injection of contrast dye to assure correct needle placement is required to verify the flow of medication. Permanent images are required to verify needle placement.

iii. Indications -- *Those patients with proven, significant, facetogenic pain. A **minority** of low back patients would be expected to qualify for this procedure.* (emphasis added). This procedure is **not recommended** (emphasis supplied) for patients with *multiple pain generators* or involvement of more than 3 levels of medial branch nerves.

Individuals should have met **all** of the following indications:

- Physical exam findings consistent with facet origin pain, **and**
- Positive response to controlled medial branch blocks, **and**
- At least 3 months of pain, unresponsive to 6-8 weeks of conservative therapies, including manual therapy, **and** (emphasis supplied)
- A *psychosocial screening* (e.g., thorough psychosocial history, screening questionnaire) with treatment as appropriate *has been undergone.*

All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients will have had prior to the procedure, will frequently require a repeat of the sessions previously ordered (Refer to F.13. Therapy-Active). (emphasis added).

It is obligatory that sufficient data be accumulated by the examiner performing this procedure such that the value of the medial branch block is evident to other reviewers. This entails documentation of patient response regarding the degree and type of response to specific symptoms. As recommended by the ISIS guidelines, the examiner should identify three or four measurable physical functions, which are currently impaired and can be objectively reassessed 30 minutes or more after the injection. *A successful block requires documentation of positive functional changes by trained medical personnel experienced in measuring range of motion or assessing activity performance. The evaluator should be acquainted with the patient, in order to determine pre and post values, and preferably unaffiliated with the injectionist's office.* Qualified evaluators include nurses, physician assistants, medical assistants, therapists, or non-injectionist physicians. To be successful the results should occur within the expected time frame and there should be pain relief of approximately 80% demonstrated by pre and post *Visual Analog Scale (VAS) scores.* Examples of functional changes may include sitting, walking, and lifting. Additionally, *a prospective patient completed pain diary must be recorded as part of the medical record that documents response hourly for a minimum requirement of the first 8 hours post injection or until the block has clearly worn off and preferably for the week following an injection.* The diary results should be compared to the expected duration of the local anesthetic phase of the procedure. Responses must be identified as to specific body part (e.g., low back, leg pain). The practitioner must identify the local anesthetic used and the expected duration of response for assessment purposes.

In almost all cases, this will mean a reduction of pain to 1 or 2 on the 10-point Visual Analog Scale (VAS) correlated with functional improvement. The patient should also identify activities of daily living (ADLs) (which may include measurements of ROM) that are impeded by their pain and can be observed to document objective functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations.

A separate comparative block on a different date should be performed to confirm the level of involvement prior to the rhizotomy. A comparative block uses anesthetics with varying lengths of activity. Medial Branch blocks are probably not helpful to determine the likelihood of success for spinal fusion. (emphasis added).

The success rate of radiofrequency neurotomy is likely to decrease with lower percentages of pain relief from a medial branch block.

Informed decision making should also be documented for injections and all invasive procedures. This must include a thorough discussion of the pros and cons of the procedure and the possible complications as well as the natural history of the identified diagnosis. The purpose of spinal injections, as well as surgery, is to facilitate active therapy by providing short-term relief through reduction of pain. Patients should be encouraged to express their personal goals, outcome expectations and desires from treatment as well as any personal habits or traits that may be impacted by procedures or their possible side effects. *All patients must commit to continuing appropriate exercise with functionally directed rehabilitation usually beginning within 7 days, at the injectionist's discretion.* Since most patients with these conditions will improve significantly over time, without invasive interventions, patients must be able to make well-informed decisions regarding their treatment. *All injections must be accompanied by active therapy.*

iv. Complications-- Bleeding, infection, or neural injury. The clinician must be aware of the risk of developing a localized neuritis, or rarely, a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures. Spinal musculature atrophy is likely to occur especially with repeat procedures as a rhizotomy denervates the multifidus-muscle in patients. For this reason, repeated rhizotomies and multiple level rhizotomies can be harmful by decreasing supportive spinal musculature. This is especially problematic for younger patients who may engage in athletic activities or workers with strenuous job requirements as the atrophy could result in increased injuries or pain, although this has not been documented.

v. Post-Procedure Therapy -- Active therapy. Implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-procedure week, barring complications. Instruction and participation in a long-term home-based program of ROM, core strengthening, postural or neuromuscular re-education, endurance, and stability exercises should be accomplished over a period of four to ten visits post-procedure. *Patients who are unwilling to engage in this therapy should not receive this procedure.*

vi. Requirements for Repeat Radiofrequency Medial Branch Neurotomy: In some cases pain may recur. *Successful RF Neurotomy usually provides from six to eighteen months of relief.* Due to denervation of spinal musculature repeated rhizotomies should be limited. Refer to the Division's Chronic Pain Disorder Treatment Guidelines. Before a repeat RF Neurotomy is done, a confirmatory medial branch injection should be performed if the patient's pain pattern presents differently than the initial evaluation. In occasional patients, additional levels of RF neurotomy may be necessary. The same indications and limitations apply.

Substantial Deviations from the Medical Treatment Guidelines

9. Using the treatment Guidelines in the current case shows that the request for a repeat L-3-L5 RFN procedure is not reasonable or necessary as the first RFN procedure was negative diagnostically. The Guidelines state that for a positive response claimant have 3-4 measureable improvements in physical function. The medical records fail to show any *measureable* improvement in her function due to the RFN procedure. Claimant's statement of improvement is not supported by the records.

10. Medical records confirm Claimant failed to receive the 80% relief in pain complaints that the Guidelines require. Medical records and Claimant's own testimony prove claimant had at best 6-6.5/10 at any point during her treatment. Dr. Malinky's single report of functional improvement and 2-3/10 pain is not supported by any of the records. Claimant herself has denied ever having told him of 2-3/10 pain. Claimant failed to complete a pain diary. Available medical records during the period of time where she should have felt the most relief, indicate she actually received little to no relief from the injections.

11. The Guidelines state that the procedure and subsequent reduction in pain should last anywhere from 6-18 months. Records show that any pain relief achieved by Claimant was lost within one to two months after she received the injection on November 27, 2017. By December 20, 2017 she had pain complaints of 8/10. The guidelines suggest that in almost all cases, Claimant will have a reduction of pain to 1 or 2 on the 10-point VAS. At no point in her claim, did Claimant ever report reduction in her pain to a 1 or 2 on the 10-point VAS. Likewise, physical examination of Claimant substantiates a correlation between her continually high complaints of pain and severe functional limitation, as she never functioned in an objective manner that would indicate she was at a 1 or 2 on the 10-point scale.

12. Claimant had an insufficiently diagnostic response to the medial branch blocks and therefore no further MBBs were then warranted. However, because Dr. Malinky apparently did not know about the Guidelines, he bypassed the requirements and safeguards and moved directly to administering an *unauthorized* RFN procedure. The evidence shows that he did not follow the Guidelines to determine if Claimant had genuine lower back pain. Claimant's circumstances called for much closer adherence to the Guidelines to ensure she was receiving appropriate and authorized care.

13. After the medial branch blocks and RFN procedures, Dr. Malinky failed in the Guidelines' requirement to collect data such that the diagnostic value of the procedure is evident to other reviewers. Dr. Ridings testified that there was a lack of data indicating a positive diagnostic response. The ALJ concurs. Dr. Malinky did not identify three or four measurable physical functions, which were then impaired and could be objectively reassessed in 30 minutes or more after the injection. He also failed to follow the recommendation that he become acquainted with the patient such that he could determine pre and post VAS values, as he spent only a few minutes getting acquainted with the patient.

14. The Guidelines recommend that the evaluator be someone other than the injectionist. Dr. Malinky himself injected Claimant and then indicated that he evaluated her. The Guidelines recommend rigorous adherence to a pain diary and objective functional testing post-injection to correctly interpret the results. Claimant was given no pain diary and no pre- or post- VAS scores were taken by Dr. Malinky.

15. The Guidelines recommend a second set of medial branch blocks to rule out the possibility of a false positive and a psychosocial evaluation. Dr. Malinky acknowledged that he might have significant concern with an individual who reported anxiety as pain. He admitted he would have concern with an individual who presented with symptom magnification. He did not have the expertise to comment on psychological issues and had only had a face-to-face conversation with claimant for no more than 5 minutes; however, at intake he noted Psychiatric issues of Depression and Anxiety.

16. Dr. Moe's assessment of Claimant's severe psychological overlay essentially mandates that a second set of injections should have been given to claimant to rule out a false positive. Dr. Malinky acknowledged that the guidelines require a second set of injections to rule out a false positive, or placebo effect, but again relied on his "couple-minute" conversation with Claimant to justify his deviation from the Guidelines. The justification given by Dr. Malinky for all of his deviations is that he did not know that the Guidelines required two injections and he had a brief face-to-face conversation with Claimant. The ALJ finds such deviation in this instance is not supportable.

17. Although Claimant testified to functional improvement, the Guidelines recommend obtaining objectively measurable functional improvements. No objectively measureable functional improvement can be found within the medical records surrounding the administration of medial branch blocks or the RFN procedure.

18. Dr. Malinky agreed that pain was subjective. A physician should look at other, more objective, data to confirm a patient's subjective description of pain. Dr. Malinky did not document or confirm Claimant's subjective description of pain with objective data. Claimant's medical providers noted their concerns with her unusually high levels of pain compared to objective data and observable function. No evidence exists within the record to support functional gains attained by Claimant from any treatment she received.

19. The Guidelines' direction in eliminating false positives is especially applicable in the current instance. Four months prior to Claimant's work-injury she complained of near whole body pain complaints. Likewise, Claimant had undergone extensive work-up of her spine due to her complaints of urinary incontinence, yet no physician could explain her symptoms. Imaging of Claimant's lumbar spine showed a fully healed L1 compression fracture, with no acute pathology in her L3-L5. Claimant's providers agreed that Claimant's L1 fracture had properly healed and that it had no

effect on her L3-L-5. All objective data has failed to show any work-related pathology in claimant's L2-L5 and diagnostic tests have failed to confirm claimant's L2-L5 facet joints as the pain generator.

20. Claimant's significant and diagnosed somatic amplification of her physical feelings of pain did not justify deviating from the guidelines. While her psychological complaints do not disqualify her from receiving injections, her psychological presentation should give any provider concern when moving forward with invasive treatments and all precautions should be undertaken. Dr. Malinky himself noted "Depression and Anxiety" on Claimant's initial consult with him. Dr. Moe has opined that Claimant was a poor candidate for the RFN procedure as numerous studies evidenced poor outcomes for individuals with severe psychological overlay, such as Claimant.

21. The Guidelines indicate that RFA is **not recommended** for patients with multiple pain generators. Claimant apparently had many. They go on to state that "a *minority* of low back patients would be expected to qualify for this procedure."

In Conclusion

22. The ALJ concludes that Dr. Malinky is sincere in his testimony, and felt it was in best interests of Claimant when he recommended the second MBB, then the second RFN. However, the ALJ concludes that that is simply insufficient to justify the numerous, substantial, deviations he would ask the Workers Compensation system to accept. While the Guidelines may be deviated from, sufficient documentation and rationale for so doing must be supplied by the treating physician in support. Otherwise, the Guidelines would mean very little. They exist for a reason-to assure appropriate, proven, and uniform care of injured workers. The ALJ finds the expert testimony of Dr. Ridings and Dr. Moe to be persuasive, in that Dr. Malinky has failed to justify why the proposed second RFA procedure is reasonable and necessary to treat Claimant's work injuries.

ORDER

It is therefore Ordered that:

1. Claimant's request for the second L3, L4, L5 bilateral radiofrequency neurotomy as requested by Dr. Malinky is denied and dismissed.
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: March 14, 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

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO

W.C. No. 5-010-740-003

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 March 5, 2019, in Denver, Colorado. The hearing was digitally recorded (reference: 3/5/19, Courtroom 3, beginning at 1:45 PM, and ending at 5:00 PM). The official Spanish/English Interpreter was Alice Her.

Claimant's Exhibits 1 through 24 were admitted into evidence, without objection, however, Exhibit 23 was withdrawn. Respondents' Exhibits A through CC were admitted into evidence, without objection, however, ruling on Exhibits Q through U and X was reserved. The objections to Exhibits Q through U are hereby overruled and these exhibits are hereby admitted into evidence. The objection to Exhibit X is hereby sustained and Exhibit X is rejected.

At the conclusion of the hearing, the ALJ established a post hearing briefing schedule. The Claimant's opening brief was filed, electronically, on March 8, 2019. The Respondents' answer brief was filed, electronically, on March 12, 2019. Because the Claimant has prevailed in the above-referenced matter, it is unnecessary to wait two days for a reply brief. Consequently, the matter was deemed submitted for decision on March 14, 2019.

ISSUES

The issues to be determined by this decision concern medical benefits; reasonably necessary left ankle surgery (juvenile allograft cartilage replacement) pursuant to the recommendation of Alan Ng, D.P.M., an authorized treating podiatrist.

FINDINGS OF FACT

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

Preliminary Findings

1. Respondents filed a General Admission of Liability (GAL), dated April 7, 2016, admitting for authorized, causally related and reasonably necessary medical benefits; an average weekly wage (AWW) of \$723.81; and, temporary total disability (TTD) benefits of \$482.54 per week from March 26, 2016 and “ongoing.” The GAL remains in full force and effect (Claimant’s Exhibit 1). The parties stipulated to an initial average weekly wage of \$750.00, effective from the date of loss until May 31, 2018, and that the average weekly wage increased to \$853.05 effective June 1, 2018, that includes the replacement cost of health insurance, and the ALJ so finds.

2. On October 9, 2015, the Claimant suffered an admitted industrial injury. Claimant’s left hip was driven into by a pickup truck driven by his supervisor. Among other injuries, the Claimant sustained a left ankle injury (Respondents’ Exhibit AA)

3. On November 12, 2015, the Claimant presented to his primary care provider with complaints of ankle pain after a truck bumped and pinned him between the gate and the truck. He reported low back pain which radiated down his left leg, left knee pain, and occasional ankle pain. The Claimant was diagnosed with an ankle strain. His instructions were to limit lifting, pushing, or pulling, to follow up with a workers’ compensation doctor due to his injury occurring at work (Claimant’s Exhibit 5).

4. On November 13, 2015, the Claimant presented to Kevin Vlahovich, M.D. at Banner Occupational Health Clinic. The Claimant reported opening a fence on October 9, 2015 when his supervisor drove the bumper of a truck into his left hip causing his left leg to twist and get pinned against the fence. The supervisor laughed and claimed it was a joke. The Claimant walked with a limp and reported pain which traveled from hip to the medial ankle. Left ankle examination was abnormal for pain on motion and palpation medially around the tibiofibular joint. The left ankle also had decreased strength and range of motion (ROM). Original x-rays of the left ankle showed abnormalities related to the incident. Objective findings were consistent with the history

of a work-related etiology, specifically caused when the Claimant was hit by a vehicle on the left hip and leg while at work (Claimant's Exhibit 6)

5. On November 30, 2015, the Claimant reported popping and catching in the left ankle (Claimant's Exhibit 6).

Medical Chronology

6. On December 8, 2015, Kevin Vlahovich, M.D. of Banner Occupational Health Clinic in Greely reviewed an MRI (magnetic resonance imaging) of the left ankle which showed both acute and chronic changes. Dr. Vlahovich referred the Claimant for an orthopedic evaluation and treatment followed by a referral of physical therapy (Claimant's Exhibit 6).

7. Upon the referral of Dr. Vlahovich on December 16, 2015, the Claimant presented to orthopedic surgeon Richard Williams, M.D. The Claimant informed Dr. Williams that he was struck by a truck at work on October 9, 2015. Since then he reported left ankle pain and swelling. Dr. Williams noted a decreased range of motion in the left ankle and positive Achilles reflexes tests. Dr. Williams reviewed x-rays and MRIs and diagnosed a chronic talar dome osteochondral lesion. The Claimant desired the beginning of conservative care. Dr. Williams performed a steroid injection to the left ankle (Claimant's Exhibit 7). Dr. Williams is within the chain of authorized referrals.

8. On January 5, 2016, the Claimant reported that he was doing the same or slightly worse after being referred to Dr. Williams, who gave him an injection of steroids into the left ankle. The injection in the ankle did not decrease the pain (Claimant's Exhibit 6).

9. On January 26, 2016, the Claimant reported the ankle injection did not provide any relief. There was clicking and swelling noted. Dr. Williams gave the Claimant an ankle brace and referred him to Steven Sides, M.D. (Claimant's Exhibit 7). Dr. Sides is within the chain of authorized referrals.

10. Upon the referral of Dr. Williams on February 8, 2016, the Claimant presented to Dr. Sides. The Claimant reported that a co-worker bumped him with a car while he was opening a gate and the Claimant had since developed severe and constant left foot symptoms. Dr. Sides diagnosed an osteochondral defect of the talus and performed a left ankle steroid injection. Dr. Sides recommended continued use of an ankle brace and following the RICE protocol (Claimant's Exhibit 9).

11. On February 9, 2016, the Claimant reported pain mostly in the left ankle. The ankle still had some popping and catching (Claimant's Exhibit 6).

12. On February 23, 2016, the Claimant reported continued left ankle pain and was noted to be walking with crutches. Dr. Vlahovich referred the Claimant for a second opinion when Dr. Sides was unavailable and Dr. Vlahovich noted the left ankle was not improving with conservative measures and was delaying recovery (Claimant's Exhibit 6).

13. Upon the referral of Dr. Vlahovich on March 1, 2016, the Claimant presented to Wesley P. Jackson, M.D. for a second opinion for the left ankle pain. The Claimant stated that he was injured when a truck hit his left hip and he developed left anterior ankle pain. Dr. Jackson diagnosed left talar dome medial cystic osteochondral defect. Dr. Jackson was of the opinion that surgery at that time was unpredictable. Dr. Jackson performed a cortisone injection in the left ankle. According to Dr. Jackson, if the Claimant had a positive response, he may benefit from an arthroscopy and debridement (Claimant's Exhibit 10).

14. On March 1, 2016, Dr. Jackson, Orthopedic specialist, noted that the Claimant was 5 feet 7 inches tall and weighed 300 pounds. Dr. Jackson reported that Claimant's cysts predated the work injury. On examination, Claimant's pain was "quite out of proportion to the findings." Dr. Jackson considered surgery unpredictable at helping the Claimant at that time but if Claimant responded well to a diagnostic injection, the Claimant may benefit from an ankle arthroscopy and debridement "albeit it would still be rather unpredictable based upon his pain pattern today" (Respondents' Exhibit G).

15. On March 30, 2016, Dr. Vlahovich noted that the Claimant had a second ankle injection on March 1st but reported no relief. A second opinion from Dr. Jackson was that the outcome would be uncertain. The Claimant's physical therapy was on hold until after the left knee surgery on April 4th (Claimant's Exhibit 6).

16. On April 4, 2016, the Claimant had a left knee arthroscopy with a trochlea microfracture (Claimant's Exhibit 7).

17. On June 28, 2017, Dr. Sides noted that the Claimant reported his left ankle pain was not getting better but in fact worse. An ankle brace did not provide relief (Claimant's Exhibit 9).

18. On July 19, 2017, Dr. Sides reviewed MRI results. He recommended an allograft transplant of the Claimant's talus and referred the Claimant to David B. Hahn, M.D. Dr. Sides was of the opinion that: "**If he does not get a replacement of his talus he will need ankle replacement soon**" (Claimant's Exhibit 9).

Division Independent Medical Examination (DIME) by Mark S. Failing, M.D.

19. At the request of Respondents, on August 10, 2016, the Claimant presented to Dr. Failing for a DIME. Dr. Failing found swelling that occurred all the time with locking sensations in the ankle. The Claimant used a cane to walk sometimes and had give-away episodes. The Claimant wore a brace for the ankle that somewhat helped. Examination revealed discomfort in the anterior and anterolateral left ankle. Dr. Failing agreed with an opinion by Dr. Williams and was of the opinion that left ankle arthroscopy was a reasonable procedure for drilling an osteochondral defect, or if the lesion is large enough, to perform an open reduction, internal fixation (ORIF) of the lesion. Due to the Claimant's "morbid obesity, however, Dr. Failing noted that the procedure would have a lower medical probability of helping (Claimant's Exhibit 14).

20. On August 24, 2016, Dr. Vlahovich noted that the Claimant was walking as tolerated with a cane but he was awaiting a second knee surgery due to "locking" in the knee. The Claimant also reported left hip, knee, **ankle** (emphasis supplied) and low back pain (Claimant's Exhibit 6).

21. On August 26, 2016, the Claimant reported anterior and that the ankle was worse than the knee. Dr. Williams explained that if the ankle was causing the Claimant problems, Dr. Sides could perform a medial malleolus osteotomy with a talus osteochondral allograft (Claimant's Exhibit 7).

22. On September 23, 2016, Dr. Failing issued an addendum to his August 10, 2016 DIME report --after reviewing diagnostic imaging. Dr. Failing was of the opinion that the Claimant's morbid obesity was a major risk factor for future ankle fusion, although ankle replacement may be considered. Dr. Failing instead recommended a subchondral bone grafting given the Claimant's age group (Claimant's Exhibit 14).

23. Dr. Williams performed left knee arthroscopy on November 3, 2016 (Claimant's Exhibit 7).

24. On November 22, 2016, Dr. Vlahovich noted that Dr. Failing performed a DIME on August 10, 2016, which supported approval of several surgeries in the left leg. The Claimant still walked as tolerated with a cane (Claimant's Exhibit 6).

Dr. Vlahovich

25. On December 20, 2016, Dr. Vlahovich discussed left ankle surgery with bone graft over osteochondral defect. Dr. Vlahovich discussed his diet and that weight loss would likely improve surgical outcome and emphasized use of a food diary (Claimant's Exhibit 6).

26. In a letter dated December 28, 2016, Dr. Vlahovich noted that the Claimant was not at maximum medical improvement (MMI) and his MMI determination was dependent upon approval for surgical procedures (Claimant's Exhibit 6)

27. On January 6, 2017, the Claimant was using a cane to ambulate following left knee surgery (Claimant's Exhibit 7).

28. On February 2, 2017, the Claimant had a left total knee arthroplasty (total left knee replacement). (Claimant's Exhibit 7).

29. On April 24, 2017, Dr. Vlahovich noted that the Claimant had complications from the knee surgery and was walking as tolerated with a cane. The Claimant's ankle pain remained the same (Claimant's Exhibit 6).

Gregory Reichhardt, M.D. and David B. Hahn, M.D.

30. Upon the referral of Dr. Vlahovich on June 20, 2017, the Claimant presented to Dr. Reichhardt for a physiatrist consultation. Dr. Reichhardt reviewed the history of the injury including the responsible coworker laughing at him. The left ankle revealed decreased range of motion and tenderness to palpation over the anterior aspect of the ankle. Dr. Reichhardt recommended an active independent exercise program (Claimant's Exhibit 18). Dr. Reichhardt was within the chain of authorized referrals.

31. On June 30, 2017, Dr. Vlahovich noted that an MRI of the left ankle showed an osteochondral defect. The Claimant reported increased left ankle pain and Dr. Sides suggested a repeat MRI. Dr. Vlahovich ordered the MRI. (Exhibit 6)

32. On July 19, 2017, the Claimant returned to Dr. Sides to review the new left ankle MRI results and discuss treatment options. At this point, Dr. Sides recommended an allograft transplant of the Claimant's talus and referred the Claimant to Dr. Hahn. Dr. Sides was of the opinion that if the Claimant did not get a replacement of the talus soon, he would need an ankle replacement soon (Claimant's Exhibit 9).

33. Upon the referral of Dr. Sides on August 2, 2017, the Claimant presented to Dr. Hahn for a second opinion on a fresh talar allograft transplantation surgery. The Claimant reported that he felt like something was stuck in his ankle and he felt his ankle lock up intermittently. Dr. Hahn did not feel that a fresh talar allograft would be as effective as a DeNovo procedure done over the top of a subchondroplasty procedure. Dr. Hahn stated, "certainly I do think that something needs to be done (*sic*) his ankle and this is going to be a difficult process because of the patient's significant weight, but I do think it would be worth it given the patient's reasonable ankle motion, although I did tell him that **there is a very good likelihood that he will require an ankle fusion if**

his discomfort continues” (Claimant’s Exhibit 11). Dr Hahn was within the chain of authorized referrals.

34. On August 25, 2017, Dr. Reichhardt noted that the Claimant continued to walk with a mildly antalgic gait, favoring the left lower extremity. He reviewed Dr. Hahn’s report recommending a DeNovo procedure instead of an allograft transplant procedure. The Claimant expressed frustration over the treatment plan of his left ankle. Dr. Reichhardt spoke with Dr. Sides’ office who referred the Claimant to Alan Ng, D.P.M. This was reasonable from a physiatric standpoint (Claimant’s Exhibit 16). Dr. Ng was within the chain of authorized referrals.

Alan Ng, D.P.M., Podiatrist

35. Upon the referral of Dr. Vlahovich, by recommendation of Dr. Hahn, on October 10, 2017 the Claimant presented to Dr. Ng, the Claimant indicated that he had stiffness and pain in the left heel and ankle. Range of motion (ROM) was limited. The Claimant reported that his symptoms were constant and he described them as mild-moderate. Dr. Ng ordered an MRI of the left ankle to evaluate a possible osteochondral defect (Claimant’s Exhibit 15).

36. The Claimant returned to Dr. Ng on October 17, 2017 to review the left ankle MRI. Dr. Ng found severe osteochondritis dissecans and recommended surgical intervention, including a juvenile allograft cartilage replacement with a subchondroplasty calcium phosphate injection to stabilize the severe osteochondral defect and insufficiency fracturing (Claimant’s Exhibit 15).

Samms Conference

37. On October 24, 2017 Dr. Vlahovich participated in a *Samms* conference. Dr. Vlahovich explained that Dr. Ng ordered an MRI that indicated an extensive cystic medial talar osteochondral insults accompanied by a significant degree of osseous inflammatory changes with attenuation of the subchondral cortex and overlying articular cartilage without frank disruption of the subchondral cortex or collapse. Dr. Vlahovich referred to Dr. Sides who recommended surgery. Dr. Vlahovich referred to Dr. Hahn who was of the opinion that the Claimant’s obesity made treatment and recovery difficult, however, he suggested a DeNovo procedure done over the top of a subchondroplasty procedure. Since Dr. Hahn did not perform that procedure, Dr. Vlahovich referred the Claimant to Dr. Ng who recommended a different surgery than he was willing to perform, *i.e.*, juvenile allograft cartilage replacement with subchondroplasty calcium phosphate injection. Dr. Vlahovich stated:

In my opinion, the Claimant has a lesion in his foot/ankle that needs surgery or the Claimant will not get better and will likely get worse. I am concerned that the Claimant's weight will make recovery more difficult because the Claimant may not be able to walk for over a month or two; time necessary to try and give the surgery a chance to heal before the Claimant puts all his weight on his ankle...

The Claimant's cystic lesion, essentially a hole in the bone, likely preexisted the work injury, however, the Claimant was asymptomatic prior to the work injury and, as a result, the need for surgery is more likely related to the work injury.

(Claimant's Exhibit 6).

38. On December 5, 2017, Dr. Vlahovich noted further left ankle surgery was put on hold until it was confirmed that the Claimant was not allergic to any surgical materials. The Claimant reported feeling the same left ankle pain (Claimant's Exhibit 6).

39. On January 3, 2018, Dr. Vlahovich noted no problem with the allergy testing and that the Claimant may move forward with the recommendation of Dr. Ng (Claimant's Exhibit 6).

40. On January 4, 2018, the Claimant returned to Dr. Ng reporting persistent left ankle pain. Dr. Ng requested pre-authorization for an ankle scope with debridement (Claimant's Exhibit 15). The request was denied, thus, the need for the hearing herein.

Independent Medical Examination (IME) by Scott Primack, D.O.

41. Dr. Primack testified at the hearing. He was of the opinion that the Claimant is not a good surgical candidate for the following reasons:

- a. Function: Claimant's function improved without surgery. Claimant exercised and lost weight. Originally, the Claimant reported that he could walk 10 - 15 minutes. Now the Claimant walks up to an hour and a half. Computerized outcome analysis reflected the Claimant's self-perception of functionality increased despite his reported symptoms of pain. Dr. Primack stated the opinion that there is a good chance that surgery will result in increased pain and decreased function. Dr. Primack recognized that an MRI reflected objective changes but Dr. Primack pointed out that findings of objective improvement in function also exist. The decision to

operate should be based on the person and functionality and not on MRI findings alone, according to Dr. Primack. The Claimant's testimony supports the fact that Dr. Ng's recommended surgery is based on the Claimant's present condition and his functionality.

- b. Obesity: Claimant is obese with a BMI over 40. Dr. Primack recognized that the possibility of surgical success, regardless of the surgery, is lower due to the Claimant's morbid obesity. Dr. Primack anticipated that significant BMI will crush the graft recommended by Dr. Ng. The ALJ infers and finds that the possibility of surgical success is generally uncertain, yet patients undergo surgeries.
- c. Expectations: Dr. Primack was concerned about the Claimant's mental state and expectations. Walking is a reasonable expectation and Claimant's ability to walk has improved without surgery. Running and jumping are not reasonable expectations. Returning to preinjury status is not a reasonable expectation. Reducing pain could be reasonable, however, in this case, Dr Primack was of the opinion that Claimant's pain levels are not terrible. Dr. Ng noted that the Claimant's symptoms were "mild" and that Claimant reported a pain level of 3. Dr. Primack stated that mild symptoms do not support the need for surgery. In this respect, his opinion differs from that of foot surgeon, Dr. Ng. Also, Dr. Primack anticipated that pain will increase following surgery and that surgery will most likely not reduce the Claimant's pain level below 3. Dr. Primack noted that the Claimant already underwent three knee surgeries and wants a fourth knee surgery which does not bode well for a positive result following ankle surgery, in Dr. Primack's opinion. The ALJ infers and finds that this opinion is speculative. Dr. Primack referenced that Dr. Jackson, an orthopedic surgeon, noted that Claimant's pain was out of proportion to the cysts which make surgery unpredictable. The ALJ finds a degree of speculation in this opinion. Indeed, the ALJ infers and finds that the outcomes of many surgeries are "unpredictable," yet the patients who chose to undergo these surgeries are not denied the opportunity to do so.
- d. Surgery is not reasonable, according to Dr. Primack's interpretation of the Medical Treatment Guidelines (hereinafter "MTG"). According to Dr. Primack, the MTG recommend a surgical progression that starts with a microfracture. In this case, microfracture surgery is not reasonable because of the size of Claimant's cyst, according to Dr. Primack. If the microfracture fails, the MTG recommend doctors consider an Osteochondral Autograft/Allograft Transfer System (OAATS). According to Dr. Primack, the OAATS procedure is not reasonable because Claimant's BMI of 40 is greater than the recommended BMI of less than

35. Dr Ng, a podiatrist, recommended a juvenile allograft cartilage replacement with subchondraplasty calcium phosphate injection, in this respect, Dr. Ng disagrees with Dr. Primack. The ALJ finds that Dr. Ng's clinical judgment herein outweighs general provisions of the MTG, as interpreted by Dr. Primack.

42. Instead of surgery, Dr. Primack recommended ongoing exercise and weight loss, and a bracing feature to support the Claimant's ankle if Claimant reports loss of function.

43. Ultimately, Dr. Primack is of the opinion that the Claimant is "doing as well as can be expected" despite the Claimant's continuing pain and Dr. Ng's recommended surgery.

The Claimant's Testimony

44. The Claimant testified at the hearing. Several doctors told him he should lose weight to lessen the pressure on his ankle. Claimant worked out at the recreation center 1 hour to 1½ hour, five to six times per week; sometimes twice per day. On occasion he drove himself to the recreation center. Claimant primarily exercised on the treadmill, stationary bike, and elliptical machine. Claimant lost 60 pounds and currently weighs around 274 pounds. The ALJ infers and finds that the Claimant has exerted maximum effort to lose weight. The ALJ further infers and finds that the Claimant presented as a naturally heavy-set individual. None of the doctors, other than Dr. Primack specified how much weight the Claimant should lose. According to Dr. Primack the Claimant's BMI should be reduced to 35 or less. The ALJ infers and finds that this could well be an impossible goal for a heavy set individual such as the Claimant, thus, effectively precluding a class of individuals with BMI's over 35 from a surgical option for the ankle despite the expert recommendation of a foot surgeon. According to the Claimant, he cannot step and put pressure on his ankle. Nonetheless, he lost weight exercising on the treadmill and on the elliptical machine despite his ankle pain which leads the ALJ to infer and find that he is determined to lose weight to undergo Dr. Ng's recommended surgery. Dr. Ng is recommending the surgery, which consists of juvenile allograft cartilage replacement with subchondraplasty calcium phosphate injection. The ALJ infers and finds that Dr. Ng has considered the Claimant's present weight status.

Ultimate Findings

45. Although Dr. Primack makes a convincing case that the Claimant's condition is now as good as it's going to get, the Claimant still experiences pain that he would like to alleviate, and a foot surgeon, Dr. Ng, is recommending a surgical procedure, juvenile allograft cartilage replacement with subchondraplasty calcium

phosphate injection, which the Claimant desires to undergo. The opinions of other physicians are not as current as Dr. Primack's opinion and the ALJ infers that they do not take into account the Claimant's present weight loss and vigorous exercise program, or Dr. Primack's opinion to the effect that the Claimant's present condition is as good as it's going to get, which the ALJ finds to be speculative. Dr. Primack's opinion in this regard, which is speculative, tends to contraindicate Dr. Ng's surgical recommendation. Dr. Ng, an authorized and accredited podiatrist, has more specific expertise than the other physicians, including Dr. Primack, whose opinions are reflected in the evidence and Dr. Ng is recommending ankle surgery, which consists of a different procedure than has been performed in the past. Indeed, the opinions of other physicians contained in the evidence support the appropriateness of ankle surgery, with the qualification that the Claimant's obesity is a factor and he should lose weight. These opinions do not take into account that the Claimant has lost 60 pounds and is engaged in a vigorous exercise regimen. The ALJ infers and finds that a reduction to a BMI of 35 or less may create an impossibly high bar for a portly individual such as the Claimant. The ALJ infers and finds that an arbitrary distinction between portly and non-portly individuals is being made for considerations of ankle surgery. For these reasons, the ALJ finds the ultimate opinion of Dr. Ng, supported by the Claimant's testimony, more credible and persuasive than other opinions to the contrary.

46. Between conflicting medical opinions, the ALJ makes a rational choice, based on substantial evidence, to accept the opinion of Dr Ng as supported by the Claimant's testimony, and to reject opinions to the contrary.

47. The ALJ finds that the Claimant's testimony concerning his present condition and desire for Dr. Ng's recommended surgery bears considerable weight in supporting Dr. Ng's recommendation

48. Based on the totality of the evidence, including the Claimant's testimony, the ALJ finds that the surgical procedure recommended by Dr. Ng, a juvenile allograft cartilage replacement with subchondraplasty calcium phosphate injection, is causally related to the admitted injury of the admitted injury of October 9, 2015 (a GAL for that injury has remained in full force and effect since March 26, 2016) and it is reasonably necessary to cure and relieve the effects thereof.

Respondents' Position on Reasonable Necessity and Causal Relatedness of Surgery Recommended by Dr. Ng

Respondents argue that the medical records, the testimony of Dr. Primack, and the Medical Treatment Guidelines support the idea that surgery is not reasonably necessary. They argue that surgical interventions should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. Later, however, they apparently concede that surgery may be necessary to relieve pain

caused by an industrial injury. As found, the Claimant's function improved with the help of exercise and weight loss and without surgery. It is just as probable that the long-term outcome of Dr. Ng's surgery, along with a vigorous exercise regimen after the surgical recovery period, could improve the Claimant's functionality. Claimant testified that he primarily exercised on the treadmill, stationary bike, and elliptical machine, that he lost 60 pounds, and that he currently weighed around 274 pounds. Claimant admitted he works out 1 – 1 ½ hours 5 to 6 times per week. Dr. Primack pointed out that when he first evaluated Claimant, he reported he could walk 10 - 15 minutes and, when Dr. Primack last evaluated the Claimant, he reported that he walks up to an hour and a half at a time. Also, computerized outcome analysis reflected Claimant's self-perception of functionality increased despite his reported symptoms of pain. It stands to reason that the Claimant's self-perception of functionality would increase even more after the recovery period from surgery. Pain reduction may support surgery in some situations, and this is exactly such a situation. Dr. Ng noted that Claimant's symptoms were "mild" and that Claimant reported a pain level of only 3. According to Dr. Primack, mild symptoms do not support the need for surgery, pain will likely increase following surgery, and it is unlikely that surgery will reduce Claimant's pain level below a rating of 3, according to Dr. Primack. The ALJ finds that this opinion is speculative. It is just as probable that ankle surgery by a foot specialist could reduce the Claimant's pain even more.

Despite the fact that Dr. Ng is within the authorized chain of referrals, referred by virtue of his foot and ankle specialty as a podiatrist, Respondents ultimately argue that his recommended surgery is no reasonably necessary to cure and relieve the effects of the admitted injury of 2015. With all due respect to the Respondents, the ALJ does not accept this argument.

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. *Arenas 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. As found, although Dr. Primack made a convincing case that the Claimant's condition is now as good as it's going to get, the Claimant still experiences pain that he would like to alleviate, and a foot surgeon, Dr. Ng, is recommending a surgical procedure, juvenile allograft cartilage replacement with subchondroplasty calcium phosphate injection, which the Claimant desires to undergo. The opinions of other physicians are not as current as Dr. Primack's opinion and the ALJ infers that they do not take into account the Claimant's present weight loss and vigorous exercise program, or Dr. Primack's opinion to the effect that the Claimant's present condition is as good as it's going to get, which the ALJ finds to be speculative. Dr. Primack's opinion in this regard, which is speculative, tends to contraindicate Dr. Ng's surgical recommendation. Dr. Ng, an authorized and accredited podiatrist, has more specific expertise than the other physicians, including Dr. Primack, whose opinions are reflected in the evidence and Dr. Ng recommended ankle surgery, which consists of a different procedure than has been performed in the past. Indeed, the opinions of other physicians contained in the evidence support the appropriateness of ankle surgery, with the qualification that the Claimant's obesity is a factor and he should lose weight. These opinions do not take into account, as found, that the Claimant has lost 60 pounds and is engaged in a vigorous exercise regimen. As found, a reduction to a BMI of 35 or less may create an impossibly high bar for a portly individual such as the Claimant. An arbitrary distinction between portly and non-portly individuals should not be made for considerations of ankle surgery. For these reasons, as found, the ultimate opinion of Dr. Ng, supported by the Claimant's testimony, was more credible and persuasive than other opinions to the contrary.

b. Compensation can be awarded where there is competent evidence other than expert opinion. *Martin Marietta Corp. v. Faulk*, 158 Colo. 441, 407 P.2d 348 (1965). Such competent evidence includes lay testimony. See *Savio House v. Dennis*, 665 P.2d 141 (Colo. App. 1983); *Colorado Fuel & Iron Corp. v. Alitto*, 130 Colo. 130,

273 P.2d 725 (1954). Also see *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). As found, although the Claimant's testimony supports the expert opinion of foot surgeon, Alan Ng, D.P.M., the Claimant's testimony plays a significant role in the determination that Dr. Ng's recommended surgery is reasonably necessary.

Substantial Evidence

c. 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); *Leeway 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 the opinion of Dr Ng, as supported by the Claimant's testimony, and to reject opinions to the contrary.

Reasonably Necessary Ankle Surgery by Alan Ng, D.P.M.

d. 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 injuries of October 9, 2015. 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, including the ankle surgery recommended by Dr. Ng, specifically, the juvenile allograft cartilage replacement with subchondraplasty calcium phosphate injection, is reasonably necessary to cure and relieve the effects of the Claimant's admitted injury of October 9, 2015.

Burden of Proof

e. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to contested medical 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 with respect to the juvenile allograft cartilage replacement with subchondraplasty calcium phosphate injection, recommended by Dr. Ng.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents shall pay the costs of causally related and reasonably necessary medical care and treatment, including the juvenile allograft cartilage replacement with subchondraplasty calcium phosphate injection, recommended by Alan Ng, D.P.M, an authorized foot surgeon, subject to the Division of Workers Compensation Medical Fee Schedule.

B. The General Admission of Liability, dated April 7 2016, shall remain in full force and effect.

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

DATED this 14th day of March 2015.

A rectangular box containing a digital signature. The text "DIGITAL SIGNATURE" is printed in the top left corner of the box. The signature itself is a handwritten-style scribble in black ink, appearing to read "Edwin L. Felter, Jr.".

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

- Did Claimant overcome the DIME's impairment rating by clear and convincing evidence? If so, what is the proper rating?
- Did Claimant prove entitlement to a general award of medical benefits after MMI?
- Disfigurement.

FINDINGS OF FACT

1. Claimant suffered an admitted injury to his lumbar spine on July 12, 2016 in a work-related motor vehicle accident.

2. Claimant has a lengthy history of low back issues, including four surgeries. Dr. Richard Lazar performed an L4-5 microdiscectomy in April 2008 and a revision left L4-5 microdiscectomy in February 2011. Dr. Sung performed a right L5-S1 microdiscectomy on November 29, 2011, and a revision L4-5 microdiscectomy on October 29, 2013. Claimant had seven physical therapy visits after the October 2013 surgery, and the final report dated December 16, 2013 indicated Claimant had made significant gains with mobility and strength.

3. The last time Claimant saw Dr. Sung before the July 12, 2016 motor vehicle accident was on February 4, 2014. At that visit, Claimant was "doing well" overall. Dr. Sung noted he had "no consistent leg pain. On occasion, he will get a twinge in the left calf. His back feels pretty good. He has no real complaints at this time." Dr. Sung released Claimant from care to follow-up "as needed."

4. After the July 12, 2016 accident motor vehicle accident, Employer referred Claimant to Dr. Robi Baptist at Colorado Springs Health Partners (CSHP). At the initial visit on July 14, 2016, Claimant reported low back pain radiating down his right leg to the calf, and tingling in his 2nd-4th toes. Dr. Baptist ordered a lumbar MRI and referred Claimant back to Dr. Sung.

5. The MRI was done on July 27, 2016. It showed an acute left-sided disc herniation at L4-5 impinging on the left L4 nerve root, and a bulging disc at L5-S1 contacting the S1 nerves and causing moderate bilateral lateral recess narrowing.

6. Claimant saw Dr. Sung on August 16, 2016. He reported low back pain and pain into his legs, worse on the left. Dr. Sung referred Claimant to Dr. Finn for injections and to physical therapy.

7. Dr. Finn administered two ESIs, neither of which were helpful.

8. The claimant followed up with Dr. Sung on October 26, 2016. Dr. Sung noted Claimant had already had four back surgeries and concluded,

[H]e did not do well with the injections and I am recommending an L4-S1 anterior-posterior fusion. Anteriorly, I would like to go into the disc space at 4-5 and pullout that recurrent fragment and then fuse. He has had too many surgeries and I think **he is just unstable at this point**. Both of these segments are involved and I believe that at the time of surgery, both need to be included. (Emphasis added).

9. On December 13, 2016, Dr. Sung performed an L4-S1 anterior lumbar decompression and interbody fusion. The final postoperative diagnoses included recurrent stenosis at L4-S1, and recurrent left L4-5 herniated nucleus pulposus.

10. The surgery was successful, and Claimant's symptoms slowly but steadily improved over the ensuing several months.

11. Dr. Lund took over for Dr. Baptist in November 2016. On March 1, 2017, Dr. Lund noted Claimant was "improving, [but] not 100% yet though." He was still having weakness in his left leg and foot. Physical examination showed EHL weakness on the left, mild atrophy of the left thigh, and decreased sensation in the left lower leg and foot.

12. On May 25, 2017, Dr. Lund documented continued left leg weakness, including ankle dorsiflexion and a "very weak" EHL.

13. Claimant followed up with Dr. Sung on June 15, 2017, and stated he felt "very good." His back pain and leg symptoms were significantly improved, but he still had some weakness on the left. On examination, Dr. Sung noted, "a little weakness in his EHL on the left compared to the right, and just a touch of weakness in dorsiflexion on the left compared to the right." Flexion-extension x-rays showed no motion, and the fusion appeared to be consolidating as expected. Dr. Sung released Claimant to follow-up "as needed."

14. Dr. Baptist resumed Claimant's care on August 24, 2017 and documented residual motor deficits in the left leg. Dr. Baptist noted, "the patient's pain is much improved but is still having tingling in his foot and difficulty raising his toes off the ground." Claimant was scheduled to see Dr. Sung later that day, although the last report from Dr. Sung in the record is dated 15, 2017.

15. ALJ Edie conducted a hearing on September 14, 2017 regarding Respondents' liability for the December 2016 surgery. Everyone agreed the surgery was reasonably necessary, but the parties disagreed about causation. One of ALJ Edie's findings of fact indicates Respondent's expert had opined the surgery was reasonably necessary to address spinal "instability." ALJ Edie resolved the causation issue in Claimant's favor and ordered Respondents to cover the surgery.

16. Dr. Baptist placed Claimant at MMI on February 15, 2018, with a 31% whole person rating. Dr. Baptist opined apportionment was not appropriate because Claimant

was “essentially asymptomatic prior to the work injury.” Dr. Baptist assigned a 13% Specific Disorder rating under Table 53(IV)(B) and (C), which applies to “Spinal stenosis, segmental instability, or spondylolisthesis, operated.” She assigned 19% for lumbar range of motion deficits, using valid measurements obtained during an FCE completed on January 25, 2018. Finally, Dr. Baptist included 2% whole person under Table 51 for weakness in plantar flexion.

17. Regarding maintenance care, Dr. Baptist recommended ongoing pain management with Dr. Finn or another physiatrist/pain specialist, follow up with Dr. Sung as directed by Dr. Sung, and home exercises. Dr. Baptist further opined, “there is a strong possibility this patient’s condition will deteriorate in the near or distant future and provision should be made for further care.”

18. Respondents challenged Dr. Baptist’s rating and Claimant underwent a DIME with Dr. Michael Janssen on July 24, 2018. Claimant credibly testified Dr. Janssen appeared irritated and complained the DIME fee was inadequate based on the size of the records packet. Dr. Janssen’s report corroborates Claimant’s perception because Dr. Janssen stated, “I only allocated the hours they agreed to compensate me for this. I stopped exactly 4.0 hours in attempting to read all this. I am a speed reader, but there was [sic] more than 165 pages and I could not read any faster, so I made all my assessments only based upon the information in the time that was allocated.” Claimant perceived the evaluation as “very rushed” and cursory.

19. The physical examination documented in Dr. Janssen’s report appears largely benign, with almost no significant clinical findings aside from minimal range of motion reduction. He stated Claimant demonstrated “non-physiological” weakness in his lower extremities and opined the strength in all muscle groups was normal. Dr. Janssen’s examination is an outlier and inconsistent with other examinations documented in the record.

20. Dr. Janssen assigned 11% for Specific Disorders under Table 53(II)(E) and (F), which applies to “intervertebral disc or other soft-tissue lesions.” Dr. Jensen did not explain why he used § (II)(E) instead of § (IV)(B). He also added 5% for lumbar range of motion, for a total rating of 16% whole person.¹ Finally, he opined, “there is no indication for maintenance management currently.”

21. Claimant saw Dr. Jack Rook for an IME at his counsel’s request on December 3, 2018. Claimant reported a good outcome with the surgery, but still had some “soreness” in his back at the end of a long workday, weakness in his left foot and ankle, and paresthesias in the left big toe. Claimant stated he was prone to stumbling on stairs because of the left leg weakness and had fallen on more than one occasion. Dr. Rook observed atrophy of the left extensor digitorum brevis compared to the right side muscle. Pinprick sensation was diminished in the left big toe compared to the right. Dr. Rook noted

¹ Although not mentioned by either party, Dr. Janssen clearly erred by *adding* the two components of the rating instead of *combining* them as required by the *AMA Guides*. See § 3.3a, p.81, and the Spine Impairment Summary form. According to the Combined Values Chart, Dr. Janssen’s final rating should have been 15%.

“obvious” weakness in the left lower extremity including 4/5 big toe extension and ankle dorsiflexion and 5-/5 plantar flexion. Claimant could walk short distances on his toes and heels but developed progressive fatigue of his left ankle dorsiflexors as he did so.

22. Dr. Rook opined Dr. Janssen committed two significant errors regarding Claimant’s impairment rating. First, Dr. Janssen erred by using Table 53(II)(E) and (F), because the appropriate section is Table 53(IV)(B) and (C). He explained,

[Dr. Janssen] gave this patient a spinal impairment for a surgically treated disc lesion per (II.E). This category refers to those patients who undergo a laminectomy and discectomy procedures, and not a spinal fusion procedure which is rated under section IV, which is for “spinal stenosis, segmental instability, or spondylolisthesis.” This patient’s surgical procedure was performed because of spinal stenosis with nerve root entrapment. At his October 2016 preoperative visit, Dr. Sung’s assessment concluded: “Large recurrent left L4-5 herniated disc, with L5-S1 severe degenerative disc disease, collapse and stenosis.” Additionally, the patient underwent a procedure whereby the discs at L4-5 and L5-S1 were removed as part of the L4 through S1 anterior and posterior fusion. Removal of these disks creates segmental instability at these two levels. Therefore, this patient was appropriately placed into this specific diagnosis category by Dr. Baptist who provided the patient with a 12% lumbar impairment (IV.B) plus the additional one % for the second level involved in the fusion (IV.C). Dr. Baptist performed her impairment rating correctly. Dr. Janssen performed his rating incorrectly, as he relied upon an erroneous specific diagnosis/Table 53 impairment.

23. Additionally, Dr. Rook opined Dr. Janssen should have assigned a rating for residual lower extremity neurological deficits,

[T]his patient continues to have weakness at his left ankle and left foot in the L5 distribution and there is muscle atrophy of the extensor digitorum brevis muscle which is innervated by the L5 nerve root. Therefore, it was appropriate for Dr. Baptist to provide this patient with an L5 motor impairment

24. Dr. Rook testified at hearing consistent with his report. He reiterated the rating Dr. Janssen gave would be appropriate for a disc herniation treated with a laminectomy, but not a fusion. He explained that, although Claimant had a herniated disc, the surgery was done for stenosis and instability, not simply the herniated disc. He emphasized it is important to rate “the actual anatomy and pathology that exists in this case.” When asked whether his disagreements with Dr. Janssen’s methodology were merely differences of opinion, Dr. Rook replied, “well, it’s my opinion to use the proper category and not use the wrong category.”

25. Regarding post-MMI treatment, Dr. Rook did not believe Claimant required any active interventional pain management, but opined annual follow-up visits with Dr. Sung would be reasonable:

I think it's reasonable that he follow-up with his surgeon at regular intervals, maybe once a year. I think that's not unreasonable because there could be changes. When you have a fusion, you can develop transitional problems above the fusion. I think it's pretty routine to have annual visits at least for several years with your surgeon to see how you're doing and to determine the integrity of the fusion and the — the hardware. Whether he needs, you know, active every three months interventional injections, that was not my impression when I saw him.

26. Claimant was a credible witness.

27. Dr. Rook's opinions regarding Claimant's impairment rating and errors committed by the DIME are credible and persuasive.

28. Claimant overcame the DIME's impairment rating by clear and convincing evidence.

29. Claimant proved by a preponderance of the evidence Dr. Baptist's 31% whole person rating is the most appropriate rating.

30. Claimant proved by a preponderance of the evidence he is entitled to a general award of medical benefits after MMI.

31. Claimant has injury-related disfigurement consisting of: (1) a 5 ½ inch long by 1 inch wide curved, irregularly-shaped, discolored, partially indented, partially raised, surgical scar on the abdomen ending at the belt line; (2) two 5 inch long by ¼ inch wide irregular, discolored, partially indented, partially raised, surgical scars on either side of his spine; and (3) each scar on the back scar is flanked along its length by many pairs of staple scars, substantially enhancing the overall noticeability of the scarring. The ALJ finds Claimant should be awarded \$3,000 for disfigurement.

CONCLUSIONS OF LAW

A. Claimant overcame the DIME regarding impairment.

A DIME's determination regarding whole person impairment is binding unless overcome by "clear and convincing evidence." Section 8-42-107(8)(C). Clear and convincing evidence must be "unmistakable and free from serious or substantial doubt." *Leming v. Industrial Claim Appeals Office*, 62 P.3d 1015 (Colo. App. 2002). The party challenging a DIME's conclusions must demonstrate it is "highly probable" that the impairment rating is incorrect. *Qual-Med*, 961 P.2d at 592; *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A "mere difference of medical opinion" does not constitute clear and convincing evidence that the DIME is incorrect. *E.g., Gutierrez v. Startek USA, Inc.*, W.C. No. 4-842-550-01 (March 18, 2016).

As found, Claimant overcame the DIME rating by clear and convincing evidence. The ALJ sees three clear errors in Dr. Janssen's rating: (1) he applied the incorrect section under Table 53, (2) he failed to assign a rating for lower extremity neurological impairment, and (3) he added the spinal impairments instead of combining them.

The ALJ is persuaded by Dr. Rook's discussion and explanation regarding the application of Table 53 § (IV) instead of § (II) to rate Claimant's impairment. Dr. Baptist also used § (IV), which corroborates and bolsters Dr. Rook's opinions. Respondents' IME at the hearing before ALJ Edie agreed the fusion was necessary to remedy "instability." The ALJ does not consider this a mere difference of opinion and is persuaded by Dr. Rook's testimony that his and Dr. Baptist's approach is "right," and Dr. Janssen's approach is "wrong."

The ALJ also concludes Dr. Janssen should have included a lower extremity neurological rating. Multiple providers have documented residual weakness in the left ankle and foot, and the ALJ has no substantial doubt Claimant still suffers from some neurological sequelae of his injury. Dr. Janssen's physical examination documenting no neurological deficits is an outlier and not credible.

Finally, Dr. Janssen erred by adding the components of Claimant's spinal rating rather than combining them.

Any of these errors could be sufficient to overcome the DIME. Taken together, they leave the ALJ free from serious or substantial doubt that Dr. Janssen's rating was incorrect.

B. Claimant has 31% whole person impairment as determined by Dr. Baptist

Once the DIME's rating has been overcome "in any respect," the proper rating becomes a factual issue for the ALJ based on a preponderance of the evidence. *Newsome v. King Soopers*, W.C. No. 4-941-297-02 (October 14, 2016).

As found, Claimant proved Dr. Baptist's rating is the most reliable and accurate. Dr. Baptist correctly applied Table 53, and the range of motion measurements were obtained during an FCE conducted by a neutral evaluator. The FCE measurements were internally consistent, and within the ranges one would expect after a spinal fusion. Dr. Janssen's range of motion measurements are suspect; it is unlikely Claimant would have full extension, near full rotation and minimal limitations on flexion after a two-level lumbar fusion. Dr. Janssen's implausible numbers lend credence to Claimant's testimony that Dr. Janssen assisted his motion, contrary to the requirement to use "passive" range of motion only. Moreover, Dr. Baptist's decision to include a neurological rating is supported by and consistent with the evidence and the *AMA Guides*. The ALJ does not find Dr. Janssen's physical examination credible, because it is inconsistent with the examinations of multiple other providers. As Claimant credibly explained, Dr. Janssen hurried through the appointment, which probably explains why he missed the residual left leg weakness documented by multiple other examining and treating providers. It appears Dr. Janssen was more focused on minimizing his time expenditure than conducting a thorough

examination and report. The ALJ considers Dr. Janssen's evaluation sloppy and unreliable, and declines to give his opinions significant weight.

C. Claimant is entitled to a general award of medical benefits after MMI

The respondents are liable for medical treatment from authorized providers reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101(1)(a); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Medical benefits may extend beyond MMI if the claimant requires maintenance care to relieve symptoms or prevent deterioration of their condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). If the claimant establishes the probability of a need for future treatment, he is entitled to a general award of medical benefits after MMI, subject to the respondents' right to dispute compensability, reasonableness, or necessity of any particular treatment. *Hanna v. Print Expeditors, Inc.*, 77 P.3d 863 (Colo. App. 2003). A claimant need not be receiving treatment at the time of MMI nor prove that a particular course of treatment has been prescribed to obtain a general award of Grover-type medical benefits. *Miller v. Saint Thomas Moore Hospital*, W.C. No. 4-218-075 (September 1, 2000).

A claimant must prove entitlement to medical benefits after MMI by a preponderance of the evidence, 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 (ICAO, Jul. 2, 2010). The DIME's opinion regarding medical treatment after MMI is not entitled to any special weight but is simply another medical opinion for the ALJ to consider when evaluating the preponderance of the evidence. See *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Story v. Industrial Claim Appeals Office*, 910 P.2d 80 (Colo. App. 1995).

As found, Claimant proved he is entitled to a general award of medical benefits after MMI. Claimant underwent a major surgical procedure, and the ALJ credits Dr. Rook's opinion he should retain access to periodic follow-up with Dr. Sung to monitor the stability of the fusion. Although Claimant had a good outcome from surgery, he remains symptomatic, and the ALJ is also persuaded by Dr. Baptist's opinion he should have access to further treatment for the symptom relief. Although Claimant has had no formal treatment since February 2018, he credibly testified he has "a call in to Dr. Finn" to discuss further treatment options.

D. Disfigurement

Section 8-42-108(1) provides that a claimant is entitled to additional compensation if he is "seriously, permanently disfigured about the head, face, or parts of the body normally exposed to public view." As found, Claimant has sustained noticeable disfigurement as a direct and proximate result of the July 12, 2016 injury. As found, Claimant should be awarded \$3,000 for disfigurement.

ORDER

It is therefore ordered that:

1. Claimant's request to set aside the DIME's impairment rating is granted.
2. Insurer shall pay Claimant PPD benefits based on Dr. Baptist's 31% whole person rating. Insurer may take credit for any PPD previously paid in connection with this claim.
3. Insurer shall pay Claimant statutory interest of 8% per annum on all benefits not paid when due.
4. Insurer shall cover reasonably necessary "*Grover*" medical treatment after MMI from authorized providers causally related to the July 12, 2016 admitted injury.
5. Insurer shall pay Claimant \$3,000 for disfigurement. Insurer may take credit for any disfigurement benefits previously paid in connection with this claim.

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: March 14, 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
WORKERS' COMPENSATION NO. WC 4-949-994-002**

ISSUES

1. Whether Claimant has overcome Division Independent Medical Examination (DIME) physician Bennett Machanic's opinion that Claimant does not suffer from chronic regional pain syndrome (CRPS) causally related to her January 2, 2014 work injury by clear and convincing evidence.
2. Determination of disfigurement related to the admitted work injury.

FINDINGS OF FACT

1. Claimant is a 58 year old female who was employed by Employer.
2. On January 2, 2014, Claimant sustained an admitted work related injury. On that date, Claimant was letting passengers in and out of an exit door during a snowstorm when the door blew closed and struck her in the back.
3. After her admitted injury, Claimant underwent treatment that eventually included a lower back fusion surgery that occurred in two parts on February 26, 2015 and February 27, 2015.
4. From the fusion surgery, Claimant has scarring on both her abdomen and her back. On the lower abdomen, Claimant has a scar measuring approximately 15 inches that remains red and discolored from her normal skin tone despite adequate time for healing. On her back, Claimant has two scars each measuring approximately 1 inch in length and each remaining white and discolored from her normal skin tone despite adequate time for healing.
5. On October 29, 2015, Matthew Lugliani, M.D. evaluated Claimant. Claimant reported minimal improvement in her symptoms with continued low back pain at a 3-4/10 in severity. Claimant reported no radiating symptoms. Claimant also reported left elbow pain at a 6/10. Dr. Lugliani assessed stable chronic lumbar pain, L4-5 and L3-4 disc bulges with nerve root impingement status post fusion on February 26 and 27, 2015, and left lateral epicondylitis. See Exhibit H.
6. On December 12, 2016, Dr. Lugliani evaluated Claimant. Dr. Lugliani noted that Claimant was status post lumbar spine fusion from February of 2015 that was complicated by left lateral epicondylitis during physical therapy. Claimant reported persistent back pain, numbness and tingling into her bilateral legs at a 5-6/10 with aching stabbing numbness and tingling. Claimant reported that prolonged standing, walking, and lifting made her symptoms worse. Dr. Lugliani noted that Claimant was scheduled for platelet rich plasma injections for her left elbow on January 13, 2017. Dr. Lugliani

assessed chronic lumbar pain and radiculopathy following lumbar fusion and left elbow epicondylitis with tears on MRI. Claimant requested referral back to Dr. Rauzzino. See Exhibit 4.

7. On December 19, 2016, Usama Ghazi, D.O. evaluated Claimant. Dr. Ghazi noted that recent bilateral sciatic nerve blocks for Claimant's persistent piriformis pain and radicular symptoms had given her excellent long-term relief. Dr. Ghazi noted remarkable improvement for Claimant with Claimant being able for the first time to control sciatica and gluteal spasms. Claimant reported concern with coldness in the tips of her toes, brittle toenails that were falling off, collapse in the arches of her feet, and unexplained intermittent edema. Dr. Ghazi was concerned with chronic regional pain syndrome (CRPS) after looking at Claimant's feet. Claimant reported that the tips of all five toes on both feet would become pale and cold sometimes hyperemic. On exam, Dr. Ghazi found a cold pallor and multiple degree hypothermia compared to proximal to the MTPs at the tips of all five toes. Dr. Ghazi found Claimant's toenails to be brittle and discolored brownish-yellow and multiple areas where the toenails had flaked off and broken. Dr. Ghazi found some hyperemia of the distal shins. Dr. Ghazi found collapse of the arch more profound on the right foot and tenderness, especially with weight bearing, over the right sinus tarsi. In his impressions, Dr. Ghazi noted his significant concern for CRPS with postoperative edema, neuritic pain, cold toes, temperature differences, vasoconstriction of the toes, and brittle and flaking toes that were discolored and fragile. Dr. Ghazi opined that the type of contusion Claimant sustained could have caused mild CRPS, which could have been worsened by the fact that Claimant had chronic radiculopathy, postoperative pain, bilateral hip bursitis, and sciatic nerve compression. Dr. Ghazi planned to schedule Claimant for two sets of lumbar sympathetic blocks back to back to be diagnostic. See Exhibit 5.

8. On December 22, 2016, Claimant underwent bilateral lumbar sympathetic blocks performed by Dr. Ghazi. He noted pre-injection that Claimant's toes measured 84 degrees bilaterally and post injection the toes showing increased temperature of 88 degrees on the left and 86 degrees on the right. Dr. Ghazi also opined that vasodilation was noted with reduction of pallor in the bilateral toes after injection. Dr. Ghazi opined that the hyperesthesia and paresthesias in the feet and the curling of the toes was relaxed post injection and that the hypersensitivity in the tips of the toes was significantly reduced. Dr. Ghazi opined that it was a successful bilateral sympathetic blockade and opined that the injections confirmed that Claimant had a portion of sympathetic mediated pain with vasoconstriction and Raynaud phenomenon. See Exhibit 5.

9. On February 9, 2017, Claimant again underwent bilateral lumbar sympathetic blocks performed by Dr. Ghazi. Claimant reported that after her first lumbar sympathetic blocks she did not have significant pain relief for the first week and a half but then began noticing a slow improvement in warming of the foot and toes as well as reduction in hypersensitivity especially when taking on and off her socks or having sheets touch her feet which caused 9/10 pain before. Claimant reported that now, her pain was reduced down to a 5-6/10 in the tips of the toes at rest but remained at an 8/10 with light touch when wearing socks or touching sheets. Dr. Ghazi noted some vasomotor changes

in Claimant's feet including paleness and coolness in the tips of the toes with vasoconstriction in the dorsum of the feet compared to the shins and calves. Dr. Ghazi noted no hyperhidrosis but pallor and brittle yellow toenails. After the February 9, 2017 injection Claimant reported 0/10 pain to light touch in the toes with 100% resolution of allodynia at rest and with light touch. Dr. Ghazi noted that the temperature in Claimant's left foot went from 87.2 to 91.2 degrees after injection and that the temperature in the right foot went from 87.9 to 90.2 degrees after injection with both feet showing palpable and measurable improvements consistent with successful sympathetic blockade. See Exhibit 5.

10. On April 3, 2017, Dr. Ghazi evaluated Claimant. Dr. Ghazi noted that Claimant's follow up MRI of the lumbar spine showed the L5-S1 fusion with right laminotomy changes and a large osteophyte in the right paracentral region causing mass effect with posterior displacement of the right S1 nerve root. He noted at L4-5 the MRI showed a diffuse disk bulge more pronounced than a prior June 2016 study and that there was moderate spinal stenosis also worsened from the prior study with possible impingement of the L5 nerve roots and possible impingement of the left L4 nerve root. At L3-4 Dr. Ghazi noted it showed mild disk bulge with facet and ligamentum flavum hypertrophy. Dr. Ghazi opined that perhaps a foraminotomy was needed for the displacement of the right S1 nerve root. Dr. Ghazi noted under history of present illness that Claimant's persistent bilateral lower extremity neuralgia appeared to be due to severe piriformis syndrome with sciatica as well as L5-S1 radiculitis with intact strength but persistent paresthesias in the S1 and L5 distributions. Dr. Ghazi also noted that Claimant had sympathetic mediated abnormalities that had progressed in the lower extremities but responded to lumbar sympathetic blocks with improvement in thermal asymmetry, pallor, and vasoconstriction. Dr. Ghazi noted that Claimant had lost almost all her toenails due to brittle vasomotor changes and that the sympathetic blocks provided 50% relief from pain but greater than 85% improvement in the vasoconstricted, cold, pale toes. Claimant reported that she was doing much better that her toes had rarely been cold and rarely had vasoconstriction since her injections. Claimant reported some return of the paresthesia and numbness and tingling as well as hypersensitivity. See Exhibits 5, F.

11. Claimant reported the pain radiated from her buttocks and hips into the bilateral feet along the lateral S1 distributions and then into the dorsum of the feet along the L5 distributions. Claimant noted hypersensitivity but was more concerned that she had lost almost all her toenails. Dr. Ghazi noted that on the left foot, Claimant had lost every toenail except for the fourth digit and that they had grown halfway back. On the right foot, Dr. Ghazi noted that Claimant had lost the toenails of digits four and five and that the brittleness and yellow discoloration of the toenails was improving as the nails had grown back. Dr. Ghazi also noted that Claimant was status post platelet rich plasma injection of the left medial lateral epicondyle and that Claimant reported her elbow pain was 90% improved. On physical examination, Claimant had a positive straight leg raise in the right S1 distribution. Dr. Ghazi noted that Claimant's reflexes were absent at 0/4 in the right Achilles consistent with the posteriorly displaced and compressed right S1 nerve root on MRI. Dr. Ghazi provided the impression of bilateral sciatica combined bilateral L5-S1 radiculitis with superimposed CRPS which was at least 50% improved from two

sets of sympathetic blocks. He opined that there had been some recurrence of CRPS with loss of almost all the toenails of the feet due to brittle trophic changes of the toenails from CRPS with symptoms much improved from prior injections, but wearing off. Dr. Ghazi also provided the impression of Raynaud syndrome with vasoconstriction and pallor in the toes remarkably improved after bilateral lumbar sympathetic blocks. Dr. Ghazi recommended Claimant follow up with Dr. Rauzzino regarding the left S1 flattening in displacement on the MRI. Dr. Ghazi opined that for the sciatic portion of Claimant's pain, Claimant should continue with piriformis stretches and physical therapy as well as pelvic tilt therapy and opined Claimant may eventually require PRP injections into the trochanteric and gluteal bursae/tendons. Dr. Ghazi recommended two additional lumbar sympathetic blocks for recurrence of vasomotor symptoms and the loss of toenails. Dr. Ghazi recommended repeat PRP injections to the left elbow down the road. See Exhibits 5, F.

12. On April 6, 2017, Dr. Ghazi requested bilateral lumbar sympathetic blocks x2 with them two weeks apart. Blocks were performed on May 18, 2017 and Claimant reported 100% anesthetic relief of the allodynia of the lower extremities. See Exhibits 5, F.

13. On June 9, 2017, Dr. Ghazi evaluated Claimant. Claimant reported complete resolution of the allodynia to light touch following the lumbar sympathetic blocks. Claimant reported that the changes in her toenails and the CRPS were almost reversed with the bluish-yellowish brittle nails appearing more healthy and pink and with the re-grown toenails coming in with a healthy pink color as opposed to the brittle discoloration. Claimant reported some coolness in the tips of the toes at times, especially on the right foot but overall her shins and thighs had no hypersensitivity to light touch and no allodynia for which she was grateful. Claimant was found to have radicular symptoms in the right L5-S1 distribution with the absence of the right S1 reflex/Achilles reflex. Claimant had a positive straight leg raise on the right radiating to the right L5 and S1 distribution. Palpation of the right sinus tarsi caused burning in the third, fourth, and fifth metatarsals and toes on the right side. Dr. Ghazi provided the impression of: chronic postoperative radiculopathy especially involving the right L5 and S1 distributions; sympathetic mediated pain remarkably improved after a series of lumbar sympathetic blocks; and right ankle pain with evidence of neuritic discomfort in the nerves of the right sinus tarsi. Dr. Ghazi planned to do a right S1 transforaminal epidural steroid injection combined with a block to the nerves of the right sinus tarsi. See Exhibit 5.

14. On August 10, 2017, Dr. Ghazi performed a right S1 lumbosacral transforaminal epidural steroid injection and a right sinus tarsi injection. Claimant reported 100% anesthetic relief and was found to have appropriate vasodilation of her foot, resolved pain, and was pain free in the leg and foot/ankle. See Exhibit 5.

15. On August 18, 2017, Dr. Ghazi evaluated Claimant. Dr. Ghazi noted that Claimant was significantly improved after a right sinus tarsi injection combined with a right S1 transforaminal epidural steroid injection. Claimant reported the neuralgia in her right foot and her radicular symptoms in the right leg were better and Claimant displayed a

negative straight leg raise on the right lower extremity. On exam, Dr. Ghazi found marked vasodilation of the right foot symmetric with the left side and no pallor or coolness in the toes. Dr. Ghazi found the toes of the right lateral foot appearing to be more warm than the medial aspect of the foot and the contralateral leg. He found the right piriformis and gluteal muscles to be completely relaxed, soft and pliable on the right side versus the non injected left side where there was continued gluteal spasm and almost a tight clenching with inability to relax. Dr. Ghazi opined that Claimant was doing well following the injection with a negative straight leg raise, without any allodynia, and without sympathetic mediated abnormalities. He planned to repeat a platelet rich plasma injection in the left elbow and recommended continued massage therapy and home exercises. See Exhibit 5.

16. On September 1, 2017, Dr. Ghazi performed an impairment rating as requested by Dr. Lugliani. Dr. Ghazi noted that Claimant had lumbar radiculopathy status post her L5-S1 fusion, postoperative chronic neuritis and sympathetic mediated pain in the lower extremities consistent with CRPS, and postoperative radicular symptoms related partially to chronic radiculopathy but mostly related to sciatic neuralgia from chronic hypertonic spasm of the gluteal and piriformis muscles. Dr. Ghazi noted that the ratable impairments would be the lumbar disk herniation with fusion, which would include lumbar range of motion, range of motion for the left elbow lateral and medial epicondylar tears, and an impairment rating for CRPS. Dr. Ghazi noted that he would not rate the persistent radiculopathy and sciatica as that would be “double dipping” since they were already rating Claimant for the most severe cause of the neuralgia in the legs with was the CRPS. For the sympathetic mediated pain, vasomotor changes, Raynaud phenomenon, and the CRPS of the bilateral lower extremities including other neuritic complaints sciatic and postradicular, Dr. Ghazi provided a 5% impairment. For the left elbow epicondylar rating, Dr. Ghazi provided a 0% rating. For the lumbar rating with history of L5-S1 anterior/posterior fusion Dr. Ghazi provided a 21% whole person impairment. Dr. Ghazi opined that the final whole person impairment rating, combing the lumbar fusion and the neuralgia/CRPS would be 25% whole person. See Exhibit 5.

17. Dr. Ghazi made several recommendations for maintenance treatment for Claimant's pain management. Dr. Ghazi recommended follow up with him on an as needed basis with as needed facet injections and rhizotomies above the fusion, and as needed SI joint injections and/or rhizotomies below the fusion. Dr. Ghazi recommended repeat bilateral S1 transforaminal epidural steroid injections, repeated sciatic nerve blocks, and repeat lumbar sympathetic blocks on an as needed basis including sympathetic blocks to the feet. Dr. Ghazi recommended continued medications including NSAIDs, muscle relaxants, opioids, topical pain creams and patches, and neuropathic pain medications. Dr. Ghazi recommended follow up with Dr. Rauzzino for any complications related to the fusion. Dr. Ghazi recommended updated imaging of a lumbar MRI on average of once per year as well as one set of x-rays once per year to evaluate postsurgical stability. Dr. Ghazi recommended 12 visits of physical therapy per year and 12 visits per year of either massage or chiropractic. Dr. Ghazi recommended Botox injections to the buttocks up to three times per year. Dr. Ghazi also recommended platelet rich plasma injections for the left medial and left lateral epicondyle in the elbow as needed. Dr. Ghazi recommended maintenance include surgical treatment for the left elbow if

needed as well as updated MRI and/or ultrasound of the left elbow on average once per year. See Exhibit 5.

18. On September 7, 2017, Dr. Ghazi issued a letter to Insurer noting that he had completed the impairment rating for Claimant. He noted that he had rated the neuralgia specifically as CRPS since Claimant had significant vasomotor changes, Raynaud phenomenon, edema, color changes, and excellent diagnostic responses with sympathetic blocks. See Exhibit 5.

19. On November 2, 2017, Dr. Lugliani evaluated Claimant. Dr. Lugliani noted that Claimant had recently followed up with Dr. Ghazi and received an impairment rating of her back and elbow. Dr. Lugliani noted that Claimant was status post her second platelet rich plasma injection in the elbow. Claimant reported minimal improvement and persistent pain in the lateral aspect of the elbow worse with heavy lifting. Claimant reported that her low back pain was unchanged and was achy with persistent bilateral lower extremity numbness and tingling involving her bilateral feet. Dr. Lugliani assessed: status post lumbar decompression and fusion, at MMI and left elbow epicondylitis, stable, and at MMI. Dr. Lugliani noted that Claimant would be placed on permanent work restrictions of 15 pounds lifting. He opined that Claimant would have continued maintenance follow up with Dr. Rauzzino and Dr. Ghazi indefinitely for repeat injections, medication refills, imaging, and/or surgery if deemed necessary. Dr. Lugliani also recommended 1 year of follow up with Dr. Clinkscales for the left elbow in the event Claimant required surgery for the left elbow. Dr. Lugliani opined that Claimant was at MMI and discharged her from care. See Exhibits 5, I.

20. On November 7, 2017, Respondents filed a final admission of liability (FAL). Respondents admitted to a 25% whole person impairment rating with an MMI date of November 2, 2017. Respondents admitted to medical maintenance benefits per Dr. Lugliani's November 2, 2017 report. See Exhibit 3.

21. Claimant objected to the FAL and sought a DIME. Claimant requested the DIME physician evaluate the low back, both legs and hips, CRPS, and left elbow. See Exhibit L.

22. On March 2, 2018, NP Fresques evaluated Claimant. Claimant reported her pain usually was a 5/10 but was up to a 9/10 that day. NP Fresques found sensory deficits in Claimant's feet migrating up to the ankle area. He found some color changes and tactile changes as well. NP Fresques assessed lower extremity CRPS and recommended a trial of Nucynta. See Exhibit 5.

23. On March 20, 2018, Dr. Ghazi evaluated Claimant. Claimant reported a return of some sympathetic abnormalities with neuralgia, hyperesthesia, and vasomotor changes in her lower extremities. Claimant also reported diffuse pain complaints in her legs that were best relieved with bilateral lumbar sympathetic blocks. Claimant reported thoracic pain, cervical pain, and paresthesias in the upper extremities. Claimant reported diffuse body aches and myalgias. On examination, Dr. Lugliani found hyperesthesia

throughout the lower lumbar dermatomes at L5 and S1 throughout the shins, calves, and dorsum and plantar aspect of the feet with cold purplish toes on the left greater than right side. He found no hyperhidrosis and no abnormal hair growth. Dr. Lugliani found no SI joint loading pain and extension pain limited to the SI joints. Dr. Ghazi opined that Claimant was having some return of the vasomotor abnormalities in the lower extremities combined with paresthesias, coolness, pallor, hypothermia, and temperature/color changes. Dr. Ghazi opined that most of Claimant's pain was neuritic but noted that Claimant did not tolerate the anti-neuropathic pain medication very well. Dr. Ghazi discussed CBD oils and CBD salve with Claimant that were THC free and recommended a trial to help Claimant's neuropathic pain and sleep. Dr. Ghazi also planned to schedule Claimant for repeat bilateral lumbar sympathetic blocks x2 to be done back to back. Dr. Ghazi explained to Claimant that he was not treating her diffuse other areas of pain not related to the work injury and that he would be focusing on her work related injuries. See Exhibits 5, O.

24. On March 28, 2018, Bennett Machanic, M.D. performed a division independent medical examination (DIME). Claimant reported low back pain, bilateral leg pain, and difficulties with her left elbow. Claimant reported that her back fusion surgery helped a lot. Claimant reported that her back and her elbow both needed more help. Claimant reported low back pain bilaterally with radiation down to both legs that fluctuated. Claimant reported the pain radiated from her back, over her hips, then down the legs and that both legs were numb and tingly and her toes sometimes felt dead. Claimant reported that her legs and toes could jerk. Dr. Machanic reviewed medical records and performed a physical examination. See Exhibits 9, G, M.

25. Dr. Machanic noted that after Claimant's fusion surgery, Claimant reported 70% improvement but worsening sciatic like pain. He also noted Claimant's report after fusion surgery that her leg pain was 80% reduced and her back pain was 70% reduced. On examination, Dr. Machanic found decreased pin sensation over the lower extremities diffusely over the feet and distal limbs becoming full at the mid calves. He found temperature sensation at a 2/10 to a cold metal object over the feet and at a 10/10 over the thighs. Dr. Machanic saw no signs of shrinkage or swelling of the feet, allodynia, or hyperalgesia. Dr. Machanic found no asymmetry or focal abnormalities and no perspiration. Dr. Machanic found there were no signs of CRPS or classical causalgia on his examination. See Exhibits 9, G, M.

26. Dr. Machanic agreed with the prior physicians that Claimant reached MMI for her back on November 2, 2017. However, Dr. Machanic opined that Claimant's elbow was not at MMI. Dr. Machanic emphasized that he found no clinical evidence or even record evidence of the true presence of CRPS and did not feel Claimant had a true causalgia. Dr. Machanic opined that most of Claimant's pain was generated from the lumbosacral spine and agreed with Dr. Rauzzino that there was post-operative scarring and chronic arachnoiditis. He also noted on clinical exam, the possibility of a small fiber neuropathy with an unknown etiology but not related in any fashion to the January 2, 2014 work injury. Dr. Machanic also noted the description of restless leg syndrome which he opined could be indirectly due to the low back problems or the small fiber neuropathy, or

both. Dr. Machanic noted that Claimant had right S1 dysfunction with an absent ankle reflex and weakness of plantar flexion plus numbness in the S1 distribution intermixed with sensory loss in both legs and provided Claimant with a 2% loss of sensation rating, 2% loss of strength in the right lower extremity, equating to 2% whole person bring Claimant to a total rating of 24% whole person permanent partial impairment rating for the lower back. He opined that the back had reached MMI and that the consequences of the low back work injury had reached permanency. Dr. Machanic opined that ongoing treatment with Dr. Ghazi and Dr. Rauzzino could be appropriate. Dr. Machanic opined that he was somewhat baffled as to why sympathetic blocks would be continued as Claimant did not have CRPS and he suggested no further injections of that sort. He opined, however, that local pain blocks might be appropriate in the future based on the opinions of Claimant's physician. Dr. Machanic opined that the left elbow was not at MMI and recommended further follow-up for the elbow. See Exhibits 9, G, M.

27. On April 30, 2018, Dr. Lugliani evaluated Claimant. Claimant reported her symptoms were unchanged and that she had persistent left elbow pain at a 5/10 and persistent back pain that she rated at a 6/10 involving her low back with radiating symptoms down into her feet described as numbness and tingling. Dr. Lugliani assessed Claimant to be status post lumbar decompression and fusion and at MMI for the lower back. Dr. Lugliani referred Claimant for follow up for her ongoing left elbow pain and noted Claimant may require left elbow surgery. See Exhibits 5, H.

28. On June 5, 2018, Carlton Clinkscales, M.D. evaluated Claimant. Claimant reported she had two platelet rich plasma injections for her chronic left lateral epicondylitis since he saw her last and reported that the injections had helped. Claimant reported that her every day aching had stopped. Dr. Clinkscales noted that Claimant had done well with right lateral epicondylitis surgery but that the right was still sore, felt different, and that she was limited on the right to 15-20 pounds lifting even with surgery. Claimant reported that she did not want to consider surgery on the left. Dr. Clinkscales opined that based on the chronicity of Claimant's left epicondylitis symptoms, the failure of non-operative treatment, the previously good results with surgery on the right, left lateral condyle debridement could be considered. Dr. Clinkscales noted that Claimant declined surgery again as she had in the past. Dr. Clinkscales opined that he had nothing further to offer Claimant regarding her left lateral epicondylitis. He opined that Claimant could accept it as is, continue non-operative treatment, get a second opinion, or undergo the left lateral epicondyle surgery. After this follow up opinion where Claimant declined left elbow surgery, Claimant returned to the DIME physician. See Exhibits 5, K.

29. On August 14, 2018, Dr. Machanic performed a follow up DIME. Claimant reported that her back was about the same. Claimant reported that she decided not to undergo left elbow surgery. Claimant reported a recent fall which worsened her low back pain but that it was fairly stable before the fall. Dr. Machanic found a bruise over the right side of Claimant's lumbar spine and over her right upper arm from the fall. He was unable to demonstrate any vasomotor or sympathetic changes in Claimant's legs and noted that his back and leg exam was very close to the exam he did previously. He found a change

in the elbow range of motion with additional lost range of motion compared to his prior exam. See Exhibits 9, M, N.

30. Dr. Machanic opined that Claimant had reached MMI in regards to both her lower back, her radicular symptoms, and her ongoing left elbow issues. He opined that MMI was reached on June 5, 2018. Dr. Machanic opined that the prior rating he did on the lumbar spine impairment was the same and included Claimant's S1 radiculopathy on the right and remained at 24% whole person. He opined that the left elbow was at a rating of 5% upper extremity, 3% whole person. Dr. Machanic noted that Claimant did have chronic low back pain and recommended that if there were exacerbation of symptoms over the lumbosacral spine perhaps one to two weeks of physical therapy in a pool be performed. He opined that an ongoing pool exercise in a health club setting or independently would be advised to maintain stability of the lumbar spine in view of the chronic pain issues and Claimant's post-operative lumbosacral arachnoiditis and scarring. He opined that it was not CRPS. He suggested additional PRP injections for the elbow pain and suggested one additional PRP injection for the elbow with Dr. Ghazi. Dr. Machanic opined that if the additional elbow PRP injection provided benefit, then Dr. Ghazi should provide a rationale for future treatment in that regard. Dr. Machanic opined that there was no indication for lumbar sympathetic blocks. The maintenance benefits recommended thus were pool exercise, and one PRP injection in the elbow. See Exhibits 9, M, N.

31. On August 17, 2018, Respondents filed another FAL. Respondents admitted to a whole person impairment of 24% and a scheduled impairment of 5% left upper extremity. Respondents admitted to medical maintenance benefits per Dr. Machanic's August 14, 2018 report. See Exhibit 3.

32. On August 31, 2018, Dr. Ghazi evaluated Claimant. Dr. Ghazi noted that Claimant had not had any steroid injections for one year and that her lower extremity pain had been controlled with a series of lumbar sympathetic blocks. Dr. Ghazi noted, unfortunately, that Dr. Machanic performed a DIME and opined that sympathetic blocks were not indicated and opined that Claimant did not have CRPS. Dr. Ghazi disagreed and opined that Claimant clearly had sympathetic mediated abnormalities. Dr. Ghazi noted that Claimant had vasomotor instability including blue toes, Raynaud type phenomenon with toes going from hot red to white to blue within minutes, multiple episodes of brittle toenails with three episodes of toenail loss after becoming brittle, intermittent edema, erythema, and thermal asymmetry. Dr. Ghazi noted that Claimant had responded positively to sympathetic blocks with marked vasodilation, increased temperature, and increased improvement in her symptomatology. Dr. Ghazi opined that Claimant met the Budapest criteria for CRPS and disagreed with the DIME. Dr. Ghazi noted that Dr. Machanic recommended thermography and QSART testing for CRPS and noted he would get that done as soon as possible. Claimant wanted to proceed with epidural steroid injections bilaterally since the lumbar sympathetic blocks were denied and reported that she had been having numbness, tingling, cramping, and instability with multiple falls where her big toe goes into extension and her other toes go into flexion causing her to be unstable. On examination, Dr. Ghazi found Claimant's toenails to be

at 75% regrowth. He found her toes to be pale and white at the tips and her feet to be several degrees cooler from the mid arch to the tips of the toes bilaterally, worse on the right foot. Dr. Ghazi also found hyperesthesia to light touch on the left foot and on the dorsum and plantar aspect of the left foot. Claimant had a positive straight leg raise shooting into the plantar aspects of both feet. Dr. Ghazi provided the impression of: failed back syndrome with history of L5-S1 fusion with a stable fusion but persistent lower extremity pain likely due to a combination of arachnoiditis, chronic post decompression radiculopathy, and sympathetic mediated pain; CRPS of the bilateral lower extremities after treating the patient for several years and documenting multiple episodes of edema, vasomotor instability, severe temperature drops in the tips of the toes, Raynaud phenomenon, loss of toenails, brittle toenails, and positive responses to multiple sympathetic blocks; and left elbow pain. Dr. Ghazi planned to request bilateral transforaminal epidural steroid injections for bilateral S1 radiculopathy, deferral of a left elbow platelet rich plasma injection, and a QSART and thermogram test to evaluate bilateral lower extremity CRPS. See Exhibit 5.

33. On October 25, 2018 and November 8, 2018, Dr. Ghazi performed S1 transforaminal epidural steroid injections. Claimant reported 100% relief of the neuralgia and pain in both legs following the injections. See Exhibit 5.

34. On November 30, 2018, Janet Stansbury, certified massage therapist, wrote a letter. Ms. Stansbury indicated that Claimant had been a medical massage client of hers since February of 2016. Ms. Stansbury observed Claimant losing toe nails three times, Claimant's hands and feet turning blue, Claimant's legs and feet cramping, and Claimant have enough pain that she could not bend over or stand up straight. Ms. Stansbury also observed Claimant to report migraines and observed muscle spasms in Claimant's back and glutes. Ms. Stansbury noted that Claimant continued to have all those symptoms and continued to have cramps in the legs and feet during every session. Exhibit 8.

35. On December 7, 2018, Dr. Ghazi evaluated Claimant. Claimant reported that following the bilateral S1 transforaminal epidural steroid injections, her legs were doing great with 100% resolution of the nerve burning and paresthesia. Claimant reported, however, that she still had tightness and vasomotor changes including temperature, cold, purple, and pale toes and feet. Claimant noted that she had lost the toenails from her feet for the third time. Claimant reported that although the burning pain in her legs was gone, she still had persistent vasoconstriction and pallor and wanted to have repeat sympathetic blocks. On examination, Dr. Ghazi found cold, pale toes bilaterally with toenails showing signs of regrowth. Dr. Ghazi also found marked vasoconstriction and coolness in the feet bilaterally. Dr. Ghazi provided the impression of: bilateral S1 radiculopathy with resolution of radicular neuralgia in the legs following epidurals at S1; CRPS/sympathetic mediated changes in the bilateral lower extremities including Raynaud phenomenon, vasoconstriction, pallor, and repeated loss of toenails; and sympathetic dysregulation with marked vasoconstrictions in the lower extremities, also known as Raynaud phenomenon versus CRPS that responds temporarily to sympathetic blocks. Dr. Ghazi planned to request repeat sympathetic blocks. Dr. Ghazi

heartily disagreed with Dr. Machanic's opinion that it was not CRPS given Claimant's lost toenails, vasoconstriction, thermal asymmetry, temperature changes, and color changes. Dr. Ghazi noted that he had ordered QSART and thermography back in August but that the tests had not been authorized or completed. Dr. Ghazi opined, however, that Claimant's issues responded to sympathetic blocks and therefore he considered Claimant to have CRPS. Dr. Ghazi planned to refer Claimant to Dr. Ament for consultation regarding CRPS and vasculopathy and also to Dr. Schneider for sciatica sacroilitis and CRPS/Raynaud-type changes and neuritis. See Exhibit 5.

36. On December 20, 2018, NP Fresques evaluated Claimant. Claimant reported up to 70% relief on the left side following bilateral S1 transforaminal epidural steroid injections that she underwent in November. Claimant reported that she was doing well but chiropractic treatment aggravated her symptoms. NP Fresques noted that Claimant had elements of CRPS with tactile and color changes in the lower extremities and that Claimant had lost her toenails on three different occasions. NP Fresques opined that work comp guidelines should cover diagnostic thermography and/or QSART testing. Following this visit, Dr. Ghazi requested authorization for repeat bilateral lumbar sympathetic blocks. See Exhibit 5.

37. On December 27, 2018, Insurer denied Dr. Ghazi's request for bilateral lumbar sympathetic blocks. See Exhibit 5.

38. On January 22, 2019, NP Fresques evaluated Claimant. Claimant reported that she was overall much improved following the bilateral S1 epidural injection in November. Claimant reported a pain level of 6/10. NP Fresques noted that Claimant continued with CRPS symptoms in her lower extremities, right greater than left and had responded to past sympathetic blocks. NP Fresques noted that Dr. Machanic suggested Claimant's symptoms were not consistent with CRPS and NP Fresques opined that Claimant would be an excellent candidate for thermography and/or QSART testing for diagnosis of CRPS. On examination, NP Fresques found some slight discoloration of the right foot and some tactile changes. He assessed low back pain with radicular symptoms, S1 dermatome; history of L5-S1 fusion; and CRPS, lower extremities. See Exhibit 5.

39. Claimant filed an Application for Hearing endorsing the casual relationship of CRPS to her January 2, 2014 work injury. Claimant seeks a determination that DIME physician Dr. Machanic was incorrect in opining that she does not suffer from CRPS and seeks further medical maintenance treatments including ongoing sympathetic block injections as needed to maintain her condition.

40. Claimant testified at hearing that following her lumbar spine fusion surgery, she had a cluster of unusual symptoms in her lower extremities. She testified that her legs cramped, her toes curled uncontrollably, her feet and legs turn colors, and that on three occasions her toenails had fallen off and regrown. Claimant testified that the injections from Dr. Ghazi had helped reduce her symptoms and bring her pain down and that the temperature in her feet would return to normal following an injection.

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. *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 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).

Overcoming DIME opinion

Under the statute MMI is primarily a medical determination involving diagnosis of the claimant's condition. *Berg v. Industrial Claim Appeals Office*, 128 P.3d 270 (Colo. App. 2005); *Monfort Transportation v. Industrial Claim Appeals Office*, 942 P.2d 1358 (Colo. App. 1997). A determination of MMI requires the DIME physician to assess, as a matter of diagnosis, whether various components of the claimant's medical condition are causally related to the industrial injury. *Martinez v. Industrial Claim Appeals Office*, 176 P.3d 826 (Colo. App. 2007). Thus, a DIME physician's findings concerning the diagnosis of a medical condition, the cause of that condition, and the need for specific treatments or diagnostic procedures to evaluate the condition are inherent elements of determining

MMI. Therefore, the DIME physician's opinions on these issues are binding unless overcome by clear and convincing evidence. See *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002).

The party seeking to overcome the DIME physician's finding regarding MMI bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, *supra*. Clear and convincing evidence is that quantum and quality of evidence which renders a factual proposition highly probable and free from serious or substantial doubt. Thus, the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician's finding concerning MMI is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). The question of whether the party challenging the DIME physician's finding regarding MMI has overcome the finding by clear and convincing evidence is one of fact for the ALJ.

Dr. Machanic, the DIME physician, opined that Claimant does not suffer from CRPS and opined that Claimant did not need any treatment, including maintenance treatment of sympathetic blocks, for that condition. Dr. Machanic did not recommend or request additional testing such as QSART or thermogram. Rather, he opined that the sympathetic blocks should not be done or approved since Claimant did not suffer from work related CRPS. This causal opinion was inherent in Dr. Machanic's overall determination on MMI and must be overcome by clear and convincing evidence. Claimant has met her burden to overcome the opinion that she does not have a diagnosis of CRPS and does not need any treatment or procedures for CRPS by clear and convincing evidence.

The medical records above establish by clear and convincing evidence that Dr. Machanic erred in his opinion that Claimant does not suffer from CRPS. Claimant, as found above, has had significant symptoms consistent with CRPS following her lumbar spine fusion surgery. Claimant's testimony is credible and persuasive. The reports of Dr. Ghazi, Claimant's massage therapist, and NP Fresques are consistent in symptoms and signs of CRPS that have been identified and documented over the past several years. Claimant responded positively to sympathetic blocks, helping to confirm the CRPS diagnosis. Thermogram and QSART testing are not necessary as Claimant's response to the sympathetic blocks combined with her symptoms observed by multiple providers, confirms by clear and convincing evidence that she has the diagnosis of CRPS. Claimant, is not challenging her MMI date and she remains at MMI as of June 5, 2018. Claimant, however, has established by clear and convincing evidence that CRPS is a work related diagnosis and that she remains in need of "as needed" sympathetic blocks to manage and maintain her work related CRPS condition. Claimant has established by clear and convincing evidence that CRPS is casually related to her work injury and Claimant is therefore entitled to reasonable and necessary medical maintenance benefits including sympathetic blocks to maintain her CRPS condition and prevent deterioration.

Disfigurement

If Claimant has sustained serious permanent disfigurement to areas of the body normally exposed to public view, Claimant is entitled to additional compensation. § 8-42-108(1),(2) C.R.S. As found above, Claimant's lumbar fusion surgery required entry both on her lower abdomen and on her back and was a two part procedure. Claimant has scarring from three scars totaling approximately 17 inches in length that remain discolored from her normal skin tone despite adequate time for healing. Insurer shall pay Claimant additional compensation in the amount of \$4,250 pursuant to § 8-42-108(1)C.R.S. for her disfigurement.

ORDER

It is therefore ordered that:

1. Claimant has overcome by clear and convincing evidence DIME physician Dr. Machanic's opinion on the casual relationship of CRPS to this claim. Claimant has CRPS, casually related to her work injury.
2. Claimant remains at MMI but has established an entitlement to reasonable and necessary medical maintenance benefits for her work related CRPS, including sympathetic blocks.
3. Claimant has established an entitlement to an award for disfigurement in the amount of \$4,250.00.
4. 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: March 12, 2019

/s/ Michelle E. Jones

Michelle E. Jones
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, CO 80203

ISSUES

- I. Has Claimant proven by a preponderance of the evidence that he sustained an injury arising out of and in the course and scope of his employment?
- II. If compensable, did Claimant's conduct constitute a willful failure to follow the employer's reasonable safety rules, violating C.R.S. 8-42-112(1)(b)?

STIPULATIONS

- A. The parties stipulated that Claimant's average weekly wage is \$2,403.84
- B. The parties stipulated that if this claim is compensable, the Claimant is entitled to TTD from July 1 – July 15, 2018.
- C. If compensable, the parties agree that medical treatment at Good Samaritan Hospital and from Dr. Koldenhoven through October 3, 2018 is authorized, reasonable, and necessary.

FINDINGS OF FACT

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

1. Claimant's date of birth is January 18, 1958. He has worked as a Physician's Assistant ("PA") for 17 years. Claimant commenced employment for the Employer as a PA on April 23, 2018. Employer is an urgent care and family practice medical office. Claimant worked in the family practice office. The Claimant had previously worked with Dr. Veras for three years at a different clinic and considered him a friend. He and Dr. Veras joined the Employer at the same time. [p. 20-21]
2. Claimant's job description provides that as a PA, he is responsible for direct patient care and other administrative duties, as designed by the Medical Director in accordance with the Colorado Medical Practice Act. Claimant is required to use sound medical judgment, know limitations, seek and consult when advisable, and advise administration of any issues that may impact the practice. Claimant is required to communicate through appropriate channels. [RS 13-17]
3. The Claimant agreed that his primary duty as a physician's assistant was patient care. The Claimant was also responsible for answering questions and doing consultations with staff, planning and teaching in-services as directed, and following medical protocol handouts and clinical standards. The Claimant is required to use sound medical judgment. [p. 32]

4. On June 27, 2018, at the end of the workday, Dr. Veras' keys became locked in his office. Claimant had completed his patient care for the day. Claimant did not speak with Dr. Veras or know where he was, but testified that he was concerned that Dr. Veras would need his vehicle keys to get home. [p. 23, 33]
5. Unbeknownst to anyone, Claimant unilaterally determined that he would attempt to access Dr. Veras' office. Claimant decided that he would get a six-foot ladder and attempt to climb the ladder in the massage therapy room adjacent to Dr. Veras' office, remove a ceiling tile, climb through the ceiling crawlspace, drop into Dr. Veras' office and unlock the door.
6. Unbeknownst to anyone, Claimant did get a six-foot ladder and climbed up the ladder and removed various ceiling tiles before finding an area in the massage therapy room that provided access to Dr. Veras' office. Claimant climbed higher up the ladder and went up into the crawlspace in the ceiling. He then removed the ceiling tile that went into Dr. Veras' office. Once the ceiling tile in Dr. Veras' office was removed, Claimant then tried to lower himself into Dr. Veras' office.
7. While trying to lower himself into Dr. Veras' office, Claimant experienced difficulty. He lost his footing and fell awkwardly into Dr. Veras' office, sustaining the injuries that give rise to this claim, a Grade 3 distal tibia and fibula fracture. [p. 25-28] [RS 61]
8. Claimant did not know where Dr. Veras was and had not spoken to him before attempting to climb through the ceiling. Nobody asked Claimant to engage in this conduct, and he had not obtained permission or consent from his employer to engage in the activities that led to his injuries. Nobody at the clinic knew what Claimant was doing. [p. 33-34] He did not check with anyone at the office to see what steps were being taken to access Dr. Veras' office, such as looking for keys, calling a locksmith, or taking any other steps to get into the office. [p. 60]
9. Claimant agreed that there was nothing in his job description that was remotely close to climbing up ladders and climbing through crawlspaces in ceilings and then dropping into offices for any purpose – let alone to retrieve a co-employee's personal items. [p. 39]
10. Maggie Ward was employed as a radiology technician for the Employer on June 27, 2018. When Ms. Ward became aware that Dr. Veras' office was locked, she attempted to access the office by first looking for keys and then trying to pry the office door open with a credit card. [p. 46] These attempts were unsuccessful. Ms. Ward then obtained Employer authorization to contact a locksmith. She called a locksmith and advised other employees, including Claimant, that a locksmith was on the way. This occurred prior to Claimant's accident. [p. 47-48]
11. Claimant acknowledged Employer was and is safety-conscious, it checked all the boxes when it came to safety, and employees were required to report unsafe practices. Claimant acknowledged receipt of the Employee Handbook and agreed to abide by the policies and procedures set forth in the Handbook. [RS 61] The Employee Handbook provided, *inter alia*, that safety must come before all other concerns [RS 36] and that "under no circumstances are employees

allowed to place themselves at risk to fulfill business needs.” [p. 36, 37] The Claimant acknowledged that safety enforcement had been explained to him, that he knew how to locate safety policies, and that he would abide by these policies. [RS 82,83]

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

For an injury to be compensable under the Act, it must “arise out of” and “occur within the course and scope” of employment. Section 8-41-301(1), C.R.S.; *Price v. Industrial Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996); *Panera Bread, LLC v. Industrial Claim Appeals Office*, 141 P.3d 970 (Colo. App. 2006); *Orist v. G4S Solutions*, (ICAO, August 17, 2012) (W.C. 4-886-126). An injury occurs “in the course of” employment where Claimant demonstrates that the injury occurred within the time and place limits of his employment. *Popvich v. Irlando*, 811 P.2d 379 (Colo. 1991). The “arising out of” requirement is narrower and requires Claimant to show a causal connection between the employment and injury such that the injury has its origins in the Employer’s work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *Triad Paining Co. v. Blair*, 812 P.2d 638 (Colo. 1991). An employee’s activities must be sufficiently incidental to the work itself as to be properly considered as arising out of and in the course and scope of employment. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). An activity arises out of and in the course and scope of employment when the activity is sufficiently related to the conditions and circumstances upon which the employee generally performs job functions such that the activity may reasonably be characterized as an incident of employment. *Price v. ICAO*, 919 P.2d 207 (Colo. 1996). There is no presumption that an injury which occurs in the course of employment, arises out of the employment. *Finn v. ICAO*, 165 Colo. 106, 437 P.2d 542 (Colo. 1968).

If an employee substantially deviates from the mandatory or incidental functions of his employment, however, then the injury is not compensable. *Kater v. Industrial Commission*, 728 P.2d 746 (Colo. App. 1986). When an employer asserts that employees should not be compensated because they have deviated from the conditions and circumstances of employment, the issue is whether the activities that caused the injuries deviated from employment in a manner that removed those activities from the employment relationship. *Phillips Contracting, Inc. v. Hirst*, 905 P.2d 9, 12 (Colo. App. 1995). As a general rule, substantial deviations curtail coverage, while minor deviations do not. *Kelly v. ICAO*, 214 P.3d 516, 518 (Colo. App. 2009).

In *Lori’s Family Dining v. ICAO*, 901 P.2d 715 (Colo. App. 1995), the Colorado Court of Appeals announced a four-part test to be applied when applying whether horseplay constitutes a deviation: (1) the extent and seriousness of the deviation; (2) the completeness of the deviation, i.e., whether it was comingled with the performance of a duty or involved in an abandonment of duties; (3) the extent to which the practice of horseplay has become an accepted part of the employment; and (4) the extent to which the nature of the employment may be expected to include some horseplay. See also, §8-40-201(8), C.R.S.

No single factor is determinative, and the Claimant need not prove the existence of every factor in order to establish compensability. The first two factors have been held to be more critical than the third and fourth, which “may be viewed merely as specific methods of proving that a claimant’s actions became part of the employment.” *Panera Bread, LLC v. Industrial Claim Appeals Office*, *supra*. Resolution of the issue is one of fact determination by the ALJ. See, *Schrieber v. Brown & Root, Inc.*, 888 p.2d 274, 277 (Colo. App. 1993).

The Claimant has failed to prove by a preponderance of the evidence that the injuries he sustained which give rise to this claim, arose out of and in the course and scope of his employment. The Claimant is a physician's assistant. His job duties as testified to, and as described in the job description, show that the Claimant's primary duties include direct patient care, following medical protocols, and clinical standards in accordance with the Colorado Medical Practice Act. The Claimant is required to use sound medical judgment, know limitations, seek consult when advisable, and advise administration of any issues that impact the practice. It is undisputed that the Claimant's conduct constituted a substantial deviation from his job functions. The Claimant admits that the activity that he was engaged in, which led to his injury was not remotely close to his job requirements. The Claimant engaged in these activities without the knowledge or consent of his Employer or any of his co-employees at the clinic, and without regard to the fact that a locksmith had been called to access Dr. Veras' office. Even if Claimant had no knowledge that a locksmith had been called, he engaged in the conduct that gave rise to his injuries without checking to see if any alternative measures were being taken to access Dr. Veras' office. Moreover, no one asked Claimant to help unlock the door and no one specifically, or even tacitly, allowed him to undertake unlocking the door in any manner-let alone the extreme and dangerous manner undertaken by Claimant.

Here, there were no specific benefits which flowed to the Employer from Claimant's conduct. Claimant was attempting to do a personal favor for a co-worker and the favor was unsolicited and involved a substantial and complete deviation from his employment. Claimant's actions did not involve patient care and in no way reflected his job duties as a physician's assistant. Claimant was not responding to an emergency situation; he simply took it upon himself to risk his personal safety from which his employer derived no benefit. Claimant's actions were not a slight deviation from his job duties but a substantial and complete deviation. The consequences of Claimant's conduct, climbing up a ladder, removing ceiling tile, and then climbing through a ceiling crawlspace and attempting to drop into another office to try and obtain car keys for a co-employee, far outweigh any benefits to his employer as can be seen from the resulting accident and Claimant's injuries.

Therefore, Claimant has failed to establish by a preponderance of the evidence that the injuries he sustained which give rise to this claim, arose out of and in the course and scope of his employment.

ORDER

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

1. Claimant's claims for benefits are denied and dismissed.
2. Consequently, all other issues are moot.

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: March 14, 2019

/s/ Glen B. Goldman _____

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

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 5-030-198-003**

ISSUES

1. Whether Claimant is entitled to temporary total disability (TTD) benefits from September 11, 2017 through October 11, 2017.
2. Whether Claimant has established by a preponderance of the evidence that a left elbow EMG and a left elbow MRI are reasonable, necessary, and causally related medical benefits for his October 27, 2016 work injury.

FINDINGS OF FACT

1. Claimant was employed by Employer as an electrician and sustained an electrocution injury on October 27, 2016.
2. Claimant was up on a ladder approximately 4 feet when someone walked in who could not see Claimant and hit a light switch while Claimant was working with 270 volts. The electrocution was significant and Claimant was able to move his feet off the ladder to fall, which disengaged him from the electricity. Before falling off the ladder, Claimant was pinned in place with a wicked titanic contraction of muscle. Claimant had significant entry and exit wounds from the electrocution.
3. As a result of the electrocution and fall from the ladder, Claimant injured multiple body parts. In his initial evaluations with Philip Findler, M.D., Robert Dixon, M.D., and John Woodward M.D. from November, 2016 through January, 2017, Claimant had multiple complaints but did not mention left elbow symptoms or left elbow deformity as one of his complaints. See Exhibits J, K, L.
4. On January 2, 2017, Douglas Scott, M.D. performed an independent medical examination. Dr. Scott noted that Claimant probably had injury to the tissues in his right arm, right shoulder, right upper chest quadrant, left upper chest quadrant, left shoulder, and left arm as was the probable course of the electrical current as it passed through Claimant's body. See Exhibit G.
5. On January 4, 2017, John Reister, M.D. evaluated Claimant. Dr. Reister recommended surgery to repair Claimant's right shoulder and recommended fixation of the near-complete subscapularis tear and subluxated biceps tendon with right shoulder arthroscopy. A request for surgery authorization was sent on January 11, 2017. See Exhibits 1, I, L.
6. On January 17, 2017, Dr. Scott performed a Rule 16 Utilization Medical Review to address whether the right shoulder surgery recommended by Dr. Reister was

reasonable, necessary, and related to the October 27, 2016 work injury. Dr. Scott concluded that it was and recommended the surgery. See Exhibit G.

7. The shoulder surgery was scheduled for February 17, 2017. On February 7, 2017 Claimant called and cancelled the surgery. Surgery was then rescheduled for April 17, 2017. Claimant again called and cancelled the surgery. Surgery was then rescheduled once again for May 5, 2017. Claimant cancelled the May 5, 2017 surgery.

8. During this period of time, Claimant moved several times. Claimant no longer resides in Colorado.

9. On September 11, 2017, ALJ Goldman issued an Order finding that Claimant's actions in moving so often and cancelling multiple scheduled surgeries was tantamount to a refusal to submit to the right shoulder surgery which was a reasonably essential surgery to promote Claimant's recovery. ALJ Goldman found an opinion from Dr. Scott that the delay in getting the surgery may be making Claimant's underlying shoulder condition worse credible. ALJ Goldman found that Claimant's refusal to undergo surgery was an injurious practice imperiling and retarding Claimant's recovery. See Exhibits 4, F.

10. ALJ Goldman's September 11, 2017 Order provided that Respondents may suspend Claimant's temporary total disability (TTD) benefits as of the date of the Order. It required Respondents to reinstate TTD benefits as of the date Claimant underwent the recommended right shoulder surgery. ALJ Goldman noted that benefits may be reduced or suspended if a Claimant persisted in injurious practice tending to imperil or retard recovery or refused to submit to surgical treatment reasonably essential to promote recovery. ALJ Goldman found that happened in this case and that suspension of TTD was appropriate per § 8-43-404(3), C.R.S. See Exhibits 4, F.

11. Consistent with ALJ Goldman's Order, Respondents suspended TTD benefits as of September 11, 2017. Claimant finally underwent the recommended right shoulder surgery on October 12, 2017 with Dr. Reister. Respondents reinstated TTD benefits on October 12, 2017. See Exhibit F.

12. On October 25, 2017, Dr. Reister evaluated Claimant. Dr. Reister noted that this was the first visit following the surgery for subscapular repair and biceps tenodesis. Dr. Reister noted that Claimant had a very easy to fix subscapular tendon but a terrible biceps. Dr. Reister noted physical therapy would not start until six weeks post surgery and provided Claimant with a physical therapy script to find a therapy center as Claimant was residing in Nevada. Dr. Reister noted Claimant was doing very well at the first post-op visit. See Exhibit 1.

13. On January 3, 2018, Dr. Reister evaluated Claimant. Dr. Reister noted that Claimant was around 10 weeks out from his surgery and that his right shoulder was improving. Overall, Dr. Reister found improved motion, strength, and forward progress and recommended Claimant continue his therapy. Dr. Reister noted that Claimant's other

injuries from the same accident included the left shoulder, which was not as symptomatic as the right shoulder but had been symptom producing all along and had been treated with physical therapy. Dr. Reister noted that an MRI showed low-grade partial tears in the left shoulder rotator cuff as well as mild bursal symptoms. Dr. Reister also noted that Claimant's exam had been classic for bursitis and impingement and that Claimant was now ready to deal with the left shoulder since his right shoulder was improving and the left shoulder was now becoming the more symptomatic shoulder. Dr. Reister noted that Claimant had failed conservative management for bursitis and partial cuff tear of the left shoulder and opined that the next step for the left shoulder would be to do an EUA arthroscopy with sub acromial decompression and thorough inspection. Dr. Reister noted the challenges in getting Claimant care in Denver while Claimant was living in Nevada. Dr. Reister noted that they would try to get Claimant into the operating room for the left shoulder. See Exhibits 1, H, L.

14. On January 4, 2018, Dr. Reister sent a request for authorization for the left shoulder surgery. On January 15, 2018, Dr. Scott issued a Rule 16 Utilization Medical Review report where he opined that the left shoulder surgery was not reasonable, necessary, or causally related to the October 27, 2016 work injury. Dr. Scott opined that the left shoulder symptoms were a result of congenital type II acromion, chronic degenerative tendinosis/bursitis, and bony osteoarthritis. See Exhibit H.

15. On May 30, 2018, Dr. Scott issued a medical records review report. Dr. Scott opined that left shoulder surgery recommended by Dr. Reister was not reasonable or necessary and that it was not indicated to treat the effects of Claimant's October 27, 2016 injury. See Exhibit G.

16. On August 30, 2018, Dr. Reister evaluated Claimant. Dr. Reister noted that it was the first time he had seen Claimant in seven months. Claimant reported that his right shoulder was significantly better than before. On examination, Dr. Reister found the subscapular tendon to be healed. Claimant reported that he had left shoulder pain and that he had numbness, tingling, odd sensation in his hands, and spasms in the hands. Claimant reported that he could only write for maybe 20 minutes before his hands went weak and numb and that he dropped things on a regular basis. Claimant reported that these symptoms were not present prior to the injury. Dr. Reister noted that an MRI had been done on the left shoulder a month after the injury that had some findings. Claimant reported difficulty in getting the left shoulder associated with the work comp injury so that Dr. Reister could try an arthroscopy evaluation, debridement, and decompression. See Exhibits 1, H, I.

17. Dr. Reister noted that Claimant brought to his attention for the first time a deformity at the left elbow. Dr. Reister opined that Claimant had classic stigmata of a distal bicep tendon tear and gross loss of supination strength in the left side. Dr. Reister opined that this would be 2 years out from the injury in 2 months' time and that it unfortunately was very unlikely to be repaired successfully with surgery. However, Dr. Reister noted it was appropriate to document the injury, the level of the tendon retraction, and would be worth seeing with a hand surgeon whether allograft reconstruction was

possible. Dr. Reister recommended an EMG/NCV of the bilateral upper extremities to see if Claimant had any stigmata of electrocution or permanent nerve injury. Dr. Reister also requested Claimant's left elbow be evaluated since Claimant would have a permanent deformity and permanent loss of some strength in supination. Dr. Reister continued to recommend left shoulder surgery with a scope decompression, debridement of the labrum and partial-thickness tears, and a good look at the subscapular. See Exhibits 1, H, I.

18. On the Physician's Report of Worker's Compensation Injury form, undated, but date stamped as received from Respondents on September 17, 2018, Dr. Reister noted the treatment plan included an MRI of the left elbow and an EMG/NCV of the bilateral upper extremities. See Exhibit 1.

19. On September 4, 2018, Dr. Reister requested authorization for an MRI of the left elbow as well as for bilateral EMG/NCV studies of the upper extremities. See Exhibits 1, H.

20. In the meantime, after the request was made for a left elbow MRI and bilateral EMG/NCV testing of the upper extremities, and on September 7, 2018, ALJ Spencer issued an Order requiring Respondents to cover the left shoulder arthroscopic surgery recommended by Dr. Reister. See Exhibit D.

21. On September 11, 2018, Respondents responded to the request from Dr. Reister for left elbow MRI and bilateral upper extremity EMG/NCV testing. Respondents denied the request for left elbow MRI but approved the authorization request for bilateral upper extremity EMG/NCV testing based on a Rule 16 Utilization Medical Review performed on September 11, 2018 by Dr. Scott. See Exhibit H.

22. Dr. Scott opined that considering the possible long-term sequelae of electrocution injuries with entry in the right hand and exit in the left hand, he recommended the EMG/NCV studies of the bilateral upper extremities to rule out mono versus poly neuropathy. Dr. Scott noted that Claimant had a history of type II diabetes and was on Metformin medication and that the testing should be done by a neurologist. Dr. Scott opined that given the lack of complaint in the medical record of left elbow pain, left elbow dysfunction, or left elbow deformity related to a possible distal biceps tendon tear, and considering that the deformity complaint was made 22 months after the electrocution accident, the request for left elbow MRI should be denied as not indicated and/or necessary to treat the October 27, 2016 accident. Dr. Scott opined that the left elbow issues should have manifested sooner than 22 months post-injury. Dr. Scott noted that Claimant, Dr. Reister, and the physical therapist did not make any mention of the left elbow issues before August of 2018. See Exhibit H.

23. On October 16, 2018, neurologist Marc Triehaft, M.D. evaluated Claimant and performed EMG testing. Claimant reported that he had sudden spasms in his hands 1-3 times per month where he suddenly loses strength and his hands open involuntarily causing him to drop objects. Claimant denied numbness and tingling in his hands.

Claimant reported that he had been followed for two years for diabetic peripheral neuropathy and had undergone several shoulder procedures for injuries sustained in the work related accident. Dr. Trieft noted that the EMG studies had been approved by Insurer and that they revealed severe bilateral carpal tunnel syndrome and a left ulnar neuropathy at the elbow. Dr. Trieft opined that the finding of left ulnar neuropathy at the elbow shown by EMG was compatible with mono neuropathy multiplex and was more likely related to diabetes than to the electroshock injury. Dr. Trieft opined that disorders associated with electrocution injury were not identified in Claimant's upper extremities. He opined that the disorders associated with electrocution injury included peripheral neuropathies, sympathetic neuropathies, and CRPS. Dr. Trieft opined that the episodic and fleeting hand spasms and weakness was of undetermined etiology but raised the question of spinal cord injury involving the cervical or thoracic regions from the electrocution. Dr. Trieft recommended cervical and thoracic MRI studies and neurological follow up afterwards. See Exhibit N.

24. On October 18, 2018, Claimant underwent a left shoulder arthroscopy performed by Dr. Reister with labral debridement, bicipital tenotomy, subscapularis tendon debridement, open sub acromial decompression, repair of supraspinatus tendon, and bicipital tendon tenodesis. See Exhibits 1, I.

25. On October 30, 2018, Dr. Reister evaluated Claimant. Dr. Reister noted that Claimant's wounds looked great, that Claimant was doing very well, and that Claimant could begin therapy four weeks post surgery. Dr. Reister noted that claimant was living out of state and provided Claimant with his physical therapy script. On the October 30, 2018 Physician's Report of Worker's Compensation Injury form, signed by Dr. Reister, Dr. Reister noted that the treatment plan included physical therapy starting in 4 weeks and that Claimant had a current restriction of no use of left arm. Dr. Reister recommended a return appointment in 4 weeks and recommended follow up care of referral for evaluation of low back pain. Dr. Reister did not recommend an MRI or an EMG at this visit. See Exhibits 1, I.

26. Dr. Scott testified at hearing. Dr. Scott opined that Claimant had no deformity in his left elbow or left elbow complaints until August of 2018, almost two years following the October, 2016 injury. Dr. Scott opined that the left elbow problems were not work related. Dr. Scott opined that he believed the left upper extremity EMG testing should have been approved to check the nerves in Claimant's arms and the electrical activity in Claimant's muscles. Dr. Scott noted that the EMG was done on October 16, 2018 and showed that diabetes was the more likely cause than electrical shock. Dr. Scott opined that diabetes can lead to reduced blood flow to nerves which damages the nerves and leads to conduction/electrical problems with the nerves. He opined that the EMG showed that the problems Claimant was having in the left elbow were due to Claimant's diabetes. Dr. Scott opined that if the problems had been acutely caused by the work injury, the symptoms would have manifested earlier in treatment and he recommended denial of the left elbow MRI.

27. Claimant did not testify or appear at hearing. Claimant's counsel requests TTD benefits from September 11, 2018 through October 12, 2018 and requests authorization of a left elbow MRI and left upper extremity EMG.

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. *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 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).

TTD Benefits

Claimant has failed to establish, by a preponderance of the evidence, an entitlement to temporary total disability (TTD) benefits from September 11, 2017 through October 11, 2017. Claimant's arguments are not found persuasive. Claimant's use of the *Sigala* case, 184 P.3d 40 (Colo. 2008) is misplaced and factually distinguishable from the facts in this matter.

In *Sigala v. Atencio's Market*, 184 P.3d 40 (Colo. 2008), a Claimant was found to be entitled to receive disability indemnity benefits withheld by her Employer during a period of suspension of benefits. The Claimant in that case missed an appointment with her attending physician and was notified that her TTD benefits could be suspended if she failed to attend a rescheduled appointment. *Id.* She failed to attend the rescheduled appointment and Respondents stopped payment of her benefits. *Id.* When she attended an appointment with her attending physician approximately 2 months later, Respondents reinstated her benefits. *Id.* The Claimant argued that the term suspend meant to withhold benefits temporarily such that the accrue and are paid once they attend the appointment under § 8-42-105(2)(c), C.R.S. *Id.* The Court noted that a different statute, § 8-43-404(3), C.R.S is in place and permits suspension of compensation to a Claimant who refuses to submit to treatment or evaluation as is reasonably essential to promote recovery. *Id.* The Court referred to language indicating that if the employee refuses to submit to such examination...or is any way obstructs the same, all right to weekly indemnity which accrues and becomes payable during the period of such refusal or obstruction shall be barred. *Id.* The Court continued to note that if any employee persisted in injurious practice which tended to imperil or retard recovery or refused to submit to such medical or surgical treatment as reasonably essential to promote recovery, the director had discretion to reduce or suspend the compensation of any such injured employee. *Id.* The Court, thus made a distinction between § 8-42-105(2)(c), C.R.S. and § 8-43-404(3), C.R.S.

The Court in *Sigala*, noted that a temporary suspension of benefits may be followed by a reinstatement and repayment of suspended benefits as long as there has been no order entered directing the claimant to submit to examination. *Id.* The Court pointed out that if the General Assembly had intended for the term suspend to mean a permanent withholding they would have used the term "barred" as they did in the penalties and enforcement provision. *Id.* The Court held that an ALJ lacked grounds to bar benefits unless a claimant's refusal to submit to a medical examination resulted in a continuing and detrimental effect on Claimant's condition. *Id.* The Court determined that provisions of the Workers' Compensation Act, such as the penalties and enforcement provision, provided stringent sanctions when Claimant's actions so demanded but differentiated the term suspend in the TTD benefits provision as applying to *Sigala* and found that the term suspend in the TTD benefits provision meant to stop temporarily and not bar or exclude. *Id.* Therefore, they ordered benefits paid to *Sigala* for the period of time in between her missed appointment when TTD had been stopped and the appointment she eventually attended. *Id.* The Court specifically noted that if the Respondent believed that *Sigala* had imperiled or retarded her recovery by refusing to submit to medical treatment, then Respondent could take action under the penalties and enforcement section of the Act where more stringent sanctions of barring or excluding benefits existed.

Here, Respondents sought action under the penalties and enforcement section of the Workers' Compensation Act when they appeared at hearing before ALJ Goldman. ALJ Goldman found, in fact, that Claimant had engaged in injurious practice and refused to submit to such medical or surgical treatment as reasonably essential to promote recovery. Claimant's argument that she should be paid benefits for the one month period

in between ALJ Goldman's Order and the surgery he eventually underwent is not persuasive. Claimant's benefits had been suspended during that time under the more stringent sanctions of the Act barring recovery as ALJ Goldman found injurious practice. Claimant has therefore failed to meet his burden to show any entitlement to TTD from September 11, 2017 through October 11, 2017 and the facts of Claimant's case are distinguishable from *Sigala*.

Medical Benefits – EMG and MRI

Claimant has failed to establish, by a preponderance of the evidence, that medical benefits of a left elbow MRI and left upper extremity EMG/NCV testing are reasonable, necessary, and causally related to his October 27, 2016 work injury.

As found above, Dr. Reister requested a left elbow MRI and EMG/NCV testing on August 30, 2018. Claimant underwent the EMG/NCV testing on October 16, 2018. Although Claimant represented that there had been an additional request for EMG/NCV testing, this is not found in the records. Rather, the EMG/NCV testing that was requested by Dr. Reister was approved by Respondents and Claimant underwent that testing on October 16, 2018. No new outstanding request for additional EMG/NCV testing exists. Therefore, Claimant's request for EMG/NCV testing of the left upper extremity is denied as he has already undergone that testing and Claimant has failed to establish that an additional EMG/NCV test is reasonable or necessary.

Further, the opinion of Dr. Scott is credible and persuasive that a left elbow MRI is not reasonable, necessary, or casually related to Claimant's October 27, 2016 injury. The ALJ finds persuasive the opinion that Claimant would have manifested symptoms much earlier if he sustained an injury to the left elbow on October 27, 2016. None of the treating providers noted any deformity in the left elbow during 22 months of treatment which is logically incredible given the opinion that by August of 2018 it was a noticeable deformity. Further, the opinion of neurologist Dr. Trihaft is persuasive that the evidence shows Claimant's problems in the left elbow are more likely due to his diabetes than his electrocution injury. Claimant has failed to establish, by a preponderance of the evidence, that a left elbow MRI is reasonable, necessary, and causally related to his October 27, 2016 work injury.

ORDER

It is therefore ordered that:

1. Claimant has failed to establish an entitlement to TTD benefits from September 11, 2017 through October 11, 2017.
2. Claimant has failed to establish by a preponderance of the evidence an entitlement to medical benefits of a left elbow MRI and EMG/NCV testing of his left upper extremity. EMG/NCV testing was already authorized and performed and there is no new request for such testing. The MRI of the left elbow is not causally related to Claimant's October 27, 2016 work injury.

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: March 14, 2019

/s/ Michelle E. Jones

Michelle E. Jones
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, CO 80203

ISSUE

- Whether Claimant met his burden of proving by a preponderance of the evidence that he requires the use of a wheelchair accessible vehicle.

FINDINGS OF FACT

1. Claimant is a 36-year-old male who sustained an occupational injury when he fell over twenty feet from a roof while working as an installer for Employer. Claimant sustained severe injuries and has undergone extensive medical treatment.

2. Respondents admitted liability by filing a general admission of liability on October 10, 2017.

3. Claimant's diagnoses include but are not limited to catastrophic traumatic brain injury, quadriplegia, spastic hemiplegia affecting his right dominant side, hypertonicity of muscles throughout his trunk and extremities, and aphasia.¹

4. Because of his injuries, Claimant is permanently paralyzed, non-ambulatory, and has lost function in his arms and legs.

5. On April 19, 2018, Claimant's treating neurologist, Dr. Michael Makley, prescribed a wheelchair accessible vehicle.

- Dr. Makley opined that Claimant's paralysis was a life-long mobility limitation for which he needs specialized equipment to perform mobility related activities of daily living.
- Dr. Makley opined that without such a vehicle, Claimant's "safety and health will be negatively impacted."
- Dr. Makley explained that rather than being transferred out of his wheelchair and into a regular vehicle, Claimant needs to remain seated in his wheelchair to "maintain positioning, skin protection, and due to the inability to transfer into a standard vehicle."
- Dr. Makley outlined that "[i]ndependence in community mobility can be essential for [Claimant's] autonomy, community mobility, personal care and daily living needs."

¹ Aphasia is the loss of ability to understand or express speech, caused by brain damage.

Claimant's specially trained and certified therapist, Sarah Davidson, co-wrote the prescription.

6. Claimant receives physical and occupational therapy from Monday through Friday at Learning Services Neurobehavioral Institute ("Learning Services"), a day center specialized in brain injury care.

7. On August 22, 2018, Jill Castro, MD, the medical director of Learning Services, also prescribed Claimant a wheelchair accessible vehicle. She noted that Claimant requires a specialized wheelchair to accommodate his spasticity and limited motion in his extremities. She noted that the vehicle Claimant used did not accommodate his wheelchair, which limited his ability to be more independent in the community. She prescribed a wheelchair accessible van as "medically necessary to allow [Claimant] access to the community, for frequent needs in therapy, physician visits, and other community integration."

8. On August 14, 2018, Claimant received occupational therapy. His therapist, Becky Cady, noted, "[Claimant] is much more oppositional, often does the opposite of what you are asking him to do. His is more verbal but he also has increased frustration when he can't communicate clearly. He often refuses assist when completing tasks, becoming a safety risk." Linda Morgan, and Rich Morgan, further noted under Physical Therapy, "[Claimant] is definitely overestimating his own abilities and has poor safety awareness. This is now a safety issue. He has unbuckled his wheelchair safety belt and has attempted to stand on his own."

9. Claimant's wife, Jessica Burd, testified that she has been married to Claimant for three years and together as a couple for five years. Although Claimant has round the clock care, she provides and assists in providing care for many of Claimant's needs. These include feeding him meals, attending to his restroom needs, taking him to appointments, taking him to Outward Bound programs, and being involved with his treatment.

10. Mrs. Burd testified that Claimant is unable to care for himself. Claimant is unable to stand on his own, and his injury hinders his motor skills. Claimant poses a danger to himself if left alone, and is at risk of re-injury if he attempts to stand on his own.

11. Mrs. Burd testified that the following complications occur when she attempts to transfer Claimant to her current vehicle.

- Claimant is at a risk of falling and injuring himself and his caregivers.
- Claimant fights and argues when she attempts to transfer him into her vehicle.
- She must use a "gap" belt to transfer Claimant into the vehicle. Doing so risks damaging Claimant's skin, which poses a risk of infection.

- Transferring Claimant overstimulates him and can cause him to experience seizures.
- Transfers are so difficult that Claimant often chooses not to participate in activities that would allow him to integrate more fully in his community.

12. When Mrs. Burd manages to transfer Claimant into their vehicle, the following problems remain:

- Claimant is unable to maintain proper posture when restrained in his seat, which limits the distance they can travel.
- Claimant is able to unfasten the car's restraints.
- Claimant becomes aggressive in the car which and has pushed her while driving.
- Claimant "plays" with controls on the dashboard and attempts to shift gears while she is driving.

13. On November 14, 2018, Claimant's wife and physicians met to evaluate Claimant's current status and management plan. Meeting notes show that Mrs. Burd remained unable to integrate the Claimant into the community.

14. Use of Claimant's current vehicle exposes Claimant to increased risks of skin damage, infection, and seizures. At the same time, it decreases his ability to participate in therapeutic activities and integration into his community. It exposes Claimant and his caregivers to heightened risks of harm from falling, straining, and unsafe driving.

15. Providing Claimant a wheelchair accessible vehicle would reduce these risks to Claimant's health and safety.

16. A wheelchair accessible vehicle would provide Claimant with numerous medical and therapeutic benefits, including the ability to integrate into his community. Claimant could leave his room to go out for haircuts, shopping, and social activities.

17. Claimant participated in several outdoor activities prior to his injury. Dr. Jim Schraa, one of Claimant's neuropsychologists, has recommended "fishing and other recreational activities," as therapeutic treatment. Having a wheelchair accessible van would allow Claimant to participate in accessible outdoor activities such as visiting a paved park in Baily, Colorado, and participating in accessible programs through Outward Bound including modified skiing.

18. Since his injury, Claimant has participated in two Outward Bound modified skiing therapy programs. Once, Claimant's wife transported him in their own vehicle. Mrs. Burd testified that Claimant smiles and "comes to life" after participating in adaptive skiing. Persuasive evidence supports a finding that Claimant would participate more

frequently in such activities if she had a wheelchair accessible vehicle because it would reduce Claimant's risk of harm.

19. Mrs. Burd testified that the primary reason Claimant is unable to engage in additional therapeutic outdoor activities is the lack of a wheelchair accessible vehicle. Using her current vehicle involves a great production, and causes too much frustration for Claimant and his family. She testified that she would travel to the mountains and an adaptive park if she had a proper mode of transportation.

20. Learning Services provides adequate transportation if Claimant needs to be transported during his day programming.

21. Mrs. Burd testified that she attends Claimant's doctor's appointments and that she has had to take Claimant to doctor appointments that fall outside the scope of Claimant's Workers' Compensation injuries. On at least two occasions, Mrs. Burd has had to use an ambulance for non-emergent trips to doctors or hospitals, because she was unable to transport Claimant in her own car. She credibly testified that she would have transported Claimant on those occasions if she had a wheelchair accessible vehicle.

22. Dr. Makley testified by telephone as an expert in neurology. He was Claimant's physician during his inpatient rehabilitation, and remains involved with Claimant's care. Dr. Makley testified that Claimant suffers from spastic tetraparesis, and has cognitive deficits. He further testified that the Claimant is dependent for care for the remainder of his life.

23. Dr. Makley testified that (1) Claimant requires a structured day program like that provided by Learning Services that engages him and keeps him moving; and (2) Claimant requires integration into the community. Dr. Makley recommended a wheelchair accessible vehicle in part to integrate Claimant into the community. *Dr. Makley testified that integrating Claimant into the community is vital to Claimant's medical treatment.* Specifically, the ability for Claimant to be back in his world is a medical benefit. Dr. Makley testified that it is important for all rehabilitation patients to return to their community, and that Claimant remaining in his room is inadequate.

24. Dr. Makley testified that proper usage of a wheelchair is vitally important, as positioning during transport poses risk of skin breakdown, as well as risk of re-injury. He testified that skin breakdown can be lethal, and proper seating is crucial to protecting his skin. He testified that transferring into a standard vehicle poses threats of falling, and could injure his caregivers.

25. On cross-examination, Claimant's wife agreed with Respondents' counsel that a wheelchair accessible van would make things easier for her, would provide peace of mind, and that it would make Claimant more independent. However, from context is clear to the ALJ that the primary purpose of a wheelchair accessible van is to provide Claimant with medical and therapeutic benefit.

26. The ALJ finds that Claimant established by a preponderance of the evidence that he requires the use of a wheelchair accessible vehicle is necessary for the treatment of Claimant's injuries and provides therapeutic relief from the effects of his injuries.

CONCLUSIONS OF LAW

Generally

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 disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. C.R.S. § 8-40-102(1). The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. C.R.S. § 8-43-201. Respondent bears the burden of establishing any affirmative defenses. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). 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 (2008).

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); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008).

Medical Benefits – Reasonably Necessary

Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). Although Respondents are liable for medical treatment that is reasonably necessary to cure and relieve the effects of the industrial injury, Respondents may, nevertheless, challenge the reasonableness and necessity of current or newly requested treatment notwithstanding its position regarding previous medical care in a case. See *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002) (upholding employer's refusal to pay for third arthroscopic procedure after having paid for multiple surgical procedures). The question of whether a particular medical treatment or modality is reasonable and necessary is one of fact for determination by the ALJ. *Kroupa v. Industrial*

Claim Appeals Office, supra; Wal-Mart Stores, Inc. v. Industrial Claims Office, 989 P.2d 251 (Colo. App. 1999).

Employers are required to provide services that are either medically necessary for the treatment of a claimant's injuries or incidental to obtaining such treatment. See *Bellone v. Indus. Claim Appeals Office*, 940 P.2d 1116, 1117-18 (Colo. App. 1997) (upholding child care services as medical in nature because they relieved the symptoms and effects of the injury and were directly associated with claimant's physical needs). However, in interpreting the scope of C.R.S. 8-42-101(1)(a), the Colorado Court of Appeals has narrowly construed the Act by stating that an apparatus must be necessary for the treatment of the injury **or** it must provide therapeutic relief from the effects of the injury. *Cheyenne Cnty. Nursing Home v. Indus. Claim Appeals Office*, 892 P.2d 443, 446 (Colo. App. 1995) (upholding employer's refusal to pay for a stair glider as being a medical apparatus because it did not provide a therapeutic benefit to the disabling injury although it provided peace of mind and access to lower levels of a home in a tornado prone area).

Respondents focus on the first clause, that if an apparatus is not medically necessary for the treatment of a claimant's injuries or incidental to obtaining such treatment then the employer will not be liable to pay for it. See *ABC Disposal Servs. v. Fortier*, 809 P.2d 1071, 1073 (Colo. App. 1990) (upholding employer's refusal to pay for a snow blower because it was not prescribed as a medical aid to cure or relieve claimant from the symptoms of his injury but rather provided an easier way to accomplish a household chore). In other recent cases, the courts have likewise denied an "apparatus" or a service where it was not found to be medically necessary, but was rather prescribed as a means to achieve an independent lifestyle or provided peace of mind in emergencies. *Bogue v. SDI Corporation, Inc.*, 931 P. 2d. 477 (Colo. App. 1996) (holding that a wheelchair accessible van was not medically necessary and therefore beyond the intent of C.R.S. 8-42-101(1)(a)); *Hillen v. Tool King*, 851 P.2d 289 (Colo. App. 1993) (Although lawn care services necessitated by Claimant's work-related condition, they are unrelated to physical condition and the lawn care was not prescribed to cure or relieve Claimant of symptoms of the injury, but simply to relieve the Claimant of the rigors of yard work).

In the Colorado cases where an apparatus or services were authorized, the courts found that the apparatus or service was medically necessary. *Bellone, supra; Atencio v. Quality Care*, 791 P.2d 7 (Colo. App. 1990) (housekeeping services allowed where Claimant had severely restricted use of hands and could not perform activities of daily living or chores without assistance); *City and County of Denver, School District 1 v. Indus. Claims Appeals Office*, 682 P.2d 513 (Colo. App. 1984) (Hot tub installed in home found medically necessary where Claimant's work hours prevented use of health club and hot tub was prescribed to cure and relieve the Claimant from the effects of his work injury).

For a particular medical benefit to be compensable, even if not curative, the benefit must provide "therapeutic relief" from the effect of the injury. Courts have defined "therapeutic relief" very narrowly. See *Cheyenne County Nursing Home, v. Indus. Claim Appeals Office*, 892 P.2d 443 (Colo. App. 1995). Despite the narrow reading of "therapeutic relief" in benefit jurisprudence, the case law referenced below supports the

proposition that Claimant's Employer is obligated to provide him with a wheelchair accessible van.

A wheelchair accessible van will provide therapeutic relief. For example, in *Theresa Carlson v. Applebee's R.C.I.*, W.C. No. 4-210-386 (ICAO, March 17, 2000), the claimant suffered injuries to her knees and hips when a 200-pound keg fell on her while at work. Afterwards, she experienced significant difficulty walking and eventually had to use crutches. Evidence presented at hearing showed that the claimant was still unsteady when walking, even while on crutches, and had fallen on occasion. Testimony was elicited that her unsteadiness and history of falling put her at risk of further injury. At hearing, the claimant testified that using crutches caused her to experience pain in her arms, knees and hips" and that "her pain was lessened by using a wheelchair." The ALJ determined that because her wheelchair relieved the symptoms of her industrial injury, it was a medical benefit her employer was obligated to provide pursuant to section 8-42-101(1) (a), C.R.S. Additionally, the ALJ found that the employer was obligated to pay for wheelchair ramps at her home because the ramps were deemed "necessary components" of a manual wheelchair. ICAO reviewed the decision of the ALJ, and acknowledged the narrow reading of the term "therapeutic relief" as defined in *Cheyenne County Nursing Home, v. Industrial Claim Appeals Office*, supra. Nevertheless, the panel ultimately distinguished the claimant's case determining that "the ALJ reasonably inferred that the wheelchair provides therapeutic relief from the symptoms of the injury", namely pain, and that the "prescribed apparatus [was] designed to prevent further deterioration of the claimant's condition which may result from additional falling injuries." See *Carlson*, W.C. No. 4-210-386 at 2, see also *Bellone v. Indus. Claim Appeals Office*, supra. ICAO also upheld the ALJ's decision regarding the wheelchair ramps finding that "instillation of wheelchair accessible ramps is a necessary component of the claimant's use of a wheelchair. Consequently, [they perceived] no basis to interfere with the ALJ's award of wheelchair accessible ramps." *Id.* In so holding, ICAO cited to *Kuziel v. Pet Fair, Inc.*, 931 P.2d 521 (Colo. App. 1996); *Cheyenne County Nursing Home, v. Indus. Claim Appeals Office*, supra, *Stockton v. Fountain Valley Plumbing & Heating*, W.C. No. 3-953-094 (ICAO, November 19, 1992) (where the employer was liable for expenses related to operation of medically prescribed hot tub).

The facts in the present case are congruous to those in *Carlson*. Claimant remains unsteady on his feet, and is unable to ambulate, and because he has a standard vehicle, he is forced to transfer from his wheelchair to his spouse's passenger seat whenever he leaves the confines of his home for certain medical and therapeutic reasons. His spasticity limits his overall mobility and ambulation, and he faces the potential for skin tears, infection, and seizures.

Similar to the Claimant in *Carlson*, substantial evidence indicates that Claimant faces an increased risk of falling and further injury. Evidence at hearing establishes that Claimant's spouse has been injured by helping lift Claimant. Claimant is further at risk of injury while seated in the passenger seat, as he is unable to situate himself in a safe position, and risks distracting his spouse while she drives. Claimant's spouse testified that Claimant attempts to unbuckle himself, and plays with knobs and handles while seated, putting all occupants at risk.

The record further supports that Claimant would suffer additional harm if he remains confined to his home. Dr. Makley testified that it is necessary to re-integrate with the community for this type of injury. Medical records establish that Dr. Jim Schraa believes Claimant will benefit from recreational activities. Claimant's spouse testified that on the two occasions she has taken the Claimant skiing, she has seen him change in demeanor, and experience considerable pleasure. This is consistent with the lifestyle Claimant enjoyed prior to his injuries, and would likely benefit from. The records also support Claimant's improvement when he engages with family activities, and fostering interactions with his two-year-old daughter. Such activities require the use of a wheelchair accessible vehicle. The facts of this case, when compared to those of *Carlson*, constitute substantial evidence that a wheelchair accessible van is necessary to relieve the Claimant's pain and symptoms as well as prevent further injury. Substantial evidence supports a finding that a wheelchair accessible van is a "necessary component" of the Claimant's use of his wheelchair; that a wheelchair accessible van would prevent further injury or falls; and that a wheelchair accessible van would relieve the fatigue Claimant experiences when transferring in-and-out of his vehicle. Finally, a wheelchair accessible van would prevent further deterioration of Claimant's condition.

Claimant's entitlement to a wheelchair accessible van finds additional support in *Gregory Harrison v. Advanced Component Systems*, W.C. No. 4-192-027 (ICAO, November 3, 2006). In *Harrison*, the employer was required to purchase for claimant, who had incomplete paraplegia, a wheelchair accessible van in order to relieve him of the symptoms of his paraplegia. In *Harrison*, the claimant had a power wheelchair but could not use it because he did not have a means to transport it. The claimant in *Harrison*, reverted back to an inadequate method of ambulation in order to engage in everyday activities. The claimant in *Harrison* would use his manual wheelchair to reach his Ford Explorer and, upon reaching his vehicle, would transfer into the vehicle on his own. Once inside, he would then have to lift his manual wheelchair inside the vehicle. At hearing, expert testimony confirmed this placed the claimant at risk of further injury to his shoulders, injuries to his back, and skin shearing. The panel in *Harrison*, similar to the panel in *Carlson*, held that the claimant was entitled to the benefit of a wheelchair accessible van because, in part, "the wheelchair accessible van is a necessary component of the claimant's use of a power wheelchair." ICAO further held that "there is substantial evidence in the record from which the ALJ reasonably inferred that the van provides therapeutic relief from the symptoms of the injury. The ALJ also found that the prescribed apparatus is designed to prevent further deterioration of the claimant's condition."

In this case, Claimant would face a worsening condition if confined to his home, and the wheelchair accessible van is an extension of his use of a manual wheelchair. Claimant requires a specialized vehicle to participate in activities outside the home, and faces injury should he utilize a standard vehicle. The record also suggests that Claimant may suffer damage to his skin if he is required to use a standard vehicle, and video evidence suggests that Claimant is at a high risk of injury if he attempts to enter or exit a vehicle on his own. Even with assistance, there is risk of injury to both the Claimant, as well as his caretakers when using a standard vehicle.

At the hearing in *Harrison*, the employer argued that the holding in *Bogue v. SDI Corporation, Inc.*, 931 P.2d 477 (Colo. App. 1996), should apply to the claimant's case. In *Bogue v. SDI Corporation, Inc.*, the court denied a conversion van for a wheelchair bound claimant where the van would only have kept claimant safe from inclement weather rather than provide him "therapeutic relief" from the symptoms of his injuries or provide him greater access to medical treatment. In response to this argument, ICAO accurately distinguished the *Harrison* claimant's case from *Bogue* by noting that the wheelchair-accessible van was "a medical aid to relieve him of the medical symptoms of his quadriplegia" not merely a benefit designed to give the claimant peace-of-mind. The facts in the present case are similar to those in *Harrison*.

As found, in order to access medical care, reintegrate into the community, pick up prescriptions, purchase groceries, or engage in any long-range activity, Claimant requires the use of a specialized vehicle. If Claimant attempts to engage in such activities, then he must use his spouse's standard vehicle. Claimant's spouse must lock the wheelchair in place, and then she must detach Claimant's wheelchair restraint, guide the Claimant into grabbing the vehicle so that he may assist her while she attempts to lift him out of his chair. Claimant's spouse must then direct Claimant's torso into the vehicle, and guide him into a sitting position into the passenger seat. Claimant's spouse must then remove the wheelchair, and place Claimant in a safe position inside the vehicle. All the while, Claimant remains unable to control parts of his body, is unable to comprehend instruction, will often resist assistance, risks damage to his skin, and injury to both himself and his spouse. These facts, in comparison to *Harrison*, represent substantial evidence that Claimant needs a wheelchair accessible van as a medically necessary component of his manual wheelchair, for relief of his industrial injury, to avoid further injury, and for greater access to medical treatment.

A wheelchair accessible van will prevent further deterioration of Claimant's condition. When comparing the ICAO decisions in *Richard Trigg v. Acoustical & Constructional Supply*, W.C. No. 3-766-426 (ICAO, September 7, 1994) and *Bellone v. Indus. Claim Appeals Office*, supra, with the facts of this case, there is additional support for the proposition that Claimant is entitled to a wheelchair accessible van. In *Trigg*, ICAO upheld the ALJ's determination that a quadriplegic needed a modified van to get "to and from medical appointments and to do his own grocery shopping in order to control his diet." ICAO upheld the ALJ's decision on the basis that it allowed the claimant greater access to treatment and prevented further degradation of claimant's condition. ICAO held that treatment designed to maintain the claimant's condition or prevent a further deterioration is considered treatment that "relieves" the effects of the injury. In this case, as in *Trigg* and *Bellone*, providing Claimant with a wheelchair accessible van will prevent deterioration of his condition. As noted at hearing, Respondents only provide Claimant with transportation for medical appointments associated with his Workers' Compensation claim. However, the medical records, as well as testimony from Dr. Makley, indicate that Claimant will benefit from engaging in recreational activities, integrating into the community, and involvement with his family. Claimant is expected to engage in everyday activities that a family unit may have, and restricting him to his home is punitive to Claimant. These facts constitute substantial evidence that if Claimant uses a standard vehicle, it will hasten the deterioration of his condition.

ORDER

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

1. Respondents shall pay the costs of a wheelchair accessible van capable of transporting Claimant's manual wheelchair in order that he might experience relief from his industrial injury and experience greater access to medical care, subject to the Division of Workers Compensation medical fee Schedule.

Dated March 15, 2019

/s/ Kimberly Turnbow
Kimberly B. Turnbow
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, C 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 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>.

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 5-006-031**

ISSUES

- I. Whether Claimant proved by a preponderance of the evidence he is permanently and totally disabled.

FINDINGS OF FACT

1. Claimant is a 71 year old native of Macedonia. Claimant earned a law degree from the University of Macedonia in 1973 and worked as a government attorney in Macedonia from 1974 until 1981. Claimant moved to the United States in 1981 and did not obtain employment in the United States until 2001. During such time period, Claimant was a stay at home father and volunteered for approximately 10 years assisting refugees with obtaining driver's licenses and housing.

2. Claimant has a pre-existing history of poorly controlled diabetes and severe hearing loss.

3. Claimant began working for Employer in 2001. Claimant worked for Employer as a custodian for approximately 16 years performing cleaning duties.

4. On January 8, 2016, Claimant sustained an admitted industrial injury to his right lower extremity when he tripped and fell while wearing a backpack vacuum. Claimant was initially diagnosed with a right ankle strain. He subsequently underwent a right ankle MRI that revealed a rupture of the anterior tibialis tendon.

5. On February 5, 2016, authorized treating physician ("ATP") Paul T. Raford, M.D. recommended surgical repair for the ruptured tendon, advising that Claimant would likely end up with a flat foot if he did not have the surgery. Claimant declined the surgery due to concerns of diabetes complications. Claimant was instructed to wear a walker boot.

6. Claimant's primary ATP, Christian U. Updike, M.D. agreed with Claimant's decision to not proceed with surgery, noting there was high "potential for medical misadventures and negative outcomes" considering Claimant's age, poorly controlled diabetes and limited English. In a February 29, 2016 medical record, Dr. Updike noted there was a paucity of research regarding the anterior tibialis, but referenced one journal article that found non-operative treatment was a reasonable option for elderly nonathletic patients. Dr. Updike recommended Claimant continue wearing the walker boot and released Claimant to perform sitting work only.

7. Claimant underwent conservative treatment, which included pain medication, Lidoderm patches, custom ankle braces and physical therapy. Claimant did not experience any significant improvement and continued to report 9.5/10 pain.

8. On June 1, 2016, Claimant presented to Yusuke Wakeshima, M.D. for a pain consultation per the referral of Dr. Updike. Dr. Wakeshima discussed the possibility of using an electrical stimulation device to treat Claimant. He noted Claimant was reluctant. Dr. Wakeshima prescribed Claimant Cymbalta for ongoing pain and explained to Claimant the medication would be utilized for neuropathic pain and chronic musculoskeletal pain and not depression. Claimant nonetheless declined to take Cymbalta due to concerns about the medication being an anti-depressant. On June 28, 2016, Claimant reported to Dr. Wakeshima that he did not feel he needed to be on any anti-depressant medication, and wanted his medical record to reflect he was not taking the medication and did not have any depression issues.

9. On August 4, 2016, Dr. Updike noted Claimant was approaching maximum medical improvement (“MMI”). Dr. Updike wanted Claimant to have an opportunity to try a second custom ankle brace. He remarked,

I think it is reasonable that he get a 2nd change at the 2nd custom ankle brace because I think that is his only chance of possibly having gainful employment. Otherwise, he will be on permanent sitting type restrictions where he will undoubtedly lose his job and likely be in financial distress given his age, demographic, and lack of transferrable skills and language barrier.

10. Dr. Updike placed Claimant at MMI on October 6, 2016. At the time, Claimant’s second custom ankle brace was in the process of being made. Claimant continued to report 9.5/10 pain. Dr. Updike provided a 21% lower extremity impairment and assigned permanent restrictions of performing sitting work only and no lifting over 10 pounds. As maintenance treatment, Dr. Updike recommended Claimant wear the ankle brace as desired and follow-up with Dr. Wakeshima.

11. Respondents filed a Final Admission of Liability (“FAL”) on November 2, 2016, admitting to Dr. Updike’s MMI date and impairment rating, as well as reasonable, necessary and related post-MMI treatment.

12. On November 28, 2016, Claimant filed an Application for Hearing endorsing compensability and permanent total disability.¹

13. Claimant subsequently received his second custom ankle brace and continued to treat with Dr. Wakeshima, reporting that the new brace was not helpful and caused more pain. Claimant expressed frustration with the company that made the brace, and declined to have the brace adjusted. Claimant also declined to be on any non-steroidal anti-inflammatory medications due to concerns of diabetes complications. Dr.

¹ The ALJ took judicial notice of the OAC electronic records associated with W.C. No. 5-006-031-04 pursuant to C.R.E. 201.

Wakeshima subsequently prescribed Claimant a TENS unit, which Claimant tried and reported caused increased pain.

14. On April 14, 2017, Claimant continued to report 9.5/10 pain to Dr. Wakeshima. Dr. Wakeshima noted that since his last evaluation, Claimant's primary care physician had prescribed Claimant lorazepam for anxiety/panic attacks. He noted Claimant had been seen in the emergency department at St. Joseph's Hospital for panic attacks as related to his ankle pain. Claimant reported to Dr. Wakeshima that his anxiety and panic attacks had been improving and that he did not want to see a psychologist at that juncture.

15. Dr. Wakeshima reexamined Claimant on May 11, 2017. Claimant's wife reported Claimant's overall condition was deteriorating. She reported Claimant had lost all motivation and was no longer taking his medications, performing self-hygiene or feeding himself. Claimant's wife reported Claimant was barely eating and had lost 50 pounds over the last two months. Dr. Wakeshima noted Claimant presented with a flat affect and was "not his usual argumentative self." Dr. Wakeshima questioned whether Claimant's failure to thrive was related to severe depression. Dr. Wakeshima referred Claimant to a psychologist for evaluation. At a follow up evaluation on June 15, 2017, Dr. Wakeshima continued to note progressive weight loss and an unrevealing medical workup. He referred Claimant for a psychiatric evaluation to determine whether Claimant's symptoms and depression were related to the work injury.

16. On June 27, 2017, Claimant was found by the police wandering the street and admitted to the emergency department at Lutheran Medical Center with worsening confusion, signs of dementia, decreased appetite and failure to thrive. It was noted that the behavioral health team and overnight team evaluated Claimant and "highly suspect[ed] dementia as the cause of [Claimant's] symptoms." The behavioral health team concluded Claimant was not an appropriate candidate for psychiatric placement and recommended Claimant be placed in an assisted living facility, which Claimant's family refused.

17. Claimant returned to Dr. Wakeshima on June 30, 2017. Dr. Wakeshima referred to Claimant's recent hospital visit, noting the behavioral team at Lutheran Medical Center suspected possible dementia. Dr. Wakeshima remarked that Claimant did not have a history of dementia. Dr. Wakeshima noted that, even after multiple hospitalizations and a CT scan of the brain, no etiology for Claimant's failure to thrive and weight loss had been identified. He opined that there was a strong possibility Claimant's failure to thrive was related to severe depression. He referred Claimant for a psychological and psychiatric evaluation to assess Claimant's condition and the relatedness to the work injury.

18. Claimant underwent a psychological evaluation with John Mark Disorbio, Ed.D. on July 10, 2017. Claimant's wife reported that she now spoon feeds Claimant, and once came home to discover Claimant had stuffed tissues in his mouth to the degree it became difficult to remove them. Dr. Disorbio noted that during his evaluation Claimant had difficulty responding to questions and remembering what happened, and was

unaware of the day, where he was, and the name of the President. Dr. Disorbio noted it was “quite clear” Claimant was suffering with significant psychological effects, was very thought disturbed, and had some definite psychotic features and difficulties. He assessed Claimant with major clinical depression with psychotic features, and opined Claimant was “extraordinarily emotionally and physically disabled. Dr. Disorbio recommended Claimant undergo a psychiatric evaluation to become stabilized with his psychotic condition. Dr. Disorbio did not address the cause of Claimant’s condition or the relatedness of Claimant’s condition to the work injury.

19. On July 24, 2017, Gary S. Gutterman, M.D. performed a psychiatric evaluation of Claimant. Dr. Gutterman issued a report dated August 7, 2017. Dr. Gutterman noted Claimant appeared somewhat catatonic and did not speak during the entire evaluation. Claimant’s wife provided Claimant’s history, reporting that Claimant was unable to return to work after being injured and had become increasingly depressed, with anxiety attacks beginning in February 2017. Dr. Gutterman noted that during his evaluation, Claimant was unresponsive and lost control of his bladder, urinating in a chair. Dr. Gutterman opined that he was unable to make a diagnosis after the brief meeting and could not offer further assistance to Claimant at the time due to Claimant’s state and level of function. He noted, if anything, Claimant had a severe depressive condition with an almost catatonic presentation. Dr. Gutterman opined Claimant required intensive outpatient treatment or, more likely, hospitalization to treat his psychiatric status. Dr. Gutterman did not offer an opinion on the cause of Claimant’s condition or relatedness to the work injury.

20. Claimant returned to Dr. Wakeshima on August 17, 2017 with severe depression issues. Claimant remained noncommunicative with a flat affect. Claimant’s spouse reported that she had made two attempts to have Claimant undergo an audiology exam, but due to Claimant being nonresponsive he was being arranged to take a hearing test utilized for infants. Dr. Wakeshima noted Claimant’s clinical presentation was most suggestive of worsening major depression and opined Claimant’s condition was related to the work injury. He stated that psychiatric evaluation of Claimant should be covered under workers’ compensation “...as depression is part of his Workers’ Compensation diagnosis.” Dr. Wakeshima noted he had spoken with both Dr. DiSorbio and Dr. Gutterman who deemed Claimant severely depressed and found Claimant warranted inpatient psychiatric admission at Porter Hospital. Dr. Wakeshima referred Claimant for inpatient psychiatric hospitalization. Claimant’s wife indicated to Dr. Wakeshima she wished to try intensive outpatient treatment if possible. Dr. Wakeshima noted there was no concern Claimant was a danger to himself at that time, and delayed further action until a follow-up evaluation.

21. Claimant was admitted to Denver Health on August 31, 2017 after being found wandering in the street. Claimant’s wife reported Claimant began an abrupt decline six months prior when he became more depressed and anxious about his job, and had significantly worsened since. She reported Claimant had no prior history of depression, mania or psychosis. The following factors were noted as indications for Claimant’s hospital admission: “[G]ravelly disabled and unable to perform basic self-care activity and maintain safety, severe problem with cognition, memory, judgment or impulse

control and management at a lower level of care not feasible until acute intervention is initiated.” Claimant was hospitalized for one week and underwent workup for dementia; however, it was noted that “normal laboratory studies and normal neuro imaging suggest[ed] a primary psychiatric etiology.” Claimant was discharged on September 6, 2017 with a diagnosis of a severe single current episode of major depressive disorder with psychotic features. He was prescribed medications for depression, catatonia and paranoia, and referred for follow up with his primary care provider and an outpatient psychiatrist.

22. Cynthia Bartmann, CCM, CDMS, performed an employability evaluation at request of Claimant. Ms. Bartmann met with Claimant on March 17, 2017. She issued an initial employability evaluation report on April 5, 2017. Claimant’s wife served as his interpreter during the evaluation. Claimant’s wife reported to Ms. Bartmann that, on occasion, Employer would call her on the telephone with instructions to translate for Claimant. Claimant reported that, even with hearing aids, it is difficult for him to hear normal conversations. Claimant reported to Ms. Bartmann that he did not obtain employment upon relocating to the United States due to language difficulties and his education not being recognized. Claimant reported continued severe pain and an inability to drive, manage stairs, stand for more than a few minutes at a time, walk more than one block, and sit for periods of time without elevating his leg. Claimant reported no limitations with his upper extremities. Ms. Bartmann noted Claimant has held only one job since living in the United States, a janitor, which she opined falls in the unskilled category. She further noted that Claimant’s permanent work restrictions of no lifting over 10 pounds and sitting work only limited him to sedentary work and precluded him from working in a janitorial position. Ms. Bartmann opined Claimant’s restrictions placed him in a sedentary work category, and noted certain jobs in the sedentary work category require a good command of the English language, which Claimant did not possess. She noted that other sedentary jobs would likely involve some amount of walking, and that potential employers would likely not be willing to train someone Claimant’s age. Ms. Bartmann further noted Claimant’s hearing loss makes it difficult for Claimant to understand directions. Ms. Bartmann opined that, based on Claimant’s age, limited work history, physical limitations, language limitations and work restrictions, Claimant is precluded from employment and unable to earn any wages.

23. Patricia A. Anctil, CRC, CDMS, CCM performed a vocational assessment at the request of Respondents. She met with Claimant on March 10, 2017 and issued a vocational report dated July 10, 2017. A professional interpreter was used during the assessment. Ms. Anctil noted Claimant presented as fluent in English. Claimant’s wife reported Claimant can speak, read, and write in English. Claimant reported being able to speak approximately 10 languages, including Macedonian, Turkish and Albanian. Ms. Anctil noted Claimant’s employment application indicated Claimant can also read, write and speak French, Italian and Swedish. Claimant reported continuing 9.5/10 pain. Claimant did not specify how long he can stand at one time. He reported an inability to walk more than 50 feet at a time and sit for extended periods of time. Claimant reported he sometimes elevates his foot when seated. Claimant reported he cannot kneel, bend, stoop or lift, but had no issues with his upper extremities.

24. Ms. Anctil noted Claimant reported he did not seek employment until 2000 because he was a stay at home dad after relocating to the United States. Claimant volunteered with Lutheran Services from 1990 until 1999 assisting refugees with obtaining identification, passing driving tests, informal translation, computer skills, and purchasing food. She further noted Claimant is computer literate. Using the Dictionary of Occupational Titles, Ms. Anctil opined that Claimant's prior employment and volunteer work was classified in unskilled, semi-skilled and skilled categories. She acknowledged Claimant had not been released to work in a janitorial position, and his physical restrictions placed him in sedentary occupation category. Ms. Anctil identified some possible sedentary occupations for Claimant, including translator and assembler. Ms. Anctil contacted some translation agencies, noting requirements varied, but that certification was not always required. Regarding Claimant's hearing loss, Ms. Anctil noted reasonable accommodations could be made. With respect to Claimant's age, Ms. Anctil referred to a newspaper article noting expected increase in labor force participation of older workers due to the slowing growth of the labor force, and a second newspaper article noting the value of older workers in bringing expertise to the workplace.

25. On December 11, 2017, Ms. Bartmann issued an updated employability evaluation. Ms. Bartmann noted Claimant remained in the sedentary work category; however, per her review of additional medical records, Claimant now appeared to be non-communicative and unable to follow directions, having problems with cognition, memory and judgment. Ms. Bartmann noted that, although Claimant was able to speak English, language difficulties were documented throughout the medical records and an interpreter was used for the majority of his medical appointments. Ms. Bartmann opined that Claimant's hearing loss would present safety concerns working in a manufacturing environment. She stated she was unaware how Claimant could perform the jobs suggested by Ms. Anctil at 70 years of age with no related work experience in the United States, severe hearing loss, work restrictions, English as his second language, an inability to drive, and an inability to respond to questions in an employment interview.

26. Ms. Bartmann testified at hearing as an expert in vocational rehabilitation. Ms. Bartmann testified consistent with her reports and continued to opine that, based on Claimant's age, restrictions, work experience, hearing issues and language issues, Claimant is unable to earn a wage. Ms. Bartmann testified Claimant's education is not recognized in the United States, and the only job Claimant has had while living in the United States has been as a custodian. Ms. Bartmann stated she considered Claimant's vocational skills from the last 15 years, as skills beyond 15 years become obsolete. Ms. Bartmann testified that Claimant's hearing and language issues present difficulties with training and communication. Regarding age, Ms. Bartmann acknowledged that there can be a niche for highly skilled older workers in certain jobs, but that this was not the case for an unskilled worker such as Claimant. Ms. Bartmann testified that, solely considering Claimant's physical restrictions and other human factors such as age, language limitations and hearing loss, Claimant is unable to earn a wage. She further testified that, considering Claimant's psychiatric issues alone, Claimant is unable to earn any wages.

27. Dr. Updike testified at hearing as an expert in occupational medicine. Dr. Updike testified that communication with Claimant was difficult due to Claimant's hard-of-hearing behaviors, even when Claimant was wearing his hearing aids. He testified he first saw Claimant with no interpreter, but subsequently requested and used an interpreter. Dr. Updike testified that poor hearing can lead to decreased mood and depression, but that he was unaware of how common a factor hearing loss is in dementia. Dr. Updike stated that depression was not a concern when he was seeing Claimant. Dr. Updike testified that Claimant's conservative treatment consisted of medications, physical therapy, custom ankle braces, splints, walker boots, and opined that nothing else could have been done for Claimant. He reiterated his opinion that surgery would not have made a significant difference in Claimant's functional outcome considering Claimant's age and other factors. Dr. Updike testified that, but for Claimant's workers' compensation injury, Claimant would most likely still be working.

28. Claimant's former supervisor, David Nelson, testified at hearing that he communicated with Claimant in English. He testified that Claimant reviewed and submitted written documents in English. Mr. Nelson further testified that Claimant is hard of hearing and he was unable to communicate with Claimant if Claimant was not wearing his hearing aids. Mr. Nelson confirmed Claimant was unable to continue performing his job as a custodian due to his permanent work restrictions.

29. On March 1, 2018, Ms. Anctil testified in a post-hearing deposition as a vocational rehabilitation expert. Ms. Anctil testified consistent with her report and continued to opine Claimant is capable of obtaining employment. Ms. Anctil testified she considered Claimant's restrictions, age, hearing issues and transferrable skills in reaching her conclusions. She stated Claimant's education and volunteer work fall within the skilled category. Ms. Anctil noted several points of disagreement with Ms. Bartmann's reports and testimony. She testified that Ms. Bartmann failed to conduct a transferrable skills analysis, which is standard methodology in the field. She further testified that the Dictionary of Occupational Titles is widely used. Ms. Anctil opined Claimant's age does not exclude him from employment, nor does his severe hearing loss. Ms. Anctil continued to opine Claimant is proficient in the English language. She acknowledged that, prior to issuing her report, she had not reviewed additional medical records regarding Claimant's mental state. She testified that she had since reviewed the reports of Drs. Wakeshima and Gutterman, but did not conduct updated labor market research, because it had not been determined Claimant's mental condition was related to the work injury. Ms. Anctil testified that Claimant would not be able to obtain or maintain work in his current psychiatric state.

30. Ms. Bartmann provided rebuttal testimony in a deposition on April 11, 2018. Ms. Bartmann testified she had no reason to complete a transferrable skills analysis as Claimant's work history consisted of janitorial work, which falls in the unskilled category with no transferrable skills. Ms. Bartmann testified that she contacted the translation agencies listed in Ms. Anctil's report, and was informed generally certification was required to be a translator, with some exceptions, and that formal training, and in some circumstances, higher education or paid experience as a translator is required.

31. Ms. Anctil offered surrebuttal deposition testimony on December 11, 2018. She testified that a transferrable skills analysis should include not only prior work experience but education, volunteer work and hobbies. She acknowledged that the standard period of time to consider when performing a vocational assessment is 15 years, but that a 15-year period is not a set rule. Ms. Anctil testified that Claimant's skills go beyond janitorial duties due to Claimant's prior vocational experience. Ms. Anctil testified she re-contacted some of the listed translator services, and was informed by some services that certification was not needed, Claimant's volunteer service could be considered, and that his hearing issues and physical restrictions would not disqualify him from employment.

32. The opinion and testimony of Ms. Bartmann is found more credible and persuasive than the conflicting opinion of Ms. Anctil.

33. The ALJ finds the opinions of Drs. Wakeshima, Gutterman and DiSorbio credible and persuasive.

34. Claimant proved it is more probable than not he is unable to earn any wages in any employment and that the work injury was a significant causative factor in Claimant's inability to earn any wages.

35. 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).

Permanent Total Disability

To prove his claim that he is permanently and totally disabled, the claimant shoulders the burden of proving by a preponderance of the evidence that he is unable to earn any wages in the same or other employment. Sections 8-40-201(16.5)(a) and 8-43-201, C.R.S. (2003); see *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). The claimant must also prove the industrial injury was a significant causative factor in the PTD by demonstrating a direct causal relationship between the injury and the PTD. *Joslins Dry Goods Co. v. Industrial Claim Appeals Office*, 21 P.3d 866 (Colo. App. 2001). The term "any wages" means more than zero wages. See *Lobb v. Industrial Claim Appeals Office*, 948 P.2d 115 (Colo. App. 1997); *McKinney v. Industrial Claim Appeals Office*, 894 P.2d 42 (Colo. App. 1995). In weighing whether claimant is able to earn any wages, the ALJ may consider various human factors, including the claimant's physical condition, mental ability, age, employment history, education, and availability of work that the claimant could perform. *Weld County School Dist. Re-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). The ALJ may also consider the claimant's ability to handle pain and the perception of pain. *Darnall v. Weld County*, W.C. No. 4-164-380 (I.C.A.O. April 10, 1998). The critical test is whether employment exists that is reasonably available to claimant under his or her particular circumstances. *Weld County School Dist. Re-12 v. Bymer, supra*. The question of whether the claimant proved inability to earn wages in the same or other employment presents a question of fact for resolution by the ALJ. *Best-Way Concrete Co. v. Baumgartner*, 908 P.2d 1194 (Colo. App. 1995).

As found, Claimant has proven it is more probable than not he is unable to earn any wages in the same or other employment. As a direct result of his work injury, Claimant is subject to permanent physical restrictions of performing only sitting work and lifting no more than 10 pounds, precluding him from continuing employment in the same or similar employment. In addition to Claimant's permanent restrictions, Claimant has consistently reported continuing functional limitations, including an inability to drive, manage stairs, and sit for extended periods of time without elevating his leg. Respondents argue, in part, that they should not be liable for permanent total disability benefits because Claimant has refused reasonable medical treatment that would

alleviate or mitigate his condition. The ALJ disagrees. Claimant attempted the majority of treatment recommended by his treating providers, including taking various medications and wearing a TENS units and two custom ankle braces, none of which provided significant sustained relief. Claimant declined to undergo surgery or take certain medications due to concerns of diabetes complications. Dr. Updike agreed with Claimant's decision to not proceed with surgery. He later credibly testified nothing more could be done for Claimant. The ALJ is persuaded Claimant's refusal of certain treatment was reasonable under the circumstances.

In addition to Claimant's physical condition and restrictions, multiple human factors contribute to Claimant's inability to earn wages. The only employment Claimant has held in the last 37 years is janitorial work, which he performed for 16-17 years prior to sustaining the work injury. It is undisputed janitorial work falls in the unskilled category. Although Claimant earned a law degree in Macedonia in 1973 and worked as an attorney for seven years, Claimant's education was not recognized upon his relocation to the United States, and such legal experience was obtained in a different jurisdiction over 30 years ago. Claimant's volunteer service took place over 15 years ago. Ms. Bartmann credibly opined that skills beyond 15 years are considered obsolete. Moreover, while Claimant assisted refugees with various tasks while volunteering, including some translation, there is insufficient credible and persuasive evidence regarding the extent of the translation services he provided.

English is not Claimant's first language. Despite a few records indicating Claimant speaks fluent English and did not wish to use an interpreter, either a professional interpreter or Claimant's wife was utilized at almost all of Claimant's medical appointments and the vocational assessments. While it is reported Claimant can speak, read and write multiple other languages, the level of proficiency in each language is unknown. Additionally, Claimant is severely hard of hearing, which Ms. Bartmann credibly opined affects Claimant's employability. Claimant is also 71 years old, which presents additional challenges to obtaining and maintaining employment. While older workers who are highly skilled may have access to certain employment opportunities, Ms. Bartmann credibly and persuasively testified that Claimant does not fall in such category, having solely performed unskilled work in the last 16-17 years.

The ALJ is persuaded the physical restrictions resulting from Claimant's work injury, along with the human factors of Claimant's age, limited work history in an unskilled position, language issues, and severe hearing loss render Claimant unable to earn any wages. As Claimant's physical restrictions and functional limitations are a direct result of the work injury, the ALJ concludes the work injury was a significant causative factor in Claimant's permanent total disability.

Beyond the aforementioned factors, Claimant's mental state further contributes to his inability to earn any wages. Claimant has been diagnosed with depression with psychotic features, and has been noted to be unresponsive and near catatonic in his presentation. Such presentation clearly precludes Claimant from obtaining and maintaining employment. Dr. Wakeshima opined that Claimant's mental state is a result

of the work injury, thus further establishing the work injury as a significant causative factor in Claimant's inability to earn any wages.

Although Ms. Ancil opined there are certain jobs Claimant can perform, the ALJ is not persuaded these jobs are reasonably available to Claimant under his particular circumstances. Based on the totality of the credible and persuasive evidence, Claimant has met his burden of proof to establish he is permanently and totally disabled.

ORDER

It is therefore ordered that:

1. Respondents shall pay Claimant permanent total disability benefits commencing on October 6, 2016, subject to any applicable credits and offsets.
2. Respondents shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
3. All matters not determined herein are reserved for future determination.

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: March 15, 2019



Kara R. Cayce
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

ISSUES

I. Whether Claimant has proven by a preponderance of the evidence that the total left knee arthroplasty proposed by David Beard M.D. is reasonable, necessary and related to his May 15, 2017 admitted left knee injury.

FINDINGS OF FACT

1. Claimant is a 65 year old man with a pre-existing history of gout. Claimant has worked for Employer for 30 years repairing vending machines. Claimant's regular work duties involved standing and walking at least 8-10 hours per shift, and required kneeling, squatting, and crawling.

2. On May 15, 2017, Claimant suffered an admitted industrial injury to his left knee when he fell off the back of a truck while unloading vending equipment. Claimant immediately reported the injury to Employer and was taken to UC Health Urgent Care. Claimant underwent a left knee x-ray that revealed mild degenerative change without acute bony finding. He was initially diagnosed with a left knee sprain.

3. Claimant subsequently began treatment with authorized provider UC Health Occupational Medicine. On May 22, 2017, Michael Deltz, PA-C assessed Claimant with the following: left knee strain with history of gout differential diagnosis gouty attack peripatellar tendon. Claimant reported he had experienced three major gout attacks in the last 15 years. The body parts that were not specified. Claimant was placed on restrictions of no lifting over 20 pounds and no walking or standing more than one hour per day.

4. On May 25, 2017, Claimant underwent a left knee MRI that revealed a complete rupture of the anterior cruciate ligament (ACL) with posterior tibial bone contusions and intermediate-sized joint effusion and a left knee medial meniscus bucket-handle tear.

5. Authorized treating physician (ATP) John D. Charbonneau, M.D. referred Claimant to orthopedic surgeon David A. Beard, M.D., who first evaluated Claimant on June 30, 2017. Dr. Beard reviewed the MRI, diagnosed Claimant with a work-related ACL tear and bucket handle tear of the medial meniscus, and recommended Claimant undergo an ACL reconstruction, allograft and partial medial meniscectomy.

6. On July 8, 2017, Mark Failing, M.D. performed a Rule 16 record review at the request of Respondents. Dr. Failing also performed an independent medical examination (IME) on July 31, 2017. Dr. Failing reviewed, *inter alia*, Claimant's x-rays and MRI and physically examined Claimant. His impression was as follows: acute ACL tear, displaced bucket-handle medial meniscus tear, mild chondromalacia of the medial

femoral condyle, and mild chondromalacia of the proximal pole of the patella. Dr. Failinger concluded that Claimant was a candidate for the proposed ACL reconstruction and partial medial meniscectomy. He opined that Claimant's need for surgery was related to his May 15, 2017 work injury, stating, "[t]here does not appear to be anything in the records that I have been supplied or in his history that indicate there was prior injury or preexisting conditions other than some mild chondromalacia which does not appear to be causing problems at this point." Dr. Failinger noted that the surgery should be performed as soon as possible to avoid permanent loss of full extension.

7. On October 18, 2017, Dr. Beard performed a left knee ACL reconstruction and partial medial and lateral meniscectomies. Dr. Beard's operative report notes areas of grade 3 and grade 4 chondral changes along the medial femoral condyle and some grade 2A chondral changes on the lateral tibial plateau. There were no operative complications.

8. Claimant subsequently treated with medication and physical therapy and was released to full-time work light office or shop work with restrictions of lifting no more than 15 pounds, no walking or standing more than one hour per day, and no crawling, kneeling, squatting or climbing. Claimant was unable to take oral anti-inflammatory medication due to kidney issues.

9. Claimant's condition did not improve as expected. Due to the continued pain and swelling in the left knee, Dr. Beard performed an aspiration of the left knee on November 9, 2017 and a second aspiration and steroid injection on November 30, 2017. Dr. Beard opined Claimant's symptoms were likely secondary to Claimant's primary osteoarthritis.

10. During a follow-up evaluation with Dr. Charbonneau on December 11, 2017, Claimant continued to complain of constant left knee pain and swelling. Claimant reported having a gout flare-up in his right ankle the previous week. Dr. Charbonneau opined that infection, gout or other potential causes of Claimant's symptoms needed to be ruled out.

11. On December 14, 2017, Dr. Beard noted Claimant underwent laboratory studies that showed no evidence of infection. He continued to opine Claimant's ongoing knee inflammation was likely secondary to osteoarthritis. Dr. Beard recommended Claimant continue conservative management. He further noted that Claimant's final option would be a total knee arthroplasty, but specified that such surgery would be due to Claimant's osteoarthritis, which he opined was not work-related.

12. On January 12, 2018, Claimant presented to his personal care physician, Richard Budensiek, M.D., reporting a gout flare-up of his right ankle. Claimant was ordered to take prednisone for five days.

13. Dr. Beard reevaluated Claimant on January 25, 2018. He noted Claimant continued to have persistent problems with pain and swelling due to pre-existing, non-work-related osteoarthritis. Dr. Beard opined Claimant was not having difficulties with

the reconstruction itself. He requested authorization for a total left knee arthroplasty, noting, "It is quite possible that this might be denied through his Worker's Compensation claim as this was preexisting...If his total knee arthroplasty is denied by his Workers' Compensation claim, it would then have to fall back on his commercial insurance."

14. On February 1, 2018 Respondents denied authorization of the total knee arthroplasty as not related to the admitted work injury.

15. Dr. Failinger performed an additional medical records review on February 3, 2018 and opined that the recommended total knee replacement was not related to the May 15, 2017 work injury, nor was it reasonable or necessary at that time, as Claimant was only a few months post-surgery. Dr. Failinger questioned whether Claimant's continued symptoms were actually the result of infection, a gouty flare-up, or arthritis. He recommended further testing and re-aspiration of Claimant's knee. He opined that if Claimant chose to proceed with the knee replacement, it should be performed under Claimant's private health insurance, as his arthritis was pre-existing.

16. Claimant underwent additional x-rays of the left knee on March 3, 2018 that revealed joint effusion and marked joint space effacement medially.

17. Claimant continued to see Dr. Budensiek, reporting continued left knee pain and worsened gout pain on March 16, 2018. The area of gout pain was not specified. Dr. Budensiek performed another left knee aspiration and steroid injection.

18. On March 22, 2018, Dr. Charbonneau reevaluated Claimant, noting the March 3, 2018 x-rays showed medial compartment degenerative joint disease. Claimant reported improvement in his left knee after his most recent aspiration and injection, but remained limited in kneeling, climbing, stairs and crawling. Dr. Charbonneau recommended Claimant return to Dr. Beard to determine if surgery was still indicated.

19. Claimant returned to Dr. Beard on March 29, 2018, who opined Claimant had reached maximum medical improvement (MMI) for his work-related injury. Dr. Beard opined Claimant ongoing symptoms were related to his primary osteoarthritis, which was not work-related. He recommended Claimant return to his primary ATP for placement at MMI and assignment of an impairment rating, and that Claimant pursue the total knee arthroplasty through his personal health insurance.

20. On April 2, 2018, Claimant returned to Dr. Budensiek's office reporting a second degree burn on his right foot and an acute gout flare-up in the right foot. By April 4, 2018 Claimant's right ankle and foot pain had improved.

21. Dr. Charbonneau reevaluated Claimant on April 17, 2018. Referring to the MTG, he that Claimant suffered a work-related aggravation of his underlying osteoarthritis and that the proposed surgery should be covered under workers' compensation. In support of his opinion, Dr. Charbonneau noted Claimant had no previous left knee injuries or symptomatic episodes of left knee osteoarthritis or left knee gouty arthritis. He further noted Claimant's had a five-month delay between the injury and the authorization for surgical repair of his ACL and medial meniscus, and that

since the surgery, Claimant had experienced constant left knee pain, recurrent effusions and, more recently, left knee weakness. He continued Claimant on work restrictions.

22. Claimant continued to see Dr. Beard, who performed left knee aspirations on June 8 and June 19, 2018. Cultures from the knee aspirate were tested and found negative for infection. Dr. Beard again opined Claimant's chronic knee effusion was secondary to osteoarthritis.

23. On September 18, 2018, Jeffrey A. Wunder, M.D. performed an IME at the request of Claimant. He noted Claimant had a history of gout primarily in his ankles, with a few episodes of gout in his great toes and right elbow, but never affecting his knees. Dr. Wunder performed a records review and physically examined Claimant. He noted Claimant had evidence of longstanding but mild underlying osteoarthritis in his knee, and Claimant reported having no history of left knee problems prior to the work injury. Dr. Wunder opined that Claimant's work injury "clearly" affected his osteoarthritis, noting that the May 2017 and March 2018 x-rays showed progression of osteoarthritic change far beyond the rate that would commonly be expected of normal degenerative changes. Dr. Wunder further noted that testing for infection was negative, as was testing for the presence of any uric acid crystals that would indicate a gouty flare-up. Dr. Wunder opined that the May 15, 2017 work injury resulted in a significant aggravation of Claimant's underlying osteoarthritis. He thus concluded that the proposed total knee replacement surgery was reasonable, necessary and related to the May 15, 2017 work injury.

24. Dr. Failing reviewed additional records and issued a report dated December 18, 2018. Dr. Failing disagreed with Dr. Wunder's on multiple accounts. He noted that the lack of uric acid crystals found in Claimant's knee aspirate did not definitively establish there was not a gouty flare-up, as crystals would not be present on testing if the testing did not occur in the early stages of the flare-up. Dr. Failing opined that there was a high probability Claimant's arthritis was preexisting and not directly affected by the work injury. He continued to opine Claimant required additional testing to definitively rule out infection. He noted that, if infection was ruled out, the need for a total knee replacement would be due to Claimant's preexisting arthritis and not the work injury. He opined that the knee replacement was medically necessary and appropriate, as significant time had passed. He recommended Claimant limit his weight bearing time to one to two hours a day, and only intermittently.

25. Dr. Failing testified by pre-hearing deposition as an expert in orthopedic surgery. Dr. Failing testified consistent with his reports and continued to opine Claimant had preexisting arthritis. He explained that, although bone contusions can cause arthritis and there was evidence of bone contusions on Claimant's MRI, those contusions were not in the same area as Claimant's arthritis. Dr. Failing acknowledged that, when comparing the May 2017 and March 2018 x-rays there appears to be an advancement of arthritis, but explained that the comparison is insufficient because it is unknown if the x-rays were non-weight-bearing or weight-bearing. Dr. Failing did state that the appearance of advanced degeneration on the imaging is more than what would be typically expected over a 10-month period.

26. Dr. Failinger testified that it is not unreasonable to proceed with a total knee replacement, as Claimant has had persistent pain despite undergoing a course of conservative treatment. He explained that the proposed surgery would be expected to significantly decrease Claimant's pain and increase his function. Dr. Failinger reiterated his opinion, however, that unless it is determined there is an infection, the proposed surgery is not related to Claimant's work injury. Dr. Failinger testified that he can acknowledge Claimant had no history of prior knee pain or functional limitations, but that he did not agree the advanced degeneration of Claimant's knee was thrown into motion by the work injury.

27. Dr. Beard testified by pre-hearing deposition as an expert in orthopedic surgery. He testified that he noted evidence of some osteoarthritis primarily in the medial compartment of Claimant's left knee during the surgery he performed in October 2017. Regarding potential infection, Dr. Beard testified that he was comfortable ruling out infection as a possible cause for Claimant's symptoms, as multiple cultures had been obtained and tested negative. Dr. Beard acknowledged that the delay in Claimant's first surgery could have caused an aggravation or acceleration of the degenerative process, and also acknowledged that there are a number of studies that reflect people with ACL injuries and meniscal repairs are likely to develop osteoarthritis. He testified that there is no way of knowing when and if Claimant would have ever had a recommendation for a total knee replacement without the events of May 15, 2017 placing everything in motion. Dr. Beard further testified that he agreed Claimant's pre-existing arthritis was substantially aggravated by the work injury, stating:

Q: Do you - - what is the cause of claimant's injury that requires the total knee replacement?

A: He was asymptomatic with regards to the osteoarthritis up until this work-related injury, which is not unusual. Oftentimes we will see people who have some preexisting arthritis and then they get an injury on top of that, that really sets in motion this chain of events of persistent pain and swelling and the arthritic changes just becoming more symptomatic.

Q: But you can't say to a reasonable degree of medical probability that this injury is the cause of that, can you?

A: I cannot say, and as I've stated in my notes, that the injury caused the osteoarthritis. It's my professional opinion that it preexists.

Q: Okay.

A: It's just that he wasn't symptomatic prior to that.

28. Dr. Beard stated the proposed surgery would be expected to improve Claimant's function significantly and significantly decrease his pain.

29. Claimant testified at hearing that, prior to the May 15, 2017 work injury, he had no prior left knee injuries, symptoms or limitations. Claimant testified that he did not have any gout symptoms in his left knee prior to the work injury. Claimant was not subject to any work restrictions prior to the work injury or had any need to modify or decline work due to any left knee issues. Claimant has been on work restrictions since sustaining the work injury and since undergoing surgery. Claimant has returned to work performing light duty, as he is physically restricted from performing his regular tasks.

30. Claimant's testimony is found credible and persuasive.

31. The ALJ finds the testimony and opinions of Drs. Charbonneau, Wunder and Beard, as supported by the medical records, more credible and persuasive than the conflicting opinion of Dr. Failing.

32. Claimant has proven it is more probable than not that the proposed total left knee replacement is reasonable, necessary and related to the May 15, 2017 work injury.

33. 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).

Claimant completed a course of conservative treatment and underwent an ACL reconstruction and medial meniscectomy, all with no substantial improvement. Claimant's continued pain, swelling and functional limitations are documented throughout the records. Claimant's treating physicians, as well as Claimant's IME physician and Respondents' IME physician all agree that, at this point, the proposed total left knee arthroplasty is reasonable, necessary and medically appropriate.

Accordingly, the crux of the dispute before the ALJ is whether the proposed surgery is related to Claimant's work injury. Dr. Failinger opined that Claimant's current need for surgery could be the result of gout, infection or pre-existing arthritis. Although Dr. Failinger is of the opinion additional testing for infection should be completed, Claimant underwent testing for infection on multiple occasions, the results of which Dr. Wunder and Dr. Beard credibly opined were negative and sufficient. Although Claimant has pre-existing arthritis and gout, Claimant has credibly and consistently reported that he did not have prior symptoms, treatment or limitations with respect to his left knee. The record is devoid of any evidence to the contrary. While there is reference in the record to gouty flare-ups, the references are limited to Claimant's ankles, toes, and elbow. While Dr. Beard has discussed the possibility of arthritis as the cause of Claimant's symptoms, he has never opined that Claimant's condition is the result of pre-existing gout. Additionally, Claimant's knee aspirate was negative for uric acid crystals which, when considered in light of the other evidence, offers persuasive support that gout is not the cause of Claimant's continuing left knee symptoms and need for surgery.

As mentioned, Claimant has not experienced any significant improvement since suffering the work injury. Claimant, who formerly had no prior left knee issues or functional limitations, has since experienced constant pain and swelling and been subject to continuing work restrictions. ATP Charbonneau and Dr. Wunder credibly opined that the work injury substantially aggravated Claimant's underlying osteoarthritis, causing the need for the proposed surgery. Dr. Beard's opinion that Claimant's osteoarthritis was pre-existing does not preclude a conclusion that the pre-existing osteoarthritis was substantially aggravated by the work injury. Dr. Beard acknowledges this in his deposition testimony, agreeing that the work injury caused Claimant's asymptomatic condition to become symptomatic. Based on the totality of the credible and persuasive evidence, Claimant has by a preponderance of the evidence the total left knee arthroplasty recommended by Dr. Beard is reasonable, necessary and related to his May 15, 2017 work injury.

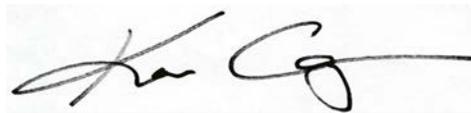
ORDER

It is therefore ordered that:

1. Respondents shall authorize and pay for the total left knee arthroplasty recommended by Dr. Beard.
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: March 18, 2019



Kara R. Cayce
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

ISSUES

1. Has Claimant proven, by a preponderance of the evidence, that he sustained compensable injuries arising out of and in the course of his employment?
2. If the claim is compensable, is Claimant entitled to medical benefits that are reasonable and necessary to cure and relieve the effects of his injuries?
3. Did the Employer provide a list of medical providers/physicians in compliance with section 8-43-404(5) to Claimant after he reported his injuries? And if not, did the right of selection pass to Claimant?

ADMISSIBILITY OF RESPONDENTS' EXHIBIT V

Two prehearing conferences contesting this Exhibit were held: October 3, 2018, and December 28, 2018. This ALJ has reviewed the subsequent Orders in their entirety. In summary, Claimant objects to the admission of said exhibit, arguing that it is so highly prejudicial that the ALJ should not even view it. Respondents argue that it is a medical report relevant to one theory of their case, and that the ALJ must view it in this context. Respondents at least wanted to allow the ALJ to view this report to issue an evidentiary ruling on the merits. The 12/28/2018 prehearing ALJ concurred.

Exhibit V is a *Psychiatric Independent Medical Examination for Fitness-for-Duty*, prepared by Robert E. Kleinmann, MD. The IME was conducted on 2/5/2015, and the report was issued on 2/17/2015. Portions have been redacted. At issue in this IME is Claimant's fitness to return to duty with the Colorado Springs Fire Department, based upon certain concerns for his mental health.

After reviewing this report this ALJ concludes that, at best, it has tangential value to one of Respondents' theories of the case, to wit: Claimant is maladapted to his work environment, thus prone to an unduly adversarial mindset. The evidence received at this hearing, taken as a whole, does not justify this report's admission. The ALJ concludes that its admission would be unduly prejudicial, and this report's usage should have been limited to the proceedings for which was originally prepared.

Further, as noted below, this matter can be decided on the medical evidence alone, without resort to divining Claimant's psychological condition. Exhibit V will not be admitted or considered by the ALJ, but the tendered copy will remain as part of the record.

FINDINGS OF FACT

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

1. Claimant is employed as a Firefighter with the City of Colorado Springs. From 2007 to 2014 he was a member of Employer's Heavy Rescue Program, ("HRP"). During this time, he was assigned to Station 17, the station at which HRP is based. In addition to typical firefighter duties, those in the HRP were required to be proficient in other disciplines, disciplines, including dive rescue, swift water, high-angle rescue, confined space, heavy machinery entrapments, auto extrication, building collapse, ice rescue, and rapid intervention. Scuba proficiency was necessary in order to conduct rescues and recoveries. For scuba diving, the heavy rescue goal is for all of the members to be rescue diver-certified, which is an advanced scuba diving certification. Claimant dived only in connection with his employment and has never dived recreationally.
2. In 2015 Claimant was reassigned to a different fire station where he did not participate in the HRP. In 2017 Claimant successfully bid to re-join the HRP at Station 17. Claimant was required to participate in scuba training dives for re-familiarization purposes since he had not dived recently.
3. On July 29, 2017, he had his first re-familiarization check-out dive with diving instructor Curt Crumb. The dive took place at Gold Camp Reservoir, and the plan was to go to the "Grizzly," the outlet structure at the bottom, which is usually between 40 and 50 feet from the surface. Claimant only got down to 12 feet, after 10 minutes in the water, due to ear-clearing issues and difficulties equalizing. Claimant told Mr. Crumb he had troubles clearing before and was generally slower going down because of clearing issues. Mr. Crumb testified this was not a successful dive, and Claimant did not perform another dive on that date. Claimant filled out a dive log and it was signed by Crumb. The log indicates the depth of the dive was 12 feet. (Ex. 7, p. 91). In his own log notes Claimant wrote, "...Re-familiarization dive. Ears/sinus wouldn't equalize..." (Ex. 7, p. 90.1) Claimant did not request an accident or injury report be completed or claim a work injury after the July 29, 2017 dive.
4. Claimant's next dive was September 21, 2017. That dive was determined to be 'successful', down 47 feet to the Grizzly with Mr. Crumb and Lt. Leach. He dove with fellow firefighter Lt. Jason Leach at Gold Camp Reservoir. Claimant completed a dive log for this dive. (Ex. 7, p. 90). In the log Claimant noted, "Confidence / ear exercising dive...No hood to assist with equalizing...slow descent / ears." The log reflects the depth of the dive was 43 feet and it lasted 14 minutes. Lt. Leach also completed a dive log for this dive. In his log he noted, "...Langmaid – worked on buoyancy / clearing. Slow descent from platform to Grizzly." (Ex. 7, p. 89.2).
5. The second dive planned for September 21, 2017 was not attempted due to Claimant's report of ear pain at the surface. Claimant did not request an accident report be completed or indicate he sustained a work injury after the September 21, 2017 dive. At hearing, Lt. Leach testified that the purpose of these dives was to re-familiarize Claimant and get him to dive to the level of his certification, which is rescue diver level.
6. At hearing, Claimant testified that attempted to participate in a dive with Curt Crumb on September 30, 2017 but was unable to equalize his ears and Crumb cancelled the dive.

He testified that he was unable to descend more than around 10 feet, but did not log this attempted dive. After this dive Claimant testified that he began experiencing additional symptoms including headaches, sinus pressure, and sinus discharge.

7. On October 1, 2017 Claimant sent a text message to Lt. Dave Barron that said, "I have a possible partial solution for my equalizing problem. However, I'd like your permission to experiment with a piece of equipment before I do it. I'd like to try modifying my hood with small holes (similar to vent on top) alongside my ears. This would allow water pressure and equalizing to be easier. However, it may not work because the cold water could potentially cause other problems like vertigo. Only one way to find out. I figured I'd start with a very small hole and perhaps extend to a slice if need be. Let me know your thoughts." (Ex. 10). Lt. Barron gave permission for the hood modification. *Id*
8. Claimant discussed his ear problems with Lt. Barron in September or October of 2017. At hearing, Lt. Barron testified that he, too, occasionally has difficulty clearing his ears when diving. He recommended some techniques he found useful, including use of Neo-Synephrine spray. Lt. Barron testified that approximately one-quarter of all divers experience ear problems when diving
9. Claimant did not participate as a diver in the water during any of the dive training sessions between September 21, 2017, and April 27, 2018. Claimant did not tell Mr. Crumb why he was not actively diving. Lt. McConnellogue testified he did not know the reason Claimant did not dive during that period, other than Claimant's expressed interest in trying to focus on a couple other things regarding the dive. Lt. Leach testified it was not clear why Claimant did not participate as an active, actual in-the-water diver.
10. Lt. Leach testified about a meeting he had with Claimant on February 14, 2018. Claimant stated he was having difficulty scuba diving and getting under the water. He also stated that he thought he had a brain tumor or other related issues going on, and sometimes he had clear liquid coming out of his nose that he thought was cerebral spinal fluid. Claimant did not indicate he had a work injury at that time. On February 20, Claimant sent Lt. Leach a text stating he had made an appointment for his 'brain leak'.
11. Lt. McConnellogue testified that he and Lt. Leach had brought up with Claimant the lapse of time in his diving and advised him it was critical that every single person on the team was a diver. Lt. McConnellogue recalled a conversation with Claimant in which Claimant expressed concern about his ear problems and requested to be assigned to more of a supporting role. Lt. McConnellogue testified that he and Lt. Leach expressed that everyone on the team had to be able to perform all diving activities. If someone is in the program, the expectation is he has to perform all of the skills within the program. Lt. McConnellogue testified Claimant had expressed some concerns with nasal drainage, and in February said he was going to schedule an appointment to get medical clearance and make sure everything was okay.
12. On March 13, 2018, Lt. Leach and Lt. McConnellogue had a meeting with Claimant to follow up on his March 12 medical appointment, and whether he had been cleared to

dive. They expressed concerns for Claimant's health and reiterated the importance of making sure everybody was a qualified, certified diver because they needed everybody to be able to perform every discipline with the program. They told Claimant they didn't want him to do anything to jeopardize his health and asked about his medical appointment. Claimant informed them he had canceled the appointment due to financial constraints.

13. Claimant did not provide a clear answer on why he wasn't diving. He thought, possibly, something medically was going on with him. Lt. McConnellogue believed Claimant, at one point in this meeting, talked about some cerebral spinal fluid had been leaking, and his wife wanted him to get that checked out. Lt. McConnellogue asked whether there was some kind of mental block, maybe some anxiety coming back. Claimant said he wasn't qualified to answer whether it was a mental block, but indicated it could be something physiological, or a little bit of a mental block, or because of the things that happened with him in the department over the course of time.
14. Lt. McConnellogue testified he was really not privy to the prior interactions to which Claimant referred, because most of those were when he was on another shift. The events to which Claimant was apparently referring were events that resulted in his being transferred out of the Station 17 heavy rescue station and reassigned to a different station in February 2015.
15. Claimant underwent a physical examination on March 13, 2018. This was a required part of his participation in the HRP. In the written "medical history statement" Claimant referenced sinusitis, and earaches "post diving (intermittent)." (Ex. 4)
16. On March 20, 2018, a memorandum, prepared by Angela Hines with HR, was tendered to Claimant by his chain of command, advising him of Employer's ADA program. It was sent to him because he had indicated he had a physical or mental issue impacting his ability to participate in the diving requirements of the Heavy Rescue program. (Ex. O, p. 41). The Memo concluded; "...Please know that I am not considering you to be disabled; I am simply providing information that may be beneficial to you based on information you have shared with your supervisors." Lt. Leach testified this was the result of his conversation with human resources about the liquid coming from Claimant's nose and his statement about a brain tumor.
17. On April 16, 2018, Claimant sent an email to Paula Homberger, PA-C, of Employer's Occupational Health Clinic, and stated, "...I am concerned that a symptom that I included in the history form was not discussed during the Heavy Rescue evaluation and that it may actually be causing difficulties with diving. Please contact me Wednesday at Station 17 if you can so that we can discuss the best course of action to determine the cause of these symptoms." Ms. Homberger responded, "No problem, PJ, I'll call Wednesday morning to discuss further. I am happy to discuss further and see if your medical symptom is a problem with diving. I apologize for not discussing it further at the time of your physical." (Ex.4 p. 40).

18. On April 23, 2018, Claimant was given a memorandum outlining a dive training plan intended to provide him with time to practice and demonstrate proficiency with the dive skills required by his level of certification. (Ex. P, pp. 42–43) Lt. McConnellogue explained the reason for the memorandum was to help Claimant become re-familiarized with the diving equipment, get comfortable with the dive operation, and make sure he was able to perform the skills for which he was certified. Lt. McConnellogue thought the plan was fair, noting they were very basic skills Claimant was being asked to perform. He testified they had full support of Battalion Chief Wheeler to alter their training schedule and were given latitude to pull their company out of service within reason in order to complete the training. They discussed with Claimant that if there were significant events that would not allow them to train, they would be able to extend the time frame for completion.
19. The April 23 Memo stated, in pertinent part: "...On March 13, 2018, your officers discussed with you a general dive training plan intended to provide you with time to practice and demonstrate proficiency with the dive skills required by your level of certification. This memorandum outlines the dive training plan." (Ex. 7. pg. 87) (emphasis supplied). The Memo went on to describe four "Phases" of training dives in which Claimant was to participate, and concluded, "...By July 31, 2018 you must have completed all phases of this dive training plan. Failure to meet the requirements herein may result in your removal from the Heavy Rescue Program." (Ex7, p. 88) (emphasis supplied).
20. Lt. Leach testified he did not feel the dive training plan was too aggressive. These were basic dives to get through in order to perform at Claimant's level of certification as a rescue diver. He also testified that assuming reasonable progress were made by Claimant towards this goal, that the compliance deadline could even be extended.
21. Battalion Chief Wheeler explained that the Fire Department needed Claimant to demonstrate he could perform to the level of his certification as a diver. It was essentially a remedial plan of dive skills which Claimant had previously accomplished, and for which he had been previously certified, to get him back to the level he was expected to dive. He also explained how the calendar could have been adjusted to accommodate the training plan. When Chief Wheeler delivered the dive training plan memorandum to Claimant, Claimant did not request an accident or injury report be completed for his ears, nor did he ask that a workers' compensation claim be completed concerning an injury to his ears.
22. Mr. Crumb was familiar with the dive training plan memorandum of April 23, 2018, which he had helped put together. In his opinion, the dive plan was not overly ambitious, because it only required Claimant to demonstrate skills for which he'd already been certified, and there was no extra class time. Mr. Crumb testified the dive training plan was appropriate from a time perspective. He discussed with Claimant that if they were finding success with the dive training plan but there were scheduling issues, there would be some leeway for the timeline for completion.

23. On April 27, 2018, a dive training session took place in the pool at Underwater Connection. It was the beginning of the 'confined water' dives (pool sessions, as opposed to 'open water' dives (lakes and oceans). This component was expected to require between two and four dive sessions to complete. Lt. McConnellogue was also present at this session. Mr. Crumb testified they planned to do five skill sets per dive, and it would have been ideal to get a couple dives in that day. Claimant only completed one dive that day, electing to end on a positive note. Although he was noted to be apprehensive with water around his nose, it was a 'successful' dive to 15 feet. (Ex. P, p. 42). Claimant reported his ears were sore or tender and he was having a little problem clearing. Mr. Crumb noted all divers eventually have ear tenderness at some point. Claimant did not request an injury or accident report be completed or indicate he sustained a work-related injury after the April 27, 2018 dive.
24. The May 6, 2018 'confined water' dive training session took place at the Colorado College pool. Claimant and Mr. Crumb completed dives 2 and 3, the first to the bottom of the 13-foot deep end and the second to 6 feet. Claimant completed almost all the skills to mastery except mask removal and mask flooding skills, which were noted to not be comfortable to Claimant. Claimant verbally mentioned his ears were sore at the end of the session, but he did not request an injury or accident report be filed and did not complain of a work-related injury.
25. The May 20, 2018 dive training session was back at Underwater Connection. The plan was to do dive #4 and then, hopefully, dive #5 of the confined water portion of Claimant's plan. They did not successfully complete the first dive that day, because Claimant, when asked to demonstrate his oral inflate and hover skill, overinflated and had a rapid ascent to the surface. (Mr. Crumb did characterize this incident as a 'common mistake'). Claimant told Mr. Crumb that the ascent had hurt his ears. At that time, since every dive had "some sort of ear component to it," Mr. Crumb aborted the dive and requested Claimant get checked out. Claimant did not request an accident report be completed or indicate that he sustained a work injury to his ear or ears.
26. On June 11, 2018, Claimant was given a memorandum regarding *Suspension of the Dive Training Plan, Station 17*. The memorandum gave Claimant options: obtain a medical release from his healthcare provider allowing him to continue with the Dive Training Plan, or initiate a request for FMLA leave or ADA accommodation, if appropriate. He was to complete one of the options within 10 calendar days, but no later than June 21, 2018. Failure to exercise one of the two options would result in his removal from the program. (Ex. Q, pp. 44–45) Based on his expertise as a diving instructor, Mr. Crumb agreed there was no reason to push forward with the Dive Training Plan until they could figure out what was going on with Claimant's ears.
27. Lt. McConnellogue and Chief Wheeler explained that the reason for the memorandum was Mr. Crumb's recommendation that the training plan be suspended. Mr. Crumb had become uncomfortable with Claimant expressing concern about his ears and inability to clear them. He didn't want to take the chance of Claimant getting injured. Lt. McConnellogue testified that at no point prior to the June 11, 2018 memorandum had

Claimant requested an accident or injury report be filed or filed a workers' compensation claim with respect to his ears.

28. Claimant sought treatment for his ear problems at the City Employee Medical Clinic on June 18, 2018. Nurse Practitioner Lorada Shrawder reported, "He is employed by CSFD and on the underwater diving unit. He is having left ear pain during diving and is having difficulty 'equalizing' during his dives. He also notes an increase of Post Nasal Drainage after dives. He wants a full evaluation to determine if diving is safe for him to continue." (Ex. 3, p. 35). NP Shrawder diagnosed "Ootalgia, left ear." She referred Claimant to Colorado ENT & Allergy. (Ex. 3, p. 37).
29. NP Shrawder issued a letter "To Whom It May Concern" on the same date, stating; "PJ Langmaid was seen in this clinic today with concern of ear pain and post nasal drainage after diving. I have referred him to Otolaryngology. I recommend he abstain from diving until he is evaluated by the specialist and receives medical clearance to resume underwater diving." (Ex. 3, p. 34). Claimant testified at hearing that as a result of seeing this information, he believed his ear problems were not the product of routine discomfort while diving, but rather that they rose to the level of an injury.
30. On June 21, 2018, (the deadline date imposed by the 6/11/18 memorandum) Claimant sent an email to Chief Wheeler, Lt. McConnellogue and Lt. Leach objecting to the June 11, 2018 memorandum and informing them he had seen a medical provider at the City Employee Medical Clinic on June 18 and initiated a request for an ADA accommodation "as prescribed in your memo to me." (Ex. R, p. 46) Later on June 21, 2018, Claimant sent another email to Lt. Leach asserting that the time he spent at the clinic on June 18 was on duty because "the department specifically told me to see a medical provider for something job related." He concluded by stating, "I want an injury report and workers comp claim filed. There is enough documentation in the form of memos and training notes to demonstrate that the injuries I am dealing with are as a direct result of the dive training and that I notified both my supervisors and the instructor of the initial injury and continued aggravation of injury due to the training plan imposed upon me." (Ex. S, p. 48)
31. Lt. Leach, Lt. McConnellogue and Chief Wheeler all testified that prior to the June 21, 2018 email from Claimant, Claimant had never requested an accident or injury report be completed or a workers' compensation claim be filed on his behalf. Chief Wheeler testified, at no point had they been made aware of an 'injury'. Up until the June 21 email from Claimant, they had no knowledge or information Claimant was alleging a work-related injury to his ears as a result of the scuba diving training program.
32. Claimant testified he knew how to submit a Workers' Compensation claim and that Workers' Compensation has always been "you go to occupational health." He testified he had not seen any medical provider between September 2017 and April 2018.
33. On June 29, 2018, a memorandum was sent to Claimant responding to his June 21 emails, and contradicting his assertions he had been directed or ordered to see a healthcare provider. The June 29 memorandum also noted that Claimant had not

previously objected or expressed concern that the dive plan would cause or exacerbate any injury, and he had never previously communicated he believed he had suffered a job related injury. The memorandum also advised him of the correct processes for filing an injury report and filing a Workers' Compensation claim. (Ex. T, pp. 50–51).

34. Claimant filed his Worker's Claim for Compensation on July 6, 2018. (Ex. 9, pp. 101-102). Employer denied Claimant's claim on July 10, 2018.
35. Employer did not provide Claimant with a list of authorized medical providers for him to choose from to treat his work injuries. Claimant chose the City Employee Medical Clinic to be his authorized medical provider.
36. Claimant saw Daniel Smith, M.D., at Colorado ENT & Allergy on July 12, 2018. Dr. Smith reported, "...Patient is city diver with left otalgia during/after dive in September of 2017. He avoided diving and left otalgia resolved although he restarted diving in April with decongestant and nasal steroids. Pain recurred when he restarted diving though. PND [post-nasal drip?] resolving and no sinus issues although he has had sinus surgery in past. **Exam clear today.** Audiogram testing in view of history ordered today and reviewed with *mild hearing gloss [sic]*. Type A tympanogram. **Etiology unclear** although suspect ETD [eustachian tube dysfunction] exacerbated by diving..." Dr. Smith diagnosed: Otolgia, left ear. Other specified disorders of Eustachian tube, left ear. Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side." Dr. Smith recommended a MRI "...in view of unilateral hearing gloss [sic] and otalgia." (Ex. B, p. 30) (emphasis added).
37. On July 17, 2018, Chief Wheeler sent Claimant a memorandum about his temporary reassignment to another station until a determination was made concerning whether his dive responsibilities could be reasonably accommodated under the ADA. (Ex. U, p. 52) Chief Wheeler acknowledged Claimant was never provided with a list of medical providers to choose from to treat his condition, explaining that Employer doesn't do that with persons who have non-job-related injuries.
38. Violet Heath, Employer's Human Resources Manager, wrote to Dr. Smith on July 31, 2018 and asked him questions about Claimant's condition. (Ex. 2, pp. 18-26). Dr. Smith responded on August 10, 2018 and explained; "I was asked to comment on difficulties that he has been experiencing with his ears. He initially noted difficulties in October following a dive during work. This did cause pain and irritation within his left ear at the time. This occurred during the dive itself. He did allow for resting of the ear and avoid diving to allow this difficulty to resolve, although he was instructed to dive again for the fire department in April. In doing so, during the dive he again experienced pain and irritation within the left ear similar to what he experienced in October. He has been seen by me, and examination including otologic examination, nasopharyngoscopy, audiologic testing, and MRI imaging have been done. **They have not demonstrated any fixed lesion;** although with his history and the difficulty during diving and the symptom he notes, this is suggestive of eustachian tube dysfunction related to his dives..." (Ex. 2, p. 17). Dr. Smith discussed treatment options for eustachian tube

dysfunction, and referred Claimant to Dr. Hegarty (“a neurootologist”) for such treatment. (emphasis added).

39. Claimant saw Joseph Hegarty, M.D., on August 21, 2018. Dr. Hegarty noted, “...This 45 year old patient reports that, in early October, he went scuba diving and was not able to equalize his pressure. In subsequent attempts to dive, he was also unable to equalize his pressure. He has been a diver for about ten years and, prior to this incident, did not experience issues equalizing. His last attempt was in April 2018. He reports that, in the last month, he has had several spells of dizziness and light-headedness when he has successfully popped his ears. He reports that he has taken prednisone and other anti-inflammatory medications prior to his dives. He reports that, recently, he has become increasingly sensitive to noise. He reports that his symptoms generally occur in his left ear, but occasionally impact the right ear as well. He reports that the pain, which has previously been consistent for several months, has begun to recede in the past few days...He comes in to consider Eustachian tube dilation procedures...” (Ex. 1 p. 11).
40. On examination, Dr. Hegarty reported, “...DIAGNOSTIC BINOCULAR MICROSCOPY shows chronic ETD (eustachian tube dysfunction) with some chronic eczema AU [both ears]. No fluid or infection seen in the middle ear. Minimal tympanosclerosis is seen.” His diagnoses included bilateral sound sensitivity; left ear pressure and symptoms suggestive of atypical hydrops, and bilateral eustachian tube dysfunction. (Id. at 12).
41. Hearing tests were performed on September 6, 2018 and the results were normal. (Ex. 1, p. 4). Dr. Hegarty met with Claimant on that date and noted, “...He reports that diving is important to him and is interested in a treatment plan that would allow him to continue to dive. He has been using a nasal steroid spray as prescribed...” The doctor reported that microscopy again showed “mild chronic ETD and chronic EAC eczema AU.” Dr. Hegarty’s diagnoses again included bilateral eustachian tube dysfunction. He recommended Claimant “...Dive once without prednisone. Dive once with taking prednisone as prescribed...If persistent fluctuant symptoms consider diuretic treatment.” (Ex. 1, p. 3).
42. On October 15, 2018, Seth A. Reiner, M.D., performed an Independent medical examination and records review. Dr. Reiner did not see any permanent impairment of Claimant’s ears. Even if Claimant had some eustachian tube dysfunction, (which Dr. Reiner noted is common, especially with patients who have sinus troubles), Dr. Reiner did not think this caused any significant hearing loss. Dr. Reiner stated that, with normal testing, he did not think Claimant had hydrops *caused by* the diving he had done for work, or any significant cochlear damage from diving.
43. Dr. Reiner opined that barotrauma, if any occurred during the dives, did not seem to have damaged the eardrum or middle ear structures. None of the typical findings of ruptured eardrum, retracted eardrum, or conductive hearing loss were described or documented on examinations. Dr. Reiner noted the hearing loss determined by the most recent audiogram was very mild and in higher frequencies, and he did not think it was due to any diving activities. (Ex. M, p. 39)

44. Dr. Reiner testified by deposition on November 8, 2018. He opined, "with a great deal of medical certainty," that a diving incident did not cause any damage to Claimant's ears. He was confident to a medical degree of certainty that Claimant has no significant hearing problems. He didn't think the diving incident Claimant described caused any significant damage to his ears. He didn't think there was anything during diving that caused any injury to Claimant's ears. He opined Claimant did not have any impairment because applying the formula used by the American Academy of Otolaryngology to Claimant's audiogram numbers gives zero disability. He opined, if Claimant sustained a work-related injury, he was at MMI at the time of his evaluation.
45. Dr. Reiner further testified that, when there is damage from diving, it is usually in both ears, rather than in one ear. Both ears are subjected to the same pressure changes, so it would be hard to damage just one ear. If there was damage to an ear from a diving incident, the most common damage one would expect would be a perforated eardrum, with blood or extreme hearing loss. That hearing loss would show as a conductive hearing loss, or if it was really severe, it would be a dramatic drop rather than flat across like Claimant has now. This was shown on Dr. Hegarty's September 6, 2018 audiogram.
46. Dr. Reiner opined that if there was damage to the ear from a barometric change or a dive, it would be a sloping curve, usually downward sloping, pretty severe hearing loss, not a notch like Claimant has. The hearing loss Claimant has is very typical of most middle-aged or older males with noise-induced hearing loss. The most common injury from barometric pressure changes is a ruptured eardrum, with acute dizziness, usually drainage, sometimes blood in the ear. Such injury drives people to the emergency room right away.
47. Dr. Reiner opined that Claimant has mild eustachian tube dysfunction, which could be caused by allergies, irritants, dust, swelling in the eustachian tube, or chronic sinus problems. Sometimes a cause for it is never identified. If a person had mild eustachian tube dysfunction and went diving, they would feel pressure in the ear. The dive would provide symptoms of a problem that the person already had.
48. On February 21, 2019, a follow-up evidentiary deposition was taken of Dr. Reiner. Dr. Reiner testified it was highly unlikely-and not probable at all-that Claimant sustained an occupational disease or injury from repeated dives. He added that for shallow dives, such as the dives Claimant made in 2017 and 2018, it was extremely unlikely there was any occupational disease or work-related injury from repeated dives. Dr. Reiner's opinion was based on the fact he couldn't find in the records any objective finding of eustachian tube dysfunction or damage. He opined that chronic eustachian tube dysfunction or damage from repeated injury would show what's called a conductive hearing loss, not a sensory hearing loss. Claimant shows no evidence of that.
49. Dr. Reiner also explained that, if there was a significant repeated eustachian tube problem from diving, they might see negative tympanometry or pressure in the ears. Claimant's were essentially normal. Dr. Reiner noted Claimant's eardrums looked completely normal upon physical examination. In all of the examination, especially in the

nasopharynx and the MRI scan, there was no objective finding that would substantiate any occupational damage.

50. Dr. Reiner testified he didn't think he had ever heard of eustachian tube problems or damage at depths of 10 to 12 feet. Even with a dive to a depth of approximately 45 feet, if Claimant had sustained eustachian tube disorder, there would have been objective findings such as conductive hearing loss, retracted eardrums, or fluid in the middle ears. It would usually affect both ears, because the water pressure is applied to both sides of the head. Dr. Reiner himself has been a recreational diver for over 40 years. He is certified through NAUI and PADI, and has made dives down to 85 feet.

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. §8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not, *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of the respondents. §8-43-201, C.R.S.

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 a workers' compensation proceeding is the 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).

D. The ALJ finds the testimony of Lt. Leach, Lt. McConnellogue, Chief Wheeler, Lt. Barron, and Engineer Crumb to be sincere, reliable, and credible. At all times, the Fire Department showed appropriate concern for Claimant's well-being, but with appropriate attention to assuring a proper state of readiness for the Heavy Rescue Program as a whole. While not necessarily dispositive of the compensability issue, the ALJ finds that the terms of the April 23, 2018 Dive Training Memorandum were reasonable, appropriate, and not overly ambitious, especially with the ability to extend the completion date as needed.

E. The ALJ further finds Claimant to be sincere in his own perception of events, but an analysis of Claimant's psychological state is not necessary for a determination of the compensability issue. There is ample evidence in the record to analyze this matter from a purely medical perspective, regardless of Claimant's unusual timing in filing a Workers Compensation claim.

F. 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).

G. Further, courts are to be "mindful that the Workmen's Compensation Act is to be liberally construed to effectuate its humanitarian purpose of assisting injured workers." *James v. Irrigation Motor and Pump Co.*, 503 P.2d 1025 (Colo 1972).

Compensability, Generally

H. A pre-existing disease or susceptibility to an injury does not disqualify a claim if the employment aggravates, accelerates, or combines with a 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). However, the mere occurrence of symptoms at work does not require the ALJ to conclude that the duties of employment caused the symptoms or that the employment aggravated or accelerated any pre-existing condition. Rather, the occurrence of symptoms at work may represent the result of a natural progression of a pre-existing condition that is unrelated to the employment. See *F.R. Orr Construction v. Renta*, 717 P.2d 965 (Colo. App. 1995).

I. The mere fact that a claimant experiences pain at work does not necessarily require a finding of a compensable injury. In *Miranda v. Best Western Rio*

Grande Inn, W.C. No. 4-663-169 (ICAO April 11, 2007), the panel stated “[p]ain is a typical symptom caused by the aggravation of pre-existing condition. However, an incident which merely elicits pain symptoms caused by a pre-existing condition does not compel a finding that the claimant sustained a compensable injury.”

Claimant’s Diving Activities, Causing an “Injury”

J. Claimant had trouble clearing his ears in shallow water on July 29, 2017 while attempting to rejoin to Station 17. Because of this trouble, he naturally experienced pain while diving. He had been away from diving since his departure in 2015. He wisely avoided diving and stayed on the shore providing dive support after his September 21, 2017 dive. When his supervisor met with him about his difficulty scuba diving and getting under the water, he complained of symptoms he said he thought could be a brain tumor or a leak of cerebral spinal fluid. Nevertheless, he did not seek medical treatment during this time-period, and he cancelled the medical appointment he had scheduled for his “brain leak” due to financial constraints. Regardless of any alleged ‘mental block’ Claimant may have concurrently been experiencing, he had apparent trouble with clearing his ears on each subsequent dive, even in shallow, confined water. It can happen to even experienced divers who maintain their skills.

K. While not dispositive of the causation issue, it is duly noted that Claimant did not allege his ongoing complaints were the result of a work injury or occupational disease until his dive training plan was suspended and he was given the options of obtaining a medical release from his healthcare provider allowing him to continue with the dive training plan or initiating a request for FMLA leave or ADA accommodation, if appropriate.

L. Dr. Reiner credibly opined that Claimant has mild eustachian tube dysfunction, which could be caused by allergies, irritants, dust, swelling in the eustachian tube, or chronic sinus problems. Sometimes they never find a cause for it. Dr. Reiner explained that if a person had mild eustachian tube dysfunction and went diving, they would feel pressure in the ear. The dive would provide symptoms of a problem that the person already had (pre-existing disease). Dr. Reiner has opined that a diving incident or incidents did not cause any damage to Claimant’s ears, and that Claimant did not sustain an occupational disease or injury from repeated dives.

M. Dr. Reiner also opined that Claimant had no significant hearing problems, and that the hearing loss Claimant does have is very typical of most middle-aged or older males or noise-induced hearing loss. Dr. Reiner’s opinion was based on the fact that he couldn’t find in the records any objective finding of eustachian tube dysfunction or damage. Dr. Reiner testified he didn’t think he had ever heard of eustachian tube problems or damage at depths of 10 to 12 feet. Even with a single dive to a depth of approximately 45 feet, if Claimant had sustained eustachian tube disorder there would have been objective findings like conductive hearing loss, retracted eardrums, or fluid in the middle ears. Also, it would usually affect both ears because the pressure is exposed equally to both sides of the head.

N. Most notably, there is nothing inconsistent with Dr. Reiner's findings and those of Dr. Hegarty and Dr. Smith-as well as the Nurse Practitioners Claimant also encountered. While Dr. Hegarty noted some *mild chronic* eustachian tube dysfunction, at no point did he even suggest that it was *caused by* Claimant's diving activities. Nor did Dr. Smith ever attempt to make a *causal* link. He merely noted his observations, and how to possibly move forward. In fact, the evidence in the record suggests this ETD problem is not uncommon in divers. If you cannot successfully address it medically, you cannot dive. It does not have to be someone's fault. It does not have to be connected to a specific cause; often it is not. Unfortunate for the diver, but true.

O. Of course Claimant felt some discomfort since he could not properly clear his ears. He then did the correct thing by aborting the dives he attempted-and with the full support at every turn of his co-workers. In so doing, he incurred no damage or injuries to his ears, either in an acute event, or cumulatively, and the ALJ so finds. His symptoms were temporary, not resulting in any aggravation requiring treatment. Stated another way, if a firefighter is standing too close to the fire, he might feel some discomfort. Before the discomfort morphs into an actual 'injury', he merely takes a few steps back. Problem solved. Similarly, Claimant has failed to show, by a preponderance of the evidence, that he suffered a compensable work injury, either acutely, or as a result of any occupational disease caused by scuba diving.

Medical Benefits/Authorized Treating Provider

P. Claimant has not suffered a compensable work injury. There is no need to further address Medical Benefits or Authorized Treating Provider.

ORDER

It is therefore Ordered that:

1. Claimant's claim for Workers Compensation benefits is denied and dismissed.
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: March 19, 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

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 5-004-352-002 & 5-025-676

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 March 5, 2019, in Denver, Colorado. The hearing was digitally recorded (reference: 3/5/19, Courtroom 3, beginning at 8:30 AM, and ending at 12:15 PM).

Claimant's Exhibits 1 through 13 and 15 were admitted into evidence, without objection. Respondents' Exhibits A through N and Q were admitted into evidence, without objection.

W.C. No. 5-004-252-002 concerns an admitted injury of January 14, 2016. W.C. No 5-025-676 concerns a fully contested injury of August 25, 2016.

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 March 11, 2019. Respondents were given two working days within which to file objections. No timely objections were filed. After a consideration of the proposed decision, the ALJ has it and hereby issues the following decision.

ISSUES

For W.C. No. 5-004-252, the sole issue for decision concerns post maximum medical improvement (MMI) medical maintenance benefits, specifically, completion of acupuncture recommended by authorized treating physician (ATP) Franklin Shih, M.D; and, counseling by Ron Carbaugh, Psy.D., a licensed clinical psychologist.

For W.C. No. 5-025-676, the issues for decision concern compensability and, if compensable, medical benefits, specifically, evaluation of the Claimant by a neurologist pursuant to the recommendation of Neha N. Patel, M.D. The parties stipulated that if W.C. 5-025-676 was found compensable, Dr. Patel was an ATP.

The Claimant bears the burden of proof on all issues by a preponderance of the evidence.

FINDINGS OF FACT

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

W.C. No. 5-004-352-002 –Admitted January 14, 2016 Injury

Preliminary Findings

1. The Claimant worked as a material handler for the Employer. On January 14, 2016, he injured his back when he turned his body to reach for a handle while exiting a trailer (Claimant's Exhibit 1). Respondents accepted the claim and medical treatment was provided.

2. ATP Dr. Michael Ladwig, M.D. originally placed the Claimant at MMI on May 26, 2016. Claimant objected and requested a Division Independent Medical Examination (DIME), which was performed by Michael Striplin., M.D. In his DIME report Dr. Striplin determined that the Claimant reached MMI on May 26, 2016.

3. Respondents filed a Final Admission of Liability ((FAL), dated November 22, 2016 consistent with Dr. Striplin's DIME report. The FAL admitted for medical maintenance benefits (Claimant's Exhibit 2). At the time he placed the Claimant at MMI, Dr. Ladwig recommended medical maintenance in the form of 3 acupuncture sessions with Dr. Shih and 3 counseling sessions with Dr. Carbaugh (Claimant's Exhibit 5, p. 99). Dr. Striplin also adopted Dr. Ladwig's medical maintenance recommendations in his DIME report (Claimant's Exhibit 2, pp. 13). Respondents subsequently denied the

medical maintenance recommendations. F. Mark Paz, M.D., Respondent's retained expert, disagrees that the treatment recommended by the ATP and DIME physician is reasonably necessary. The ALJ accepts the opinions of the ATP and the DIME and rejects the opinion of IME Dr. Paz in this regard.

Dr. Ladwig – Claimant's Authorized Treating Physician (ATP)

4. In his MMI report of May 26, 2016, Dr. Ladwig states "MMI with maintenance: allowed to see Dr. Shih for acupuncture times 3 sessions for 6 months also allowed to see Dr. Carbaugh times 3 sessions for 6 months if needed" (Claimant's Exhibit 5, p. 99).

Dr. Carbaugh, Psy.D. – Psychological and Pain Management Services

5. In his report of May 13, 2016, Dr. Carbaugh states, "At this point, [Claimant] has completed three of the initial authorized six treatment sessions through this practice. If Dr. Shih has placed him at MMI, the remaining three sessions would appropriately be considered part of his maintenance care plan" (Claimant's Exhibit 6, p. 107).

Dr. Striplin – Division Independent Medical Examiner (DIME)

6. Regarding Claimant's maintenance treatment, Dr. Striplin states in his DIME report of November 1, 2016 that "The patient should be offered up to three follow-up visits with Dr. Shih, for acupuncture treatments if needed, and two additional counseling sessions with Dr. Carbaugh if needed, to be completed by May 31, 2017" (Claimant's Exhibit 2, p. 13). At the time of the DIME appointment, the Claimant had completed one of the three recommended counseling sessions with Dr. Carbaugh-- under maintenance care.

Dr. Paz – Respondents' Independent Medical Examiner (IME)

7. Dr. Paz performed a records review as the basis of his report and findings, as he did not perform a physical evaluation of the Claimant. Regarding the recommended medical maintenance Dr. Paz's IME report only highlights that "Dr. Striplin, the DIME physician, recommended no additional treatment medical maintenance would be required beyond May 31, 2017, for the low back pain which was attributable to the January 14, 2016, incident" (Respondent's Exhibit G, p. 21).

8. At the hearing, Dr. Paz testified consistently with his report. He stated that the Claimant is beyond the six-month window for completion of his medical maintenance recommendations, therefore; the recommendations are no longer reasonably necessary. Because Respondents would not pay to complete the

implementation of the recommendations of the ATP and the DIME, Dr. Paz's opinion in this regard is based on a conundrum involving the expiration of 6-months. Carried to its logical conclusion, a carrier could simply delay the implementation of recommended treatment for six months and then take the position "tume's up.". Such a proposition, in part, undermines Dr. Paz's opinion. The ALJ finds Dr. Paz's opinion regarding the reasonableness and necessity of the recommended medical maintenance neither credible nor persuasive.

The Claimant

9. The Claimant credibly testified at hearing that following being placed at MMI, he was informed by his medical providers that his case was closed and they were unable to schedule completion of the recommended medical maintenance treatment. The Claimant contacted the adjuster who confirmed that his case was closed and that the additional treatment recommendations were denied. Following the denial, the Claimant attempted, unsuccessfully, to seek treatment at an urgent care facility. According to the Claimant, he was symptomatic at the time he was placed at MMI and he continues to have ongoing symptoms. He has not sustained any subsequent injury to his low back. He wishes to proceed with the medical maintenance recommendations for follow up treatment with Dr. Shih and Dr. Carbaugh. The ALJ finds that the Claimant's testimony concerning being denied the recommended medical treatment, his ongoing symptoms, and desire for treatment is credible, convincing and unrefuted by any other evidence.

Ultimate Findings

10. The ALJ finds the opinions of Dr. Ladwig, Dr. Carbaugh, and Dr. Striplin highly credible and persuasive. On the other hand, the ALJ finds the opinions of Dr. Paz inadequately based, contrary to the weight of medical opinions in evidence, and lacking in credibility for the reasons herein above stated. Further, the ALJ finds the Claimant's testimony to be consistent with the weight of the medical evidence and therefore, credible and persuasive.

11. Between conflicting testimonies and opinions, the ALJ makes a rational choice, based on substantial evidence, to accept the Claimant's testimony and the opinions of Dr. Ladwig, Dr. Carbaugh, and Dr. Striplin and to reject opinions to the contrary.

12. The ALJ finds that the Claimant has proven by a preponderance of the evidence that his need for the medical maintenance, including completion of 3 sessions of acupuncture and 3 counseling sessions is reasonably necessary to treat the effects of the compensable injury of January 14, 2016.

13. Dr. Ladwig was an authorized treating physician and Dr. Carbaugh was within the chain of authorized referrals.

W.C. No. 5-025-676 –August 25, 2016 Injury

Preliminary Findings

14. The Claimant continued to work as a material handler for Employer. On August 25, 2016, he responded to a chemical overflow that occurred while unloading a tanker truck. As a result, he was exposed to Caustic Soda, a hazardous chemical. The Caustic Soda overflow resulted in the chemical coming from a pipe below the tanker and also from the manhole on the top of the tanker. This resulted in a mist like rain that came down on top of the Claimant, resulting in exposure to his eyes, head, and neck. The Claimant immediately reported the injury and flushed his eyes followed by a shower at the job site. Later that day, the Claimant was driven to the Emergency Room (ER) at Rose Medical Center by his supervisor, William Bell. The Claimant filled out a formal First Report of Injury on September 15, 2016 (Claimant's Exhibit 8, p. 143). He sought medical treatment from Neha N. Patel, M.D., following his date of the exposure incident, based on the referral from the ER physicians. Respondents filed a Notice of Contest on October 12, 2016 (Claimant's Exhibit 9, p. 144).

15. On October 31, 2016, Dr. Patel referred the Claimant for evaluation by a neurologist (Claimant's Exhibit 8, p. 218). Following this referral, Respondents invoked their Notice of Contest and refused approval of future medical treatment. Dr. Paz, Respondent's retained expert witness, is of the opinion that Dr. Patel's referral to a neurologist is not reasonably necessary and the Claimant reached MMI on January 9, 2017. For the reasons specified herein below, the ALJ rejects Dr. Paz's opinion in this regard.

Rose Medical Center – Emergency Room

16. On the day of his toxic exposure incident, the Claimant sought treatment at the ER of Rose Medical Center. The ER record states "39yoM with no pertinent pmh presents to the ED c/o eye pain, photophobia, and skin irritation being sprayed on by a "20% caustic/corrosive" chemical at 1730 today while at work at [Employer] chemical plant. Pt reports that the truck overflowed and was sprayed in his face/neck by the wind" (Claimant's Exhibit 10, p. 147). The report further outlines "Pt states he was exposed indirectly to misted solution after it spilled over" (Claimant's Exhibit 10, p.149).

17. The ER report states "Pt was able to call his boss and he was able to identify substance he was exposed to: caustic soda 20%" (Claimant's Exhibit 10, p. 150). The Claimant was released from the ER with "close f/u through work comp. Pt also given ophthalmology referral. Encouraged to return to ER for any change or worsening in condition" (Claimant's Exhibit 10, p. 150).

Dr. Patel – Oculoplastics & Ophthalmology

18. On August 26, 2016, the Claimant sought follow up treatment with Dr. Patel, an oculoplastic specialist. Dr. Patel diagnosed the Claimant with a “Chemical injury to conjunctiva” (Claimant’s Exhibit 13, p. 208).

19. In her report of September 26, 2016, Dr. Patel diagnosed the Claimant with a chemical injury to conjunctiva and notes that the Claimant has intermittent episodes of blurred vision. At that evaluation, Dr. Patel contemplated a “neuro op” referral (Claimant’s Exhibit 13, p. 212).

20. On October 31, 2016 Dr. Patel noted that Claimant is reporting “headaches that begins around eye and radiates out toward temple.” (Claimant’s Ex 13, pp. 217). Dr. Patel concludes that she “will refer to neurology.” (Claimant’s Ex 13, pp. 218).

Joel H. Goldstein, M.D. - UC Health Urgent Care

21. Due to the denial of his claim and medical treatment, Claimant sought treatment at UC Health Urgent care due to an increase of eye symptoms. The medical record states “2 day history of FB sensation and redness and blurry vision RE. Previous history of chemical keratitis RE.” (Claimant’s Ex 11, pp. 147). Claimant was provided artificial tears, medications, and lubricating gel. (Claimant’s Ex 11, pp. 147).

David Reinhard, M.D. – Colorado Rehabilitation & Occupational Medicine

22. ATP Dr. Patel referred the Claimant to David L. Reinhard, M.D. Dr. Reinhard diagnosed THE Claimant with “1. Work-related chemical exposure to face, eyes, and skin with resultant chemical conjunctivitis. 2. Ongoing visual complaints including reduced visual acuity, photophobia and dry eyes secondary to chemical exposure. 3. Migraine headaches secondary to #1” (Claimant’s Exhibit 12, p. 204).

Material Safety Data Sheet (MSDS)

23. The Material Safety Data Sheet (MSDS) classifies Caustic Soda as a hazardous material. The MSDS outlines that exposure “causes severe skin burns and eye damage.” (Claimant’s Ex 15). The MSDS further warns that Caustic Soda is “corrosive to eyes. Contact with the eyes rapidly causes severe damage to the tissues. may cause redness, pain, blurred vision. May cause severe, deep burns and permanent impairment to, or total loss of, sight” (Claimant’s Exhibit 15, p. 229).

Dr. Paz – Respondent’s Independent Medical Examiner (IME)

24. Dr. Paz performed a records review as the basis of his report and findings, as he did not perform a physical evaluation of the Claimant. Dr. Paz outlines in his report that Claimant reached maximum medical improvement for his August 25, 2016 injury on January 9, 2017. As a result, Dr. Paz concludes that Claimant’s headaches and visual disturbances are not causally related to his industrial injury.

25. At THE hearing, Dr. Paz testified consistently with his report. Dr. Paz stated that Dr. Patel’s referral to a neurologist for further evaluation is not reasonably necessary as related to the Claimant’s industrial injury. The ALJ finds Dr. Paz’s opinion regarding the reasonableness of the referral to a neurologist neither credible nor persuasive. Any opinion by Dr. Paz that Claimant did not sustain a compensable injury on August 25, 2016 is also found to be neither credible nor persuasive. Dr. Paz opined in his report and at hearing that Claimant reached MMI on January 9, 2017, which indicates by his own admission that Claimant sustained a compensable injury.

The Claimant

26. The records from the ER corroborate Claimant’s testimony regarding the industrial exposure. Claimant’s account of the exposure is uncontested. Claimant’s testimony regarding his symptoms is also consistent with the medical reports from the Rose Hospital emergency room, Dr. Patel, Dr. Goldstein, and Dr. Reinhard. Claimant testified that he currently has ongoing symptoms consistent with those reported to his treating doctors. The ALJ finds that the Claimant’s testimony concerning the injurious event and ongoing symptoms is credible and persuasive.

Ultimate Findings

27. The ALJ finds the opinions of the Rose Medical ER physicians, Dr. Patel, Dr. Goldstein, and Dr. Reinhard highly credible and persuasive regarding their diagnosis of a work related injury. On the other hand, the ALJ finds the opinions of Dr. Paz inadequately based, contrary to the weight of medical opinions in evidence, and lacking in credibility for the reasons herein above stated. Further, the ALJ finds the Claimant’s testimony to have been consistent with the weight of the medical evidence and, therefore, credible and persuasive.

28. Between conflicting testimonies and opinions, the ALJ made a rational choice, based on substantial evidence, to accept the Claimant’s testimony and the opinions of Dr. Patel, Dr. Goldstein, Dr. Reinhard, and the Rose Medical ER physicians and reject opinions to the contrary.

29. The ALJ finds that the Claimant has proven by a preponderance of the evidence that he sustained a compensable injury on August 25, 2016. The Claimant has proven, by preponderant evidence, that Dr. Patel's neurological referral is causally related to the August 25, 2016 industrial injury and reasonably necessary to cure and relieve the effects thereof. Further, the treatment that Claimant has received to date is causally related to his August 25, 2016 injury.

30. The Rose Center ER was an authorized medical provider. Its referral to Dr. Patel was within the authorized chain of referrals; and, referrals by Dr. Patel, or within the unbroken chain, to Dr. Goldstein and Dr. Reinhard were within the authorized chain of referrals.

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. *Arenas 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 opinions of Dr. Ladwig, Dr. Striplin and Dr. Carbaugh with respect to W.C. No. 5-004-352-002 were high credible and persuasive. With respect to W.C. No. 5-025-676, the opinions of the Rose Medical ER physicians, Dr. Patel, Dr. Goldstein, and Dr. Reinhard were highly credible and persuasive regarding their diagnosis of a work related injury. On the other hand, as found, the opinions of Dr. Paz, in both cases, were inadequately based, contrary to the weight of medical opinions in evidence, and lacking in credibility for the reasons herein above stated. Further, as found, the Claimant's testimony, as related to both cases, was consistent with the weight of the medical evidence and, therefore, credible and persuasive.

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); *Leeway 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 testimonies and opinions in W.C. No. 5-004-352-002, the ALJ made a rational choice, based on substantial evidence, to accept the Claimant's testimony and the opinions of Dr. Ladwig, Dr. Carbaugh, and Dr. Striplin and to reject opinions to the contrary. With respect to W.C. No. 5-025-676, between conflicting testimonies and opinions, the ALJ made a rational choice, based on substantial evidence, to accept the Claimant's testimony and the opinions of Dr. Patel, Dr. Goldstein, Dr. Reinhard, and the Rose Medical ER physicians and reject opinions to the contrary.

Medical

c. An employee is entitled to continuing medical benefits after MMI if reasonably necessary to relieve the employee from the effects of an industrial injury. See *Grover v. Indus. Comm'n of Colorado*, 759 P.2d 705 (Colo. 1988). The record must contain substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve a claimant from the effects of an injury or to prevent further deterioration of his condition. *Stollmeyer v. Indus. Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995); *Grover v. Indus. Comm'n, supra*. Such evidence may take the form of a prescription or recommendation for a course of medical treatment necessary to relieve a claimant from the effects of the injury or to prevent further deterioration. *Stollmeyer v. Indus. Claim Appeals Office, supra*. An injured worker is ordinarily entitled to a general award of future medical benefits, subject to an employer's right to contest causal relatedness and reasonable necessity. See *Hanna v. Print Expeditors*, 77 P.3d 863 (Colo. App. 2003). Treatment to **improve** a claimant's condition does **not** fall under the purview of *Grover* benefits. *Shalinbarger v. Colorado Kenworth, Inc.*, W.C. No. 4-364-466 [Indus. Claim Appeals Office (ICAO), March 12, 2001]. As found, Claimant is entitled to maintenance medical care, which is reasonably necessary to address the injury in W.C. No. 5-004-352-002. Dr. Ladwig was an ATP and his referral to Dr. Carbaugh was within the chain of authorized referrals.

d. An employer must provide an injured employee with reasonably necessary medical treatment to "cure and relieve the employee from the effects of the injury." § 8-42-101(1) (a), C.R.S. The employee must prove a causal relationship between the injury and the medical treatment for which the worker is seeking benefits. *Snyder v. Indus. Claim Appeals Office*, 942 P.2d 1337, 1339 (Colo. Ct. App. 1997). Treatments for a condition not caused by employment are not compensable. *Owens v. Indus. Claim Appeals Office*, 49 P.3d 1187, 1189 (Colo. Ct. App. 2002). An industrial accident is the proximate cause of a claimant's disability if it is the necessary precondition or trigger of the need for medical treatment. *Subsequent Injury Fund v. State Compensation Insurance Authority*, 768 P.2d 751 (Colo. App. 1988). In order to prove that an industrial injury was the proximate cause of the need for medical treatment, an injured worker must prove a causal nexus between the need for treatment and the work-related injury. *Singleton v. Kenya Corp.*, 961 P.2d 571 (Colo. App. 1998). It is for the ALJ, as the fact-finder, to determine whether a need for medical treatment is caused by the industrial injury, or some other intervening injury. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). Respondents are liable for the "direct and natural consequences" of a work-related injury, including consequential injuries caused by the original compensable injury. See *Travelers Ins. Co. v. Savio*, 806 P.2d 1258 (Colo. 1985). The chain of causation, however, can be broken by the occurrence of an independent intervening injury. See 1 A. *Larson, Workers' Compensation Law*, section 13.00 (1997). As found, the medical care and treatment for the Claimant's toxic exposure was causally related thereto and reasonably necessary to cure and relieve the effects thereof. As found, with respect to W.C. No. 5-004-352-002,

e. To be authorized, all referrals must remain within the chain of authorized referrals in the normal progression of authorized treatment. See *Mason Jar Restaurant v. Indus. Claim Appeals Office*, 862 P. 2d 1026 (Colo. App. 1993); *One Hour Cleaners v. Indus. Claim Appeals Office*, 914 P. 2d 501 (Colo. App. 1995); *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). When an ATP refers an injured worker to his personal physician, under the mistaken belief that the claim was not compensable, the referral was nonetheless within the chain of authorized referrals and, thus, subsequent treatment was authorized. See *Cabela v. Indus. Claim Appeals Office*, 198 P.3d 1277 (Colo. App. 2008). As found, all of the referrals in both cases were within the chain of authorized referrals.

Burden of Proof

f. 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 his burden of proof in both cases.

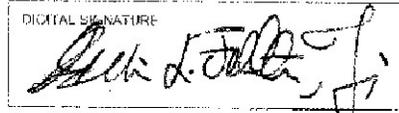
ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents shall pay all the costs of competing the recommended acupuncture treatment by Dr. Shih and the counseling recommended by Dr. Carbaugh as maintenance medical care (W.C. No. 5-004-352-002); and, the costs of medical treatment for the Claimant’s compensable toxic exposure of August 25, 2016 (W.C. No. 5-025-676), subject to the Division of Workers’ Compensation Medical Fee Schedule.

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

DATED this _____ day of March 2019.

A rectangular box containing a digital signature. The text "DIGITAL SIGNATURE" is printed in small letters at the top left of the box. Below it is a handwritten signature in black ink that appears to read "Edwin L. Felter, Jr.". The signature is written over a light gray grid.

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>.**

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 5-039-027-001**

ISSUES

1. Whether Respondent has produced clear and convincing evidence to overcome the Division Independent Medical Examination (DIME) opinion of David W. Yamamoto, M.D. that Claimant has not reached Maximum Medical Improvement (MMI) as a result of his February 2, 2017 admitted industrial injuries.
2. Whether Claimant is entitled to a disfigurement award pursuant to §8-42-108, C.R.S.

FINDINGS OF FACT

1. Claimant worked for Employer as a Security Facilitator. On February 2, 2017 he suffered admitted industrial injuries during the course and scope of his employment. Claimant specifically slipped and fell on black ice and suffered a right femur fracture. He was transported by ambulance to the Good Samaritan Medical Center Emergency Room.
2. On February 3, 2017 Claimant underwent surgery with George Chaus, M.D. Dr. Chaus characterized the fracture as "significantly more difficult for fixation and reduction than a standard intertrochanteric or subtrochanteric hip fracture with significant deforming forces requiring an open reduction, cerclage cable wiring and advanced trauma techniques." He prescribed postoperative antibiotics and DVT prophylaxis.
3. On February 6, 2017 Claimant was transferred to a rehabilitation facility. He remained at the location and received treatment for approximately one month. When he returned home in early March, 2017 he utilized a hospital bed on the main floor for sleeping and required a wheelchair to move around the house.
4. On March 10, 2017 Claimant visited Authorized Treating Physician (ATP) Dean L. Prock, M.D. He reported right upper and lateral right leg pain. Dr. Prock diagnosed Claimant with right hip pain, right knee pain and acute intractable tension-type headaches.
5. On April 11, 2017 Claimant returned to light duty work with Employer. He had restrictions of no lifting or carrying more than two pounds, and no walking, crawling, kneeling, squatting, climbing or driving. Claimant was directed to use the wheelchair for movement a maximum of two to four minutes per hour.
6. On May 19, 2017 Claimant returned to Dr. Prock for an examination. Claimant did not report any lower back pain. He utilized a walker instead of a wheelchair. Claimant advised Dr. Prock that he would be leaving soon for a one month-

long vacation in the Philippines. Dr. Prok referred Claimant to Nicholas K. Olsen, D.O. for an examination. However, Claimant noted that he would not be able to undergo an evaluation until after he returned from vacation.

7. On June 29, 2017 Claimant visited Dr. Olsen for an evaluation. Claimant mentioned a recent trip to the Philippines with his family. While in the water he was able to walk with a normal gait and significantly reduced pain. Claimant noted a marked increase of pain with a single-legged stance on the right lower extremity, difficulty walking upstairs and relief when sitting in a recliner or propping his leg up with pillows in bed. Dr. Olsen noted mild forward flexed posture and moderate range of motion deficits in both flexion and extension. He prescribed land-based physical therapy and pool therapy because of Claimant's good experience with water walking while in the Philippines.

8. Claimant underwent land-based physical therapy from July 10, 2017 through August 31, 2017 with CACC Physical Therapy. He received pool therapy with SCLP Broomfield Rehab from June 28, 2017 through September 13, 2017. Claimant did not report any lumbar spine complaints.

9. On August 24, 2017 Claimant visited Dr. Olsen for an examination. Claimant was using a straight cane mostly at work but less at home. He reported anterior right groin pain when weight-bearing as well as pain in his right knee and hip. Claimant did not mention pain in his lumbar spine or SI joint. Dr. Olsen noted "neutral mechanics" in the lumbar spine and full range of motion.

10. Claimant continued to visit Dr. Prok from September 22, 2017 through March 5, 2018. Claimant reported right knee pain and Dr. Prok included "acute pain of right knee" in his diagnoses.

11. On February 5, 2018 Dr. Olsen added, "acute deep vein thrombosis (DVT) of distal vein of right lower extremity" to his diagnoses. He noted that Claimant's personal physician was managing the DVT with blood thinners.

12. On March 5, 2018 Claimant visited Dr. Prok for an evaluation. After performing a physical examination Dr. Prok determined that Claimant had reached Maximum Medical Improvement (MMI). He assigned a 21% right lower extremity impairment rating for loss of range of motion of the hip. Dr. Prok also assigned a 20% right lower extremity impairment rating pursuant to Table 45 of the *AMA Guides for the Evaluation of Permanent Impairment Third Edition (Revised)* (*AMA Guides*). Combining the ratings yielded a 37% right lower extremity impairment. The 37% lower extremity impairment converts to a 15% whole person rating. Dr. Prok remarked that "[Claimant] reports having some swelling in the lower leg after the DVT event that was not considered occupational due to the duration from the surgical date was a very long time and this was discussed previously and that he should continue management of this issue to his personal physician separately from this claim." He authorized medical maintenance benefits.

13. On March 22, 2018 Respondent filed a Final Admission of Liability (FAL) consistent with Dr. Prok's date of MMI and 37% right lower extremity impairment rating. Respondent also agreed that Claimant was entitled to receive medical maintenance benefits. Claimant timely filed an objection to the FAL and sought a Division Independent Medical Examination (DIME).

14. On September 7, 2018 Claimant underwent a DIME with David W. Yamamoto, M.D. Dr. Yamamoto determined that Claimant had not reached MMI. After reviewing Claimant's medical records and conducting a physical examination Dr. Yamamoto diagnosed Claimant with the following: (1) right hip intertrochanteric fracture/subtrochanteric fracture with extension to the proximal right femur requiring an intramedullary implant; (2) antalgic gait requiring frequent use of a cane; (3) mechanical lower back pain secondary to the antalgic gait; and (4) DVT following the right hip fracture, lengthy immobilization and inactivity post-injury. He summarized that Claimant's continuing antalgic gait secondary to his industrial injury resulted in persistent lower back pain and dysfunction that had not been formally treated. Dr. Yamamoto recommended a trial of physical therapy. However, if Claimant did not respond, he suggested referral to a physiatrist for evaluation and treatment.

15. Dr. Yamamoto provided a provisional impairment rating of 33% for Claimant's right lower extremity. The rating included 25% for loss of range of motion and 10% for peripheral vascular system impairment. The right lower extremity 33% impairment rating converts to a 13% whole person impairment. Dr. Yamamoto also provided a provisional lumbar spine impairment rating of 12%. The rating included 5% pursuant to Table 53 of the *AMA Guides* and 7% for loss of range of motion. When combined with the lower extremity ratings the provisional whole person impairment rating was 23%.

16. Respondent filed an Application for Hearing seeking to overcome Dr. Yamamoto's opinion regarding MMI. In support, Respondent obtained an independent medical examination with Carlos Cebrian, M.D. Dr. Cebrian performed the examination on November 29, 2018 and issued a report dated December 18, 2018. He concluded that Dr. Yamamoto clearly erred in determining that Claimant had not reached MMI. Dr. Cebrian explained that the medical records did not contain documentation of any lumbar spine complaints. He specifically reviewed the medical records and noted the various dates of service where the treating physicians directly addressed the lumbar spine. Physicians did not record spinal complaints or symptoms in any of the reports. Instead, Dr. Cebrian noted that the first documentation of lumbar spine complaints occurred during Dr. Yamamoto's DIME over 18 months after Claimant's date of injury. Notably, Dr. Cebrian's examination of the lumbar spine was unremarkable with no discomfort or positive findings. He summarized that there was simply no objective pathology to support a Table 53 diagnosis or permanent impairment rating for the lumbar spine pursuant to the *AMA Guides*. Finally, Dr. Cebrian explained that Dr. Yamamoto's recommendation for an evaluation with a physiatrist was incorrect because Claimant had already been examined by physiatrist Dr. Olsen.

17. Dr. Cebrian also explained that Dr. Yamamoto clearly erred in attributing Claimant's DVT to his February 2, 2017 industrial injuries because of the significant temporal delay in the onset of symptoms. Claimant specifically did not mention symptoms of a DVT until approximately June 29, 2017. The symptoms occurred after Claimant returned from a long plane ride and vacation in the Philippines.

18. Claimant testified at the hearing in this matter. He explained that he was initially confined to a wheelchair but transitioned to a walker by early May 2017 and no longer used a wheelchair by June 2017. He subsequently began using a cane. Claimant explained that he reported lower back pain to Dr. Prok sometime after he started occasionally walking with a cane. He had not suffered any lower back pain while using a wheelchair. However, Dr. Prok told him that he could not place the lower back complaints in his report because he did not report lower back pain after his initial injury on February 7, 2017. Claimant maintained that his lower back pain has not changed and he has never been evaluated for lumbosacral problems.

19. Claimant underwent a disfigurement evaluation at the hearing. As a result of Claimant's February 2, 2017 industrial injuries, he sustained permanent disfigurement to his right hip area. The disfigurement consists of an approximately four inch long scar on his right thigh and an approximately one inch long scar on his abdomen. Claimant also exhibited a noticeable limp. The disfigurement is serious, permanent and normally exposed to public view. Claimant is thus entitled to a disfigurement award in the amount of \$2,000.00.

20. Dr. Cebrian testified at the hearing in this matter. He maintained that Dr. Yamamoto erroneously concluded that Claimant had not reached MMI. Instead, Dr. Cebrian agreed with Dr. Prok that Claimant reached MMI on March 5, 2018 and warranted an 18% right lower extremity impairment rating. He emphasized that Claimant's medical records revealed normal lumbar spine examinations and no lumbar spine complaints. Moreover, Dr. Yamamoto incorrectly attributed Claimant's lumbar spine complaints to an altered gait based on the use of a cane. Dr. Cebrian noted that the medical literature reflects that the use of a cane lessens the stress associated with an altered gait on the lumbar spine. Furthermore, Dr. Yamamoto's referral to a physiatrist was erroneous because physiatrist Dr. Olsen had completed a thorough examination of Claimant's lumbar spine. Finally, Claimant's DVT was unrelated to his February 2, 2017 industrial injuries because Claimant was never completely immobile and the symptoms did not arise until several months after his February 3, 2017 surgery.

21. Respondent has failed to produce clear and convincing evidence to overcome the DIME opinion of Dr. Yamamoto that Claimant has not reached MMI as a result of his February 2, 2017 industrial injuries. Initially, on February 2, 2017 Claimant suffered a right femur fracture when he slipped and fell while performing his job duties for Employer. He underwent surgery on February 3, 2017 and subsequently spent approximately one month in a rehabilitation facility. Claimant also underwent evaluations with Dr. Olsen and received physical therapy. He developed a DVT in approximately June 2017 that was treated through his personal medical providers. On

March 5, 2018 ATP Dr. Prok determined that Claimant had reached MMI and assigned a 37% right lower extremity impairment rating.

22. On September 7, 2018 Claimant underwent a DIME with Dr. Yamamoto. Dr. Yamamoto determined that Claimant had not reached MMI. After reviewing Claimant's medical records and conducting a physical examination Dr. Yamamoto diagnosed Claimant with the following: (1) a right hip fracture; (2) antalgic gait requiring frequent use of a cane; (3) mechanical lower back pain secondary to the antalgic gait; and (4) a DVT following the right hip fracture because of lengthy immobilization and inactivity. He summarized that Claimant's continuing antalgic gait secondary to his industrial injury resulted in persistent lower back pain and dysfunction that had not been formally treated. Dr. Yamamoto recommended a trial of physical therapy. However, if Claimant did not respond, he suggested referral to a physiatrist for evaluation and treatment.

23. Respondent challenged Dr. Yamamoto's DIME determination based on an independent medical examination with Dr. Cebrian. Dr. Cebrian concluded that Dr. Yamamoto clearly erred in determining that Claimant had not reached MMI. He reasoned that the medical records did not contain documentation of any lumbar spine complaints. Dr. Cebrian noted that the first documentation of lumbar spine complaints did not occur until Dr. Yamamoto's DIME over 18 months after Claimant's injury. Dr. Yamamoto also incorrectly attributed Claimant's lumbar spine complaints to an altered gait based on the use of a cane. Dr. Cebrian further commented that Dr. Yamamoto's recommendation for an evaluation with a physiatrist was incorrect because Claimant had already been examined by physiatrist Dr. Olsen. Finally, Claimant's DVT was unrelated to his February 2, 2017 industrial injuries because he was never completely immobilized and the symptoms did not arise until several months after his February 3, 2017 surgery.

24. Respondent has failed to demonstrate that Dr. Yamamoto improperly applied the *AMA Guides* or otherwise erred in concluding that Claimant had not reached MMI. Although Dr. Cebrian disagreed with Dr. Yamamoto's determination that Claimant has not reached MMI, the conclusion was not clearly erroneous. The medical records and credible testimony reflect that Claimant was initially confined to a wheelchair after his industrial injuries, transitioned to a walker and then began using a cane. Claimant explained that he reported lower back pain to Dr. Prok sometime after he started occasionally walking with a cane. He had not suffered any lower back pain while using a wheelchair. Dr. Yamamoto reasoned that Claimant suffered an antalgic gait requiring frequent use of a cane that caused him to develop lower back pain. Dr. Cebrian's disagreement regarding Claimant's development of lower back pain does not undermine Dr. Yamamoto's reasonable reliance on Claimant's clinical history and credible reports. Moreover, although Claimant had been evaluated by physiatrist Dr. Olsen, Dr. Yamamoto sought a more complete examination of Claimant's lower back dysfunction if physical therapy failed. Finally, Dr. Yamamoto's determination that Claimant's DVT was related to his February 2, 2017 industrial injury based on immobilization constituted a reasonable inference from the medical records despite the temporal delay in the development of symptoms. Accordingly, Respondent has failed to produce

unmistakable evidence free from serious or substantial doubt that Dr. Yamamoto's determination that Claimant has not reached MMI is incorrect.

CONCLUSIONS OF LAW

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

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

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

Overcoming the DIME

4. In ascertaining a DIME physician's opinion, the ALJ should consider all of the DIME physician's written and oral testimony. *Lambert & Sons, Inc. v. Industrial Claim Appeals Office*, 984 P.2d 656, 659 (Colo. App. 1998). A DIME physician's determination regarding MMI and permanent impairment consists of his initial report and any subsequent opinions. *In Re Dazzio*, W.C. No. 4-660-149 (ICAP, June 30, 2008); see *Andrade v. Industrial Claim Appeals Office*, 121 P.3d 328 (Colo. App. 2005).

5. A DIME physician is required to rate a claimant's impairment in accordance with the *AMA Guides*. §8-42-107(8)(c), C.R.S.; *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117, 1118 (Colo. App. 2003). However, deviations from the *AMA Guides* do not mandate that the DIME physician's impairment rating was incorrect. *In Re Gurrola*, W.C. No. 4-631-447 (ICAP, Nov. 13, 2006). Instead, the ALJ may consider a technical deviation from the *AMA Guides* in determining the weight to be accorded the DIME physician's findings. *Id.* Whether the DIME physician properly

applied the *AMA Guides* to determine an impairment rating is generally a question of fact for the ALJ. *In Re Goffinett*, W.C. No. 4-677-750 (ICAP, Apr. 16, 2008).

6. A DIME physician's findings of MMI, causation, and impairment are binding on the parties unless overcome by "clear and convincing evidence." §8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004). "Clear and convincing evidence" is evidence that demonstrates that it is "highly probable" the DIME physician's rating is incorrect. *Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998). In other words, to overcome a DIME physician's opinion, "there must be evidence establishing that the DIME physician's determination is incorrect and this evidence must be unmistakable and free from serious or substantial doubt." *Adams v. Sealy, Inc.*, W.C. No. 4-476-254 (ICAP, Oct. 4, 2001). The mere difference of medical opinion does not constitute clear and convincing evidence to overcome the opinion of the DIME physician. *Javalera v. Monte Vista Head Start, Inc.*, W.C. Nos. 4-532-166 & 4-523-097 (ICAP, July 19, 2004); see *Shultz v. Anheuser Busch, Inc.*, W.C. No. 4-380-560 (ICAP, Nov. 17, 2000).

7. As found, Respondent has failed to produce clear and convincing evidence to overcome the DIME opinion of Dr. Yamamoto that Claimant has not reached MMI as a result of his February 2, 2017 industrial injuries. Initially, on February 2, 2017 Claimant suffered a right femur fracture when he slipped and fell while performing his job duties for Employer. He underwent surgery on February 3, 2017 and subsequently spent approximately one month in a rehabilitation facility. Claimant also underwent evaluations with Dr. Olsen and received physical therapy. He developed a DVT in approximately June 2017 that was treated through his personal medical providers. On March 5, 2018 ATP Dr. Prok determined that Claimant had reached MMI and assigned a 37% right lower extremity impairment rating.

8. As found, on September 7, 2018 Claimant underwent a DIME with Dr. Yamamoto. Dr. Yamamoto determined that Claimant had not reached MMI. After reviewing Claimant's medical records and conducting a physical examination Dr. Yamamoto diagnosed Claimant with the following: (1) a right hip fracture; (2) antalgic gait requiring frequent use of a cane; (3) mechanical lower back pain secondary to the antalgic gait; and (4) a DVT following the right hip fracture because of lengthy immobilization and inactivity. He summarized that Claimant's continuing antalgic gait secondary to his industrial injury resulted in persistent lower back pain and dysfunction that had not been formally treated. Dr. Yamamoto recommended a trial of physical therapy. However, if Claimant did not respond, he suggested referral to a physiatrist for evaluation and treatment.

9. As found, Respondent challenged Dr. Yamamoto's DIME determination based on an independent medical examination with Dr. Cebrian. Dr. Cebrian concluded that Dr. Yamamoto clearly erred in determining that Claimant had not reached MMI. He reasoned that the medical records did not contain documentation of any lumbar spine complaints. Dr. Cebrian noted that the first documentation of lumbar spine complaints did not occur until Dr. Yamamoto's DIME over 18 months after Claimant's injury. Dr. Yamamoto also incorrectly attributed Claimant's lumbar spine complaints to an altered

gait based on the use of a cane. Dr. Cebrian further commented that Dr. Yamamoto's recommendation for an evaluation with a physiatrist was incorrect because Claimant had already been examined by physiatrist Dr. Olsen. Finally, Claimant's DVT was unrelated to his February 2, 2017 industrial injuries because he was never completely immobilized and the symptoms did not arise until several months after his February 3, 2017 surgery.

10. As found, Respondent has failed to demonstrate that Dr. Yamamoto improperly applied the *AMA Guides* or otherwise erred in concluding that Claimant had not reached MMI. Although Dr. Cebrian disagreed with Dr. Yamamoto's determination that Claimant has not reached MMI, the conclusion was not clearly erroneous. The medical records and credible testimony reflect that Claimant was initially confined to a wheelchair after his industrial injuries, transitioned to a walker and then began using a cane. Claimant explained that he reported lower back pain to Dr. Prok sometime after he started occasionally walking with a cane. He had not suffered any lower back pain while using a wheelchair. Dr. Yamamoto reasoned that Claimant suffered an antalgic gait requiring frequent use of a cane that caused him to develop lower back pain. Dr. Cebrian's disagreement regarding Claimant's development of lower back pain does not undermine Dr. Yamamoto's reasonable reliance on Claimant's clinical history and credible reports. Moreover, although Claimant had been evaluated by physiatrist Dr. Olsen, Dr. Yamamoto sought a more complete examination of Claimant's lower back dysfunction if physical therapy failed. Finally, Dr. Yamamoto's determination that Claimant's DVT was related to his February 2, 2017 industrial injury based on immobilization constituted a reasonable inference from the medical records despite the temporal delay in the development of symptoms. Accordingly, Respondent has failed to produce unmistakable evidence free from serious or substantial doubt that Dr. Yamamoto's determination that Claimant has not reached MMI is incorrect.

Disfigurement

11. Section 8-42-108, C.R.S. provides that a claimant may obtain additional compensation if he is seriously disfigured as the result of an industrial injury. As found, as a result of Claimant's February 2, 2017 industrial injuries, he sustained permanent disfigurement to his right hip area. The disfigurement consists of an approximately four inch long scar on his right thigh and an approximately one inch long scar on his abdomen. Claimant also exhibited a noticeable limp. The disfigurement is serious, permanent and normally exposed to public view. Claimant is thus entitled to a disfigurement award in the amount of \$2,000.00.

ORDER

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

1. Respondent has failed to overcome Dr. Yamamoto's DIME opinion. Claimant has not reached MMI for his February 2, 2017 industrial injuries.

2. Claimant is entitled to receive disfigurement benefits in the amount of \$2,000.00 for his February 2, 2017 industrial injuries.

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

If you are a party 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 certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at <http://www.colorado.gov/dpa/oac/forms-WC.htm>.*

DATED: March 19, 2019.

DIGITAL SIGNATURE:


Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

ISSUES

- Did Claimant prove injuries she suffered on October 15, 2017, including a fractured left wrist, arose out of and occurred within the course and scope of her employment?

FINDINGS OF FACT

1. Claimant worked for Employer as a manager and bartender. On October 15, 2017, she fractured her left wrist after being pushed to the ground by a bar patron engaged in a fight. Neither party disputes Claimant was injured at work. The disagreement involves how Claimant came to be involved in the altercation and whether the injury "arose out of" her employment.

2. During the shift, Claimant received a call from the bar owner (Joel Notario) on her cell phone regarding various work issues. It was very loud inside the bar, so she stepped outside to hear better. While she was on the call, she saw two individuals in the street fighting. The men were down past a few vehicles parked diagonally along the street in front of the bar. She recognized at least one combatant as a customer who had been drinking in the bar that evening. She exclaimed to the bar owner "there are two guys from the bar tonight out in the street beating the crap out of each other."

3. At this point, the parties' versions of events diverge. Respondents believe Claimant physically intervened between the two men. Respondents reason that, "claimant took herself outside the scope of her employment at the moment she approached the individuals and physically intervened in a fight happening a half-block away in the middle of the street."

4. Claimant testified "in no way, shape or form" did she physically insert herself into the fight. She testified she moved toward the men yelled something to the effect of, "Knock it off you guys!" Claimant testified she never left the sidewalk and did not go out in the street. She then turned away and continued her phone conversation. A moment later, she turned back and saw one of the combatants ("Jarrett") running toward her. She was standing near a parked Ford pickup truck and put her phone on the hood just before the man pushed her to the ground. She hit her head on a "2-hour parking" sign embedded in the sidewalk and broke her wrist when she hit the ground.¹

5. After being knocked down, Claimant got up and looked for her phone but could not find it. She went into the bar and put her wrist into a bucket of ice. She then called her daughter about deactivating the phone from their shared plan. Claimant's

¹ Based on the bodycam video, the 2-hour parking sign was approximately two diagonally-oriented parking spaces away from the front door of the bar, in front of Rockee's Restaurant. The Ford pickup was in the adjacent parking space.

daughter is a dispatcher for the Pueblo Police Department, and she dispatched police to the scene.

6. Jarrett went back into the bar to speak with Claimant and see if she was okay. Jarrett remained in the bar and was served another beer.

7. Multiple police units arrived at the bar a few minutes later.² One of the officers (“Officer 1”) entered the bar and asked what was going on. Claimant was standing behind the bar with her wrist in a bucket of ice. Jarrett was sitting at the bar drinking a beer, and the other bartender, Lisa Quintana, was standing with them.

8. Officer 1 asked what happened, and Claimant replied, “There was an altercation outside, I intervened, and I got pushed and somebody took my cellphone.” Ms. Quintana said, “And that guy that’s out[side], he’s” She gestured with her arm, but did not finish the thought. The individual outside to whom Ms. Quintana was referring was named “Micah.” Another man sitting at the bar indicated Jarrett was fighting with Micah. Ms. Quintana seemed to think Micah was the instigator and Jarrett “had nothing to do with it.” Shortly thereafter, Ms. Quintana can be seen patting Jarrett on the arm and stating, “you’re alright, you’re alright.”

9. Jarrett and Micah were semi-regular customers of the bar and known to Claimant before the accident. Both men had been drinking in the bar that evening before the accident.

10. Claimant went outside and discussed the incident with another officer (“Officer 2”). Claimant stated,

I was over here talking on the phone and two different people were out here fighting. And all I said was, “dudes, you guys have to — you have to move it.” Plain and simple. Before you know it, somebody pushed me. My head hit right there, you know, and I bit it pretty bad.

11. Officer 2 asked Claimant if she knew who was involved. Claimant identified Micah but said she was not sure who else was involved.

12. A few moments later, Officer 2 asked,

Q: So you’re talking on the phone, two people approached you —

Claimant: No. I approached them.

Officer 2: And why was that? Because they had to move what?

Claimant: They were fighting. I mean, there was gonna be a physical altercation, it was like an instinct I guess. Told ‘em to knock it off. And that’s all I said was “Knock it off guys, you know, come on.” And I don’t even know

² Multiple officers responded because the call had been mistakenly coded as an armed robbery.

who pushed me. But I got pushed, and then before you know it I hit the back of my head and landed on my left wrist and left side.

13. Officer 1 intervied Jarrett separately while Claimant was speaking with Officer 2. Jarret was obviously very intoxicated.³ Jarrett said he gave Micah a cigarette, and while they were talking, Micah “got all loudmouthy” and made what Jarrett perceived as a homophobic comment. The argument escalated and Jarrett punched Micah. Jarrett said Micah then “ran away.” Officer 1 asked, “How did her wrist get broken,” and Jarrett replied, “because she came up to me when I was approaching [Micah], and I pushed her aside.”

14. Officer 1 then went to discuss the matter with Officer 2, who was still speaking with Claimant. Officer 1 relayed what Jarrett had said. Officer 2 said, “Did we establish that he [Jarrett] was the one that pushed her out of the way?” Officer 2 replied, “Yeah, he’s telling me that he pushed her out of the way to get towards him [Micah].” Claimant interjected,

I don’t know though. . . . He [Jarrett] is really pretty cool. It’s the bald guy [Micah]

Officer 1: But [Jarrett’s] telling me basically he’s the instigator because of comments that guy [Micah] made. . . . He told me you were trying to separate them⁴ and he pushed you to the side to get towards him.

Claimant: Okay.

15. Claimant declined to press charges against Jarrett because, “regardless, I don’t know if it was him, so I can’t say for sure.”

16. One officer accompanied Micah back into the bar to retrieve his jacket. Ms. Quintana yelled at Micah about the incident. Most of what she said was drowned out by loud music playing in the background, but she clearly told him, “don’t ever come back here again.” After Micah walked out, the officer asked, “what about the other one [Jarrett], is he [banned too]?” Ms. Quintana replied, “No he’s good. . . . That guy [Micah] gets really belligerent and we usually keep an eye on him, every time he comes in here we’re like ‘keep an eye on that guy, don’t serve him too much.’”

17. Ms. Quintana testified at hearing for Respondents. She admitted she saw none of the events outside and her knowledge was primarily based on hearsay from other patrons. Ms. Quintana asked Claimant about the incident and testified, “She said she got in the way of the fight and broke her arm.”

18. Claimant’s testimony and statements on the video are largely, but not entirely, credible. Specifically, her testimony that Jarrett knocked her down and then

³ Officer 1 colorfully (and correctly) described Jarrett as “fucked up,” “freakin’ hammered,” and “trashed.”

⁴ This is not an accurate summary of Jarrett’s statement; he did not say Claimant was “trying to separate” Micah and himself.

looked her in the eye contradicts her statements to the police she did not know who pushed her. The ALJ suspects Claimant did not want to identify Jarrett to police because she knew he was drunk and he appears to have been popular with the bar staff. Nevertheless, she provided two irreconcilable accounts on that point. But the fact that part of a witness' testimony is unreliable does not necessarily mean their testimony should be disregarded in its entirety. The ALJ has relied on Claimant's testimony to the extent it is reasonably consistent with the Body Cam video.

19. The ALJ disagrees with Respondents' argument the accident occurred "in the middle of the street." The persuasive evidence shows the accident occurred on the sidewalk in front of Rockee's Restaurant next door, where Claimant was standing and talking on the phone. She put her phone on the hood of Ford pickup truck, which the video shows was parked in front of Rockee's. She hit her head on the signpost shown in the video to the left of the truck. The ALJ interprets Claimant's statement that "I approached them" to mean she moved in their direction on the sidewalk and yelled for them to "knock it off." There is no persuasive evidence Claimant ever left the sidewalk. It is not likely Claimant went out into the street and physically intervened between Jarrett and Micah.

20. After reviewing all the available evidence, the ALJ finds the following scenario probably occurred: Claimant was speaking on the phone with her boss when she heard Jarrett and Micah arguing/fighting out in the street. She moved toward them and shouted, "Knock it off!" She resumed her telephone conversation while the men continued arguing/fighting. One or more punches were thrown and Micah eventually tried to get away from Jarrett, heading back toward the bar. Jarrett was on the sidewalk and moving quickly to get at Micah. Claimant saw Jarrett coming toward her and threw her phone on the hood of the pickup truck. At that point, Claimant was probably between the two men, which is consistent with her statement to Ms. Quintana "she got in the way of the fight." Jarrett pushed her aside to get at Micah. The ALJ finds Claimant was not attempting to physically separate the two men.

21. Claimant proved by a preponderance of the evidence her injuries arose out of and occurred in the course and scope of her employment.

22. Claimant's injuries proximately caused a need for medical treatment.

CONCLUSIONS OF LAW

A. Claimant proved a compensable injury

To receive compensation or medical benefits, a claimant must prove she suffered an injury "arising out of" and "in the course of employment." Section 8-41-301(1). The course of employment requirement is satisfied where the injury occurred within the time and place limits of the employment and during an activity that had some connection with the employee's job-related functions. *Popovich v. Irlanda*, 811 P.2d 379 (Colo. 1991).

Respondents do not dispute Claimant's injuries occurred "in the course of employment." Rather, the dispute centers on whether the injuries "arose out of" Claimant's employment. Respondents argue, "the fight and her intervention had

absolutely nothing to do with her job responsibilities or the bar.” Respondents argue Claimant stepped out of her employment and “inserted herself into a purely personal dispute, for purely personal reasons, and was injured as a result.”

An injury “arises out of” employment when it “has its origin in an employee’s work-related functions and is sufficiently related to those functions to be considered a part of the employee’s employment contract.” *Horodysj v. Karanian*, 32 P.3d 470, 475 (Colo. 2001). The claimant need not actually be performing work duties at the time of the injury, nor must the activity be a strict employment requirement or confer an express benefit on the employer. *Price v. Industrial Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996). Rather, the question is whether the activity “is sufficiently interrelated to the conditions and circumstances under which the employee generally performs the job functions that the activity may reasonably be characterized as an incident of employment.” *Id.* at 210; see also *Panera Bread LLC v. Industrial Claim Appeals Office*, 141 P.3d 970 (Colo. App. 2006). Whether an injury arises out of and in the course of employment are questions of fact for the ALJ, based on the totality of circumstances. *Dover Elevator Co. v. Industrial Claim Appeals Office*, 961 P.2d 1141 (Colo. App. 1998).

An employee can step outside the scope of employment by engaging in a purely personal deviation. When a personal deviation is asserted, the question is “whether the claimant’s conduct constituted such a deviation from the circumstances and conditions of the employment that the claimant stepped aside from his job and was performing an activity for his sole benefit.” *Panera Bread, LLC v. Industrial Claim Appeals Office*, 141 P.3d 970, 972 (Colo. App. 2006). The deviation must be “substantial” to remove the claimant from the course and scope of employment. *Kelly v. Industrial Claim Appeals Office*, 214 P.3d 516 (Colo. App. 2009).

As found, Claimant proved her injuries arose out of her employment. She was on the phone with her boss immediately before the accident occurred. The man who caused her injuries was a drunken bar patron attempting to “get at” another patron. The fight had nothing to do with Claimant personally. She only became involved because she was the manager of the establishment where the men had been drinking. Admittedly, Claimant’s comments that she “intervened” in the fight and “approached” the men are ambiguous. But the ALJ accepts Claimant’s explanation she “intervened” *verbally* rather than physically. Claimant “approached” the men in the sense of moving toward them and yelling, “Knock it off.” She did not go out into the street and try to break up the fight. The ALJ gives no weight to Jarrett’s statement Claimant “came up to him.” Perhaps that was his perception because she moved toward the hood of the truck to toss her phone. Regardless, given his level of intoxication, the ALJ does not find Jarrett a reliable source of specific details regarding the event, other than the fact that he knocked Claimant down.

B. Treatment for the fractured wrist was reasonably necessary

A compensable injury is one that causes disability or a need for medical treatment. *Montgomery v. HSS, Inc.*, W.C. No. 4-989-682-01 (August 17, 2016). The persuasive evidence shows Claimant fractured her left wrist because of the industrial accident and required treatment.

ORDER

It is therefore ordered that:

1. Claimant's claim for injuries sustained on October 15, 2017 is compensable.
2. Insurer shall cover medical treatment from authorized providers reasonably needed to cure and relieve the effects of Claimant's compensable injury.
3. 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: March 20, 2019

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

STATE OF COLORADO
OFFICE OF ADMINISTRATIVE COURTS
W.C. NO. 5-079-980

I ISSUES TO BE DETERMINED

- Whether Decedent proved by a preponderance of the evidence that the injury and death are compensable.
- Whether Respondents proved by a preponderance evidence that Decedent deviated from the course and scope of his employment thereby removing himself from travel status.
- Whether Decedent proved by a preponderance of the evidence that Decedent returned to the scope of his employment.
- If compensable, whether Respondents have proved by a preponderance of the evidence that they are entitled to a 50% reduction in benefits for intoxication.

II STIPULATED FACTS

1. Decedent was a pilot for Employer since 2007, and resided in the State of California.
2. At the time of his death, Decedent was married to Alayna Ordonez. Wife and two minor children are dependents of Decedent.
3. Decedent traveled to Denver, Colorado to participate in Employer's flight training to become a captain flying the E175 aircraft. The flight training began mid-January 2018, and took place at the Flight Safety Denver Learning Center located at 6755 Yampa Street, Denver, Colorado 80249. The training center is located west of North Tower Road between East 68th Avenue and East 67th Avenue.
4. During his training, Decedent stayed at the SpringHill Suites by Marriott Denver Airport, located at 18350 East 68th Avenue, Denver, Colorado 80249. This hotel is located on the west side of North Tower Road.
5. Baylee Ladner is a pilot for SkyWest Airlines, Inc. Mr. Ladner's flight training for Employer overlapped in part with Decedent's. Mr. Ladner and Decedent partnered during flight simulator training.
6. During his training, Mr. Ladner stayed at the Fairfield Inn & Suites by Marriott Denver Airport located at 6851 Tower Road, Denver, Colorado 80249. This hotel also is located on the west side of North Tower Road.

7. On February 14, 2018, at 10:00 p.m., Decedent and Mr. Ladner completed the Initial Maneuvers Validation (IMV) testing halfway through their training. Both Decedent and Mr. Ladner passed the testing.

8. Decedent and Mr. Ladner were off from work on February 15, 2018 and were to return to their training on February 16, 2018.

9. That evening, at approximately 10:27 p.m., Decedent and Mr. Ladner ate dinner and drank beer at Ruby Tuesday. Decedent and Mr. Ladner left Ruby Tuesday and went downtown to one or more bars to continue celebrating having passed the IMV test.

10. At approximately 2 a.m. on February 15, 2018, Decedent and Mr. Ladner returned to the Fairfield Inn & Suites where Mr. Ladner was staying.

11. Around 6 a.m. on February 15, 2018, a car heading southbound on North Tower Road struck Decedent, just south of Tower Road and 69th Avenue. Emergency services transported Decedent to the University of Colorado Hospital.

12. Decedent died at University of Colorado Hospital at approximately 9 a.m. the same day.

13. A blood sample was taken while Decedent was receiving treatment at University of Colorado Hospital. No second sample of the blood was preserved.

14. Decedent was a max wage earner at the time of the accident. Upon finding of compensability, the TTD rate for calculation of death benefits is \$948.15.

III FINDING OF FACTS

15. Decedent and Mr. Ladner spent time together rehearsing, testing and studying, and had a friendly relationship.

16. Mrs. Ordonez testified that Decedent left California for training in Denver on January 12 or 13, and was to be gone for one-and-half to two months for training. Ms. Ordonez testified that he remained in Denver training until his death.

17. The night auditor for the Fairfield Inn & Suites, Melissa Arciniega, testified that at approximately 2:00 a.m. on February 15, 2018, Decedent came to the front desk asking to have a new room key made as his was not working. Ms. Arciniega noted that the logo on his room key was for Springhill Suites, not Fairfield Inn & Suites. Ms. Arciniega explained to Decedent that he was at the wrong hotel. Mr. Ladner convinced Decedent to go up to his room as he was staying at the Fairfield Inn & Suites.

18. Ms. Arciniega observed Decedent at 2:00 a.m. walking as if he was intoxicated. She testified that Decedent smelled of alcohol. As a night auditor, she had observed this type of activity before.

19. At approximately 5:30 a.m. on February 15, 2018, Ms. Arciniega interacted with Decedent when he again asked for a room key. Ms. Arciniega again informed him that he was staying at the Springhill Suites, not the Fairfield Inn & Suites. Her written statement provides, "He was drunk and he spent about twenty minutes talking to me about how he couldn't put a lid on the coffee cup." She informed him that the Springhill Suites was approximately two buildings away and pointed in the direction of Springhill Suites.

20. Ms. Arciniega testified that Decedent still appeared very intoxicated and she worried he might burn himself on the hot coffee. Ms. Arciniega observed Decedent struggling with his coffee, unable to put the lid on his cup. She observed Decedent for approximately 10 minutes, and then became distracted helping other hotel guests. Ms. Arciniega testified that she was not sure whether Decedent was trying to get to his hotel or not.

21. Ms. Arciniega testified that Decedent's attempt to cross Tower Rd. from the Fairfield Inn was in the opposite direction from the Springhill Inn and Suites. Ms. Arciniega testified that she was not aware of where the Decedent was going.

22. The police report contains Ms. Arciniega's handwritten statement on the day of the accident. Her testimony at hearing was very similar to her written statement. Neither her written statement nor her testimony provide information about where Decedent was heading at the time of the accident.

23. The ALJ finds Ms. Arciniega to be credible and her testimony to be persuasive.

24. Mr. Ladner testified that he and Decedent went to Ruby Tuesday to have dinner, and that he and Decedent consumed two beers each. After Ruby Tuesday, they went to a bar for approximately two hours and returned via Uber to the Fairfield Inn. Mr. Ladner could not remember how many drinks they had, but that they ordered an Uber to return to his hotel, the Fairfield Inn and Suites. Mr. Ladner testified after he and Decedent made it up to his room, he fell asleep in hotel room. He did not awaken until shortly before noon. He also testified that as they had the following day off from work, so it was no big deal to go out and drink.

25. The ALJ finds Mr. Ladner to be credible and his testimony to be persuasive.

26. Morgan Simmons, who is a captain, a fleet training manager, and a chief instructor, confirmed that Decedent's training before his death was on February 14, 2018 and he did not have to return to training until February 16, 2018. He explained where the training facility was, and that at the time of the accident, Decedent was heading in the opposite direction of the facility when the vehicle struck him. Mr. Simmons testified that new-hire pilots, such as Mr. Ladner start training three to four weeks earlier, which is why Decedent and Mr. Ladner were staying in different hotels.

27. The Denver Police Department report indicates that Decedent was crossing Tower Road in the 6800 block from the west side to the east side of the street when

tragically he was struck by a motor vehicle. The collision occurred while it was still dark at approximately 6:09 a.m.

28. A bystander provided CPR until first responders arrived approximately three minutes later. First responders provided emergency care and transported Decedent to University Hospital, which admitted Decedent at approximately 6:39 a.m. Claimant sustained numerous serious traumatic injuries.

29. During attempts to stabilize Decedent's condition, a critical care doctor initiated a massive transfusion protocol. Decedent received five units of blood at 7:39 a.m. and began receiving his sixth unit of blood at 7:40 a.m.

30. A blood sample was taken at the hospital at approximately 7:47 a.m. Hospital records show Decedent had a blood alcohol concentration of .209 g/100ml.

31. A urine sample was collected from Decedent's catheter at 7:51 a.m. Hospital records show that Decedent tested positive for Ethanol in his Urine, his results being above the 10mg/dL triggering level.

32. Decedent died from his injuries at approximately 9:00 a.m.

33. The Denver Police Department report includes three witness statements from the drivers at or near the accident – two from nearby drivers and one from the driver whose vehicle struck the Decedent. Tina Gresley was driving southbound on Tower Rd. "when she saw a person running across Tower Rd." Larry Hurst was driving southbound on Tower Rd. and as he was passing the Fairfield Inn, he saw a man "come out of nowhere trying to cross Tower Rd." Thomas Poliwka, the driver of the vehicle that struck Decedent stated, "I was southbound Tower Rd. at 40 mph when a pedestrian suddenly jumped in front of my vehicle." Mr. Poliwka confirmed that Decedent "was crossing from the west side of Tower Rd. to the east side."

34. The police report categorized Decedent's attempted crossing as a violation, "Prohibited Crossing of Roadways." Mr. Poliwka received no citation for any moving violation and was absolved of any other criminal charges.

35. Matthew Garrow, one of the first officers arriving at University Hospital for investigation purposes, issued a statement contained in the police report. He noted that while the hospital staff was going through Decedent's personal items, "[t]here were numerous receipts from businesses in the area of 6900 N Tower Rd, Denver Colorado."

36. The police report diagram on page 59 of Respondents' exhibits shows that Decedent was crossing Tower Road away from the training facility and away from his hotel.

IV CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the ALJ draws the following 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. Section 8-40-102 (1), C.R.S. A Decedent in a workers' compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is probably more true than not. *Page v. Clark*, 197 Colo. 306, 591 P.2d 792 (1979). The facts in a workers' compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S.

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

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. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936). *Colorado Jury Instructions, Civil*, 3:16.

COMPENSABILITY

For a claim to be compensable, an injury must occur in the "course and scope" of employment and "arise out of the employment." See Section 8-41-301(1)(b), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origin in an employee's work-related functions and be sufficiently related thereto to be considered part of the employee's service to the employer. Additionally, it is the decedent's burden to prove by a preponderance of the evidence that there is a direct causal relationship between the employment and the injuries. Section 8-43-201, C.R.S.; *Ramsdell v. Horn*, 781 P.2d 150 (Colo. App. 1989). Whether there is a sufficient causal relationship between the Decedent's employment and the injury is generally a question of fact, which the ALJ must determine based on the totality of the circumstances. Section 8-43-301(8), C.R.S. *In Re Question Submitted by the United States Court of Appeals*, 759 P.2d 17 (Colo. 1988); *Moorhead Machinery & Boiler Co. v. Del Valle*, 934 P.2d 861 (Colo. App. 1996).

DEVIATION FROM EMPLOYMENT AND TRAVEL STATUS

An employee required to travel away from the employer's premises is considered to be in travel status, and is covered for workers' compensation during the entire trip.

Phillips Contracting, Inc. v. Hirst, 905 P.2d 9 (Colo. App. 1995). However, an exception to this rule exists where the employee engages in a personal errand unrelated to the employer's business and other matters incident to the travel.

If the employee makes a distinct departure on a personal errand, coverage will cease and will not be restored until the errand has been completed. *Pat's Power Tongs, Inc. v. Miller*, 474 P.2d 613 (Colo. 1970); *Wild West Radio, Inc. v. Industrial Claim Appeals Office*, 905 P.2d 6 (Colo. App. 1995). Whether an employee has returned to the scope of employment after a personal excursion is an issue of fact, with the burden of proof placed on the Decedent. *Wild West Radio, supra*.

The Court of Appeals held in *Pacesetter Corp. v. Collet*, 33 P.3d 1230 (Colo. App. 2001), that "in some circumstances the act of consuming alcohol, by itself, can constitute a personal deviation sufficient to remove the Decedent from the scope of employment." *Id.* at 1234.

Determining when an errand has been completed is a factual determination for the court. *Wild West Radio supra*. Colorado courts have held that a personal errand ends and the claimant returns to the scope of employment the "moment he commences his return to his home or his lodging." *Pat's Power Tongs, Inc., supra*.

In the case of *Nathan Bunn v. Woody's Paint*, W.C. No. 4-370-167 (May 17, 1999) the Industrial Claim Appeals Office upheld an ALJ's order which determined that even though the claimant had returned to and passed his hotel after an evening of drinking, his deviation had not ended when he was injured while heading away from the hotel. The ALJ found a deviation due to the claimant having a "night on the town" of substantial amounts of drinking over several hours after work. The ICAO affirmed the ALJ's holding and concurred that *Pat's Power Tongs* did not require a finding that the deviation had concluded because the ALJ specifically determined that the claimant was heading away from his hotel and rather than on a direct path.

The parties stipulate that Decedent traveled to Colorado to undergo flight training at the Flight Safety Denver Learning Center. Thus, pursuant to the general rule, Decedent was in travel status while in Colorado.

However, the issue is whether Decedent deviated from his employment and said travel status, and if so, whether he returned to the scope of employment after this deviation. Based on the totality of the circumstances, the ALJ finds and concludes Decedent engaged in a deviation and had not returned to the course and scope of his employment at the time of his injury.

As found, Decedent and Mr. Ladner set out at approximately 10:27 p.m. to celebrate their success in completing IMV training. They started with dinner at Ruby Tuesday where they consumed beers. After leaving Ruby Tuesday, they traveled to a bar where they spent an additional couple of hours drinking.

After they finished drinking at approximately 2:00 a.m. on February 15, 2018, Decedent and Mr. Ladner returned to Mr. Ladner's hotel, which was two buildings from

Decedent's hotel. The night auditor, Melissa Arciniega, testified that Decedent and Mr. Ladner stopped by the front desk. Decedent requested a new key as his did not work. Ms. Arciniega noticed that the Decedent's key card was for the Springhill Suites and told him he was at the wrong hotel. Decedent and Mr. Ladner left to go upstairs. Decedent appeared intoxicated, as he was not steady when handing her his card key and she smelled alcohol. She had observed these behaviors before with intoxicated guests.

At approximately between 5:30 a.m., Decedent again asked Ms. Arciniega for a room key. She informed Decedent that his hotel was two buildings over. She watched Decedent get coffee and became concerned because it was very hot and Decedent appeared intoxicated. He was unable to put a lid on his coffee cup.

When Decedent left the Fairfield Inn, he travelled east and attempted to cross Tower Road at an unsafe crossing point. Decedent headed in the opposite direction of the training facility and his hotel.

Although Decedent's counsel argued that Decedent was returning to his hotel and was lost, Decedent offered no persuasive evidence to support that argument. Although Decedent attempted to cross Tower Road sometime after Ms. Arciniega pointed in the direction of his hotel, the ALJ cannot infer that Decedent intended to return to his hotel. Although Decedent had spent approximately one month in the immediate area, evidenced by receipts he possessed, he was travelling away from his hotel.

Neither can the ALJ infer that Decedent was returning to Employer's Training Center, because the uncontradicted testimony of Mr. Ladner and Mr. Simmons established Decedent was not working the day of his injuries.

Persuasive evidence supports a finding and conclusion that Decedent was intoxicated when he sustained his injuries.

- Claimant's blood sample taken at approximately 7:47 a.m. showed Decedent had a blood alcohol concentration of .209 g/100ml. When the sample was taken, Decedent had already received six units of blood that likely would have diluted the alcohol content of the sample.
- Claimant's urine sample taken at approximately 7:51 a.m. showed that Decedent tested positive for Ethanol, his results being above the 10mg/dL triggering level.
- Ms. Arciniega observed Decedent shortly before he sustained his injuries and observed that he was confused about which hotel he was staying at, was unable to put a lid on his coffee cup, and smelled like alcohol.
- Decedent exercised poor judgment in trying to cross a road with a fifty-five mile per hour speed limit in the middle of the block wearing dark clothes in the dark.

The Judge finds and concludes Decedent was in a personal deviation at the time of the accident, due to hours of consuming alcohol. The ongoing consumption and resulting intoxication amounted to a continuous deviation that began starting at Ruby Tuesday with the consumption of two beers and continued up until the time of the accident. The consumption of alcohol and high level of intoxication provides no benefit to Employer and is of such a personal nature that one cannot conclude it to be within the course and scope or arise from Decedent's position as a commercial airline pilot.

Decedent bears the burden of showing the return to employment. *Wild West Radio, Inc. v. Industrial Claim Appeals Office of State of Colo.*, 905 P.2d 6 (Colo. App. 1995). While *Pat's Power Tongs, Inc.* held that a worker's personal deviation ends the moment he begins to return to his lodging, the facts here do not support a finding that Decedent began to return to his lodging. Decedent was not heading toward the Springhill Inn and Suites, but rather was heading in the opposite direction. Our facts are more similar to those in *Wild West Radio* and *Bunn*. While Decedent did return to his co-worker's hotel, he never returned to his own hotel. When the motor vehicle struck him, Claimant undisputedly was heading not towards the Springhill Inn and Suites or Employer's training facility. Both are located on the west side of Tower Road and neither location would require Decedent to cross Tower Road. Even if the Judge were to infer that Decedent was trying to return to his hotel by asking for a replacement room key, the facts show he decided not to head in the direction of the Springhill Inn and Suites. These facts are similar to *Dunn*, where an intention eventually to return to a hotel room is not sufficient to end the deviation and specific travel away from the hotel continues the personal deviation.

While Decedent argues he was heading in the wrong direction because he was confused, the Judge finds no persuasive evidence to support it. Persuasive evidence shows that Decedent had been in the location of the hotels and accident since January 12 or 13, 2018, he had been staying at the Springhill Inn and Suites through the date of his death, and hospital staff found "numerous" receipts of restaurants around the area.

Based on a totality of the circumstances, the Judge finds and concludes that Decedent has not met its burden of proving that, more likely than not, Decedent had returned to his employment. Decedent remained on a continuous personal deviation and was not in the course and scope of his employment at the time of the accident. Consequently, this claim is not compensable.

Based on this conclusion, the Judge declines to address other issues.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the ALJ hereby Orders:

1. Decedent's claim is denied and dismissed.

DONE AND ENTERED this 20th day of March 2019.

BY THE COURT:

/s/ Kimberly Turnbow
Kimberly B. 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, Denver, Colorado, 80202. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.*

ISSUES

Whether the claimant had demonstrated, by a preponderance of the evidence, that the L5-S1 anterior lumbar interbody fusion surgery, as recommended by Dr. Douglas Orndorff, is reasonable medical treatment necessary to cure and relieve the claimant from the effects of the admitted August 17, 2017 work injury.

FINDINGS OF FACT

1. The claimant worked for the employer at a gravel pit. The claimant's job duties included using a front end loader to load gravel into trucks. He would then "weigh out" the customer trucks and repeat the process. The claimant suffered an injury while performing these job duties on August 17, 2017. The claimant testified that the loader he operated on that date had a faulty air seat. The air in the seat would empty, resulting in little to no support in the seat. On August 17, 2017, the air seat was deflated while the claimant was driving over a rut. The claimant testified that this caused the seat to hit metal on metal resulting in immediate pain in his low back and up into his neck.

2. Prior to his 2017 injury, the claimant treated for low back issues in 2012 and 2013. On May 20, 2013, Dr. Douglas Orndorff performed a L4-5 laminectomy with decompression, medial facetectomy, and foraminal decompression. The claimant testified that following that 2013 surgery he fully recovered and was "pain free".

3. Following the August 17, 2017 incident, the claimant first received medical treatment at Lightning Bolt Chiropractic on August 22, 2017. The claimant testified that he sought treatment at Lightning Bolt Chiropractic at the direction of the employer.

4. Thereafter, the claimant was seen on September 6, 2017 by Dr. Larry Welling with Reliance Medical Group. At that time, Dr. Welling ordered an MRI and discussed a possible referral to Dr. Orndorff given the claimant's prior back surgery.

5. On September 19, 2017, a magnetic resonance image (MRI) of the claimant's lumbar spine showed evidence of the prior L4-5 decompression. In addition, there was evidence of mild reduced disc height and disc desiccation at both the L4-5 and L5-S1 levels; mild bulging the L4-5 and L5-S1 levels; and minimal lateral recess narrowing at the L4-5 level. The MRI also showed that the S1 nerve roots were close to contacting the L5-S1 disc bulge.

6. Thereafter, the claimant's authorized treating provider (ATP) became Animas Occupational Medicine. At that practice, the claimant has primarily treated with Robert Hill, PA-C. The claimant's treatment has included physical therapy, chiropractic treatment, massage, use of an inversion table, and a TENS unit.

7. The claimant first treated with Mr. Hall on October 23, 2017. At that time, Mr. Hall diagnosed a thoracic strain with radiculopathy and a lumbar strain with radiculopathy. Mr. Hall assigned work restrictions of no lifting, pushing, or pulling over 10 pounds and no crawling, kneeling, squatting, or climbing. Dr. Hall recommended the claimant undergo physical therapy. In the October 23, 2017 medical record, Mr. Hall noted that the claimant was scheduled to see Dr. Cyril Bohachevsky. Mr. Hall agreed with that consultation and made the referral to Dr. Bohachevsky.

8. On October 26, 2017, the claimant was seen at Spine Colorado by Dr. Bohachevsky. At that time, the claimant reported aching pain in his low back with tingling into his posterior legs and into his feet. He also reported an occasional sharp pain in this left calf muscle. Dr. Bohachevsky opined that although the claimant had undergone prior surgical treatment of his lumbar spine, the claimant's current symptoms were new and directly related to the August 17, 2017 work injury. Dr. Bohachevsky recommended that the claimant continue with physical therapy.

9. Subsequently, on February 23, 2018, Dr. Bohachevsky administered a L5-S1 epidural steroid injection (ESI). The claimant testified that following the injection he had pain relief for 10 to 13 days. However, the pain returned when he bent over and felt a "shock" in his back. The claimant returned to Dr. Bohachevsky on March 12, 2018 and they discussed additional treatment options, including a second ESI. However, that requested ESI was denied by the respondents at that time. Ultimately, Dr. Bohachevsky referred the claimant to Dr. Orndorff for a surgical consultation.

10. The claimant was seen by Dr. Orndorff for this current claim on April 17, 2018. On that date, Dr. Orndorff noted that the claimant had recovered well after his 2013 surgery. Dr. Orndorff opined that the claimant's work injury exacerbated his low back condition. Dr. Orndorff recommended the claimant undergo an L4-5 and L5-S1 anterior lumbar interbody fusion. Dr. Orndorff indicated that the surgery would help restore lumbar lordosis and address the instability at those levels.

11. On May 15, 2018, the claimant attended an independent medical examination (IME) with Dr. Robert Messenbaugh. In connection with the IME, Dr. Messenbaugh reviewed the claimant's medical records, obtained a history from the claimant, and completed a physical examination. In his IME report, Dr. Messenbaugh opined that the claimant suffered a myofascial strain/sprain of his low back at the time of the August 17, 2017 work injury. Dr. Messenbaugh further opined that the pathology found on the claimant's MRIs predated the work injury. Following the IME report, Dr. Messenbaugh responded to an email from respondents' counsel on June 8, 2018. In his reply, Dr. Messenbaugh clarified that it is his opinion that the need for fusion surgery is not related to the August 17, 2017 work injury. Dr. Messenbaugh further clarified that it is his opinion the fusion surgery is not reasonable and necessary medical treatment for the claimant. Based upon Dr. Messenbaugh's opinions, the respondents denied the recommended L4-5 and L5-S1 anterior lumbar interbody fusion.

12. Thereafter, the respondents authorized a second ESI. On June 19, 2018, Dr. Bohachevsky administered a left S1 transforaminal ESI.

13. On June 27, 2018, Dr. Bohachevsky administered electromyography (EMG) testing of the claimant's bilateral lower extremities. The EMG showed no evidence of active left S1 radiculopathy, and no evidence of sensorimotor peripheral neuropathy or compressive neuropathy.

14. On July 16, 2018, an MRI of the claimant's lumbar spine showed no significant changes from the prior September 18, 2017 MRI. It was noted that the degenerative disc disease appeared stable without central canal stenosis at any level. The MRI also showed diffuse moderate facet arthrosis with areas of mild to moderate foraminal narrowing.

15. The claimant returned to Dr. Orndorff of July 24, 2018 to discuss the results of the EMG testing and the most recent MRI. At that time, Dr. Orndorff opined that the claimant had exhausted all conservative treatment for his symptoms. Dr. Orndorff recommended an L4-5 and L5-S1 discography to confirm that the claimant's issues were arising from the L5-S1 level.

16. On August 21, 2018, Dr. Bohachevsky performed a left sided L4-5 and L5-S1 discography. Dr. Bohachevsky noted "provocation positive" at the L5-S1 level, but not at the L4-L5 level.

17. The claimant was seen by Dr. Orndorff on August 21, 2018. At that time, Dr. Orndorff noted that the discography showed "clear concordant pain at the L5-S1 level". Dr. Orndorff amended his prior surgical recommendation and has now requested authorization for an L5-S1 interbody fusion.

18. On October 3, 2018, the claimant attended an IME with Dr. Brian Reiss. In connection with the IME, Dr. Reiss reviewed the claimant's medical records, obtained a history from the claimant, and completed a physical examination. In his IME report, Dr. Reiss opined that the claimant's current symptoms and need for treatment are not related to the August 17, 2017 work injury. It is the opinion of Dr. Reiss that the claimant's symptoms are related to his preexisting condition. In support of his opinions Dr. Reiss noted that the claimant reported pain levels of 1 out of 10 following the work injury. Dr. Reiss opined that the claimant reached maximum medical improvement (MMI) in December 2017. With regard to the recommended fusion surgery, Dr. Reiss opined that the surgery would likely not decrease the claimant's pain, nor increase his function. Dr. Reiss's testimony by deposition was consistent with his written report.

19. In his testimony, Dr. Reiss reiterated his opinion that the claimant's current symptoms are not related to the work injury. Dr. Reiss also testified that in his opinion the August 17, 2017 work injury caused a temporary aggravation of the claimant's preexisting condition, but that aggravation resolved when his pain returned to baseline. With regard to the specific surgery recommended, Dr. Reiss testified that the claimant's symptoms would not be resolved by a fusion at the L5-S1 level. Dr. Reiss opined that

the claimant might benefit from a L4-5 decompression, but such a procedure would also be unrelated to the claimant's work injury.

20. Dr. Orndorff testified by deposition in this matter. Dr. Orndorff testified that following the claimant's 2013 L4-5 laminectomy and decompression surgery, the claimant had resolution of both his back pain and his leg pain. Dr. Orndorff also testified that it is his opinion that the claimant's need for surgery is both reasonable and related to the August 17, 2017 work injury. In support of his opinion, Dr. Orndorff noted that the claimant had close to four years without symptoms between recovering from his 2013 surgery and the 2017 work injury. Dr. Orndorff also reiterated his opinion that the claimant has exhausted all conservative treatment.

21. The claimant testified that currently his average pain is 6 out of 10. The claimant also testified that that his current symptoms include low back pain, pain into his left calf muscle, with tingling into his left foot. The claimant testified that he wants to undergo the recommended lumbar surgery so he had return to work.

22. The claimant's spouse also testified at hearing. Specifically, she noted that within two weeks of the claimant's 2013 surgery, the claimant was "up and around" and "better every day". The claimant's spouse also testified that after recovering from the 2013 surgery the claimant had no back issues until the work incident in 2017. Since the claimant's injury, his spouse has observed that he is unable to do various activities he could prior to the injury. These activities include yard work, fixing fences, repairing the roof, hiking, camping, and skiing.

23. The ALJ credits the claimant's testimony, the medical records, and the opinions of Drs. Orndorff and Bohachevsky over the contrary opinion of Dr. Reiss. Therefore, the ALJ finds that the claimant has demonstrated that it is more likely than not that the claimant's August 17, 2017 aggravated and/or accelerated the claimant's preexisting low back condition, resulting in the need for medical treatment.

24. The ALJ further credits the claimant's testimony, the medical records, and the opinions of Dr. Orndorff over the contrary opinion of Dr. Reiss and finds that the claimant has demonstrated that it is more likely than not that the recommended L5-S1 anterior lumbar interbody fusion surgery is reasonable and necessary to cure and relieve the claimant from the effects of the August 17, 2017 work 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. The ALJ's factual findings concern only evidence that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2017).

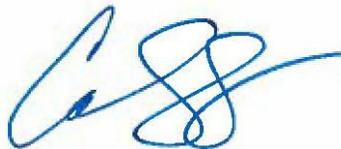
3. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

4. As found, the claimant has demonstrated by a preponderance of the evidence that the need for surgical intervention of his low back is related to the August 17, 2017 work injury. Specifically, the claimant's preexisting long back issues were aggravated and/or accelerated by the work injury. As found, the claimant has demonstrated by a preponderance of the evidence that the recommended L5-S1 anterior lumbar interbody fusion surgery is reasonable and necessary to cure and relieve the claimant from the effects of the August 17, 2017 work injury. As found, the claimant's testimony, the medical records, and the opinions of Drs. Orndorff and Bohachevsky are credible and persuasive.

ORDER

It is therefore ordered that the respondents shall pay for the recommended L5-S1 anterior lumbar interbody fusion surgery, pursuant to the Colorado Medical Fee Schedule.

Dated March 27, 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

Whether the claimant has demonstrated, by a preponderance of the evidence, that the right ankle surgery recommended by Dr. Waqqar Khan-Farooqi (specifically a right lateral ankle reconstruction with arthroscopic debridement, and a peroneal tendon synovecotomy) is reasonable medical treatment necessary to cure and relieve the claimant from the effects of the admitted October 16, 2017 work injury.

FINDINGS OF FACT

1. The claimant is employed by the employer as a checker. On October 16, 2017, the claimant was working in the self-checkout area when she stepped on a dip in the floor and rolled her right ankle. The claimant testified that she immediately felt pain in her right ankle.

2. After the claimant reported the incident to the employer, she was referred to Dr. Craig Stagg for treatment. Dr. Stagg has been the claimant's authorized treating physician (ATP) for this claim.

3. The claimant was first seen by Dr. Stagg on October 17, 2017. On that date, an x-ray of the claimant's right ankle showed no acute fracture. Dr. Stagg diagnosed an ankle sprain. In addition, Dr. Stagg placed the claimant in a splint and instructed her to use crutches.

4. The claimant returned to Dr. Stagg on October 20, 2017. Dr. Stagg instructed the claimant to use a controlled ankle motion (CAM) boot and referred her to physical therapy. The claimant testified that physical therapy treatment made her symptoms worse.

5. On November 3, 2017, the claimant was seen by Dr. Stagg. At that time, the claimant continued to have swelling and bruising on her right ankle. Dr. Stagg ordered an x-ray of the claimant's right foot and a magnetic resonance image (MRI) of the claimant's right ankle. In addition, he referred the claimant to Dr. Christopher Copeland for consultation.

6. On November 3, 2017, an x-ray of the claimant's right foot showed no fracture or dislocation. It was read as a "normal study of the right foot".

7. The claimant was first seen by Dr. Copeland on November 9, 2017. At that time, Dr. Copeland noted that the claimant's symptoms included, bruising, swelling, weakness, and decreased range of motion in her right ankle. Dr. Copeland diagnosed a right ankle sprain and recommended that the claimant continue using the CAM boot. Dr. Copeland agreed that an MRI was appropriate.

8. On November 16, 2017, an MRI of the claimant's right ankle showed grade 2 sprains of the anterior talofibular and calcaneofibular ligaments with mild periligamentous and soft tissue edema.

9. Thereafter, the claimant's symptoms continued. On January 23, 2018, the claimant returned to Dr. Copeland who diagnosed a right ankle sprain with probable anterolateral impingement and possible peroneal tendinitis. On that date, Dr. Copeland recommended and administered a diagnostic therapeutic injection. Dr. Copeland opined that if the claimant continued to have symptoms, she could require surgery, including ankle arthroscopy, lateral ligament repair, and possible peroneal tendon exploration.

10. On January 29, 2018, the claimant returned to Dr. Stagg and reported that the injection administered by Dr. Copeland did not provide any immediate relief. On that same date, Dr. Stagg noted that the claimant should wean from her use of the CAM boot.

11. On February 20, 2018, the claimant was seen by Dr. Copeland and reported that the injection caused more pain for ten days after the January 23, 2018 injection. On that date, Dr. Copeland recommended and administered a second injection.

12. On February 21, 2018, the claimant attended an independent medical examination (IME) with Dr. Lawrence Lesnak. In connection with the IME, Dr. Lesnak reviewed the claimant's medical records, obtained a history from the claimant, and completed a physical examination. At the IME, the claimant described the most recent injection administered by Dr. Copeland as a numbing shot that provided no relief from that injection. In his IME report, Dr. Lesnak noted that the claimant continued to use her CAM boot. Dr. Lesnak opined that the claimant suffered an acute right lateral ankle sprain as a result of the October 16, 2017 work injury. Dr. Lesnak opined that the claimant did not need further injections and was not a surgical candidate. Dr. Lesnak recommended that the claimant undergo electromyography (EMG) testing of her right lower extremity to evaluate her right distal peroneal nerve. Dr. Lesnak also opined that the claimant had an underlying somatic disorder/somatoform disorder.

13. On February 28, 2018, the claimant returned to Dr. Stagg. At that time, the claimant requested a referral to another orthopedic surgeon. The claimant testified that she no longer wished to treat with Dr. Copeland because she had lost confidence in him. At that time, Dr. Stagg made a referral to Dr. Cota.

14. On March 16, 2018, Dr. Lesnak was asked to review additional medical records and opine regarding whether a second opinion from Dr. Cota would be reasonable and necessary to address the claimant's injury. Dr. Lesnak opined that a second opinion was not necessary. In that same report, Dr. Lesnak opined that the claimant should be placed at maximum medical improvement (MMI). Based upon Dr. Lesnak's opinion, the respondents denied the referral to Dr. Cota.

15. The claimant returned to Dr. Stagg on March 20, 2018. Dr. Stagg referred the claimant to Dr. Michael Burnbaum for EMG studies, as recommended by Dr. Lesnak in his IME. On that date, Dr. Stagg again encouraged the claimant to stop using her CAM boot.

16. On April 2, 2018, Dr. Burnbaum completed an EMG study of the claimant's right lower extremity. Dr. Burnbaum recorded that it was a normal EMG study. In addition, he found no significant nerve injury in the claimant's right leg.

17. Following the EMG, Dr. Stagg referred the claimant to Dr. Ellen Price for a determination regarding whether the claimant had complex regional pain syndrome (CRPS). The claimant was first seen by Dr. Price on May 11, 2018. At that time, Dr. Price did a bone scan to rule out an occult fracture. In addition, Dr. Price opined that the claimant did not have CRPS.

18. On May 8, 2018, the claimant was seen by Dr. Waqqar Khan-Farooqi regarding her right ankle. The claimant was not initially referred to Dr. Khan-Farooqi by her ATP. The claimant testified that she sought treatment with Dr. Khan-Farooqi independently. On exam, Dr. Khan-Farooqi noted "clinical evidence of chronic laxity" and opined that the claimant had insufficient anterolateral ankle ligaments. He recommended that the claimant undergo a lateral ankle reconstruction "of the Brostrom Gould variety".

19. On May 24, 2018, Dr. Stagg noted that two surgeons had recommended surgery for the claimant's right ankle. At that time, Dr. Stagg made a referral for the claimant to be seen by Dr. Khan-Farooqi.

20. Subsequently, Dr. Stagg referred the claimant for further testing for CRPS, specifically thermography and QSART testing. On July 6, 2018 a phase 3 bone scan was performed and showed no findings related to CRPS.

21. On August 22, 2018, the claimant returned to Dr. Lesnak for an additional IME. In his IME report, Dr. Lesnak reiterated his opinion that the claimant was at MMI. He specifically noted an MMI date of April 2, 2018 as this was the date Dr. Burnbaum found no neurologic abnormalities. Dr. Lesnak further opined the claimant did not have permanent impairment of her right lower extremity.

22. On August 28, 2018, Dr. David Reinhard noted that claimant's QSART results were negative for CRPS. In that same medical record, Dr. Reinhard opined that a CRPS diagnosis could be ruled out.

23. On October 18, 2018, the claimant returned to Dr. Khan-Farooqi. At that time, Dr. Khan-Farooqi noted that the claimant had "pretty significant laxity of the ankle and varus hindfoot." He again recommended lateral ankle reconstruction. Dr. Khan-Farooqi also recommended the claimant undergo arthroscopic debridement of soft tissue impingement lesion and a peroneal tendon synovectomy.

24. On January 2, 2019, Dr. Stagg noted that the claimant has “laxity on stress testing”.

25. On January 8, 2019, the claimant was seen by Dr. James Lindberg for an IME. Dr. Lindberg reviewed the claimant’s medical records, obtained a history, and performed a physical examination. In his IME report, Dr. Lindberg noted on his exam that the claimant had more instability in her left ankle than in her right ankle. Based upon his exam and his review of the imaging and testing (including x-rays, MRI findings, bone scan, and EMG testing), Dr. Lindberg found no evidence of ligament laxity. Dr. Lindberg opined that the surgery recommended by Dr. Khan-Farooqi is not reasonable or necessary medical treatment of the claimant’s symptoms. Dr. Lindberg’s testimony was consistent with his written report.

26. Dr. Lindberg testified that the only reason to perform the recommended surgery would be evidence of laxity. Dr. Lindberg reiterated that he could find no evidence of laxity on exam, or upon review of the various imaging studies.

27. The claimant testified that she wishes to pursue the surgery recommended by Dr. Khan-Farooqi.

28. The ALJ credits the medical records and the opinions of Drs. Lesnak and Lindberg over the contrary opinions of Drs. Stagg and Khan-Farooqi. The ALJ finds that the claimant has failed to demonstrate that it is more likely than not that the recommended ankle surgery is reasonable and necessary to cure and relieve the claimant from the effects of the work injury. The ALJ is persuaded by the opinion of Dr. Lindberg that the claimant’s right ankle does not have the necessary laxity to warrant the recommended surgery. The ALJ finds as persuasive Dr. Lindberg’s findings on exam that the claimant had more instability in her left ankle than in her right ankle.

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. The ALJ’s factual findings concern only evidence that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider,

among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2017).

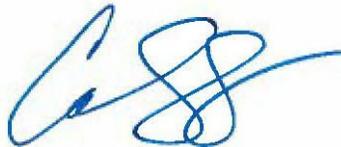
3. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; see *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

4. As found, the claimant has failed to demonstrate, by a preponderance of the evidence, that the recommended right ankle surgery is reasonable medical treatment necessary to cure and relieve the claimant from the effects of the October 16, 2017 work injury. As found, the medical records and the opinions of Drs. Lesnak and Lindberg are credible and persuasive.

ORDER

It is therefore ordered that the claimant's request for a right lateral ankle reconstruction with arthroscopic debridement, and a peroneal tendon synovecotomy is denied and dismissed.

Dated March 28, 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.**

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 5-077-006**

ISSUES

- Whether Claimant established by a preponderance of the evidence that he suffered a compensable work injury on May 8, 2018.

STIPULATIONS

1. The Parties agree that if the claim is compensable that Claimant's average weekly wage is \$980.00.
2. The Parties agree that if the claim is compensable that Claimant is entitled to Temporary Total Disability benefits from May 8, 2018 to May 20, 2018.

FINDINGS OF FACT

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

1. Claimant worked as a long haul truck driver with Employer.
2. He was driving in the Midwest when his truck's air conditioning unit failed on or about May 3, 2018. It was repaired on or about May 6, 2018. During that three-day period, Claimant testified that temperatures reached as high as 103 degrees. Claimant testified that he sweat continuously because of the heat, including at night when he attempted to sleep in his truck. He eventually stopped sweating.
3. Claimant testified that between May 5 and May 8, 2018, he vomited after eating. Initially, the vomit was a normal color and did not have blood in it.
4. On May 8, 2018, Claimant began vomiting bright red blood and contacted emergency services. Flight for Life ultimately transported Claimant to Northern Colorado Medical Center where medical providers diagnosed him with a bleeding gastrojejunal anastomotic ulcer. Claimant remained hospitalized through May 12, 2018.
5. In the "History of Present Illness/ Injury" note from Northern Colorado Medical Evacuation, the attending provider stated that Claimant called 911 after feeling light headed and vomiting blood. "He states he hasn't been feeling well for 3-4 days. He has been vomiting fresh red blood and coffee ground like emesis for 3-4 days."
6. Claimant attributed his vomiting to the heat and his subsequent dehydration. However, medical records do not support a finding that Claimant was dehydrated. Rather, the Northern Colorado Medical Center notes provide that when Claimant arrived, emergency room doctors tested Claimant's creatinine levels, which can indicate dehydration. Claimant's results were within normal limits. The notes do not indicate that

Claimant complained of dehydration at admission or during his hospital treatment. While Claimant did receive blood and IV fluids during transport to and at the hospital, medical records provide that they were given because Claimant had severe hypotension and do not mention dehydration.

7. Under "Social History" Matthew Remakus, M.D., noted that Claimant smoked three to four cigars a day. Other records provide that Claimant smoked a half pack of cigarettes daily for forty years.

8. On May 9, 2018, Dr. Ahmed M. Sherif performed an upper endoscopy. Dr. Sherif found a gastric ulcer with a visible, actively bleeding vessel. He successfully placed a clip over the vessel and stopped the active bleed. The endoscopy also revealed a large fistula between the bypassed stomach and the native stomach. Fistulas contain gastric acid which can reenter the stomach.

9. Claimant experienced a similar incident in 2010 after he underwent a Roux-en-Y gastric bypass surgery with Dr. Richard Tillquist, M.D. on August 4, 2010.

10. After his surgery, Claimant continued taking a non-steroidal anti-inflammatory although the medication his bypass surgery contraindicated doing so. He also did not take his prescribed proton pump inhibitor.

11. On September 18, 2010, Claimant reported that he had been feeling nauseous and began vomiting blood. He treated at Medical Center of Aurora-South where providers diagnosed an upper gastrointestinal bleed. Providers discontinued Claimant's non-steroidal anti-inflammatory, noting the probability that Claimant's ulcer was NSAID induced. They prescribed the proton pump inhibitor Protonix, but only for a three-week course.

12. While Claimant testified that providers diagnosed a torn esophagus in 2010, an upper GI endoscopy performed on September 18, 2010 showed a normal esophagus. The endoscopy also showed anastomotic ulcers at the site of Claimant's anastomosis.

13. Claimant maintained behaviors that put him at risk of additional upper gastrointestinal bleeds. Medical records from September 2014, note:

- Claimant's medical history was remarkable for acid reflux,
- Claimant took 81 mg aspirin tablets daily,
- Claimant smoked four cigars per day, and
- Claimant's BMI was 37.4.

14. Medical records from October 2014, February 2015, May 2015, June 2015, August 2016, January 2017, March 2017, April 2017, March 2018, and May 14, 2018 show aspirin as one of Claimant's current medications. May 2015 and August 2016 records note, "Patient was encouraged to take daily baby aspirin." On March 16, 2017, Claimant's provider counseled him to "hold aspirin" until after cataract surgery. While

Claimant denied taking aspirin, the ALJ finds the numerous and specific records to the contrary to be more persuasive.

15. While Claimant reportedly stopped smoking in 2014, he resumed smoking three to four cigars a day by May 1, 2015.

16. Claimant alleges that his May 5 through May 8, 2018 vomiting caused his bleeding gastrojejunal anastomotic ulcer. While Dr. Tillquist provided some support for Claimant's position, the greater weight of the evidence supports a finding that Claimant's ulcer caused his vomiting.

17. Respondents retained Dr. Jonathan Fishman, M.D., to review records and literature regarding the medical causation of Claimant's ulcer. Dr. Fishman opined that Claimant's May 8, 2018 nausea and vomiting *resulted from* the anastomotic ulcer, identified in the 2010 upper gastrointestinal endoscopy.

18. Dr. Fishman explained that gastrointestinal ulcers tend to form at the gastrojejunal anastomosis following a Roux-en-Y gastric bypass surgery, the one Claimant underwent in 2010. Ulcers form at that site because acid from the native stomach can enter the new stomach pouch, particularly where a gastric fistula allows even more acid from the native stomach to enter the new stomach. The anastomotic site is a weak area because it is close to the surgical site.

19. Further, Dr. Fishman opined that Claimant's 2010 ulcer became asymptomatic, but that it did not actually heal. Claimant's elevated risk factors including tobacco use, aspirin use, and the gastric fistula noted in Dr. Sherif's endoscopy, caused it to become symptomatic again in 2018.

20. Dr. Fishman therefore concluded there was no connection between Claimant's employment or work environment and the formation or symptoms of the gastric ulcer.

21. On December 10, 2018, Dr. Tillquist responded to Dr. Fishman's report. Dr. Tillquist opined that:

- dehydration can cause vomiting,
- vomiting can cause a pre-existing ulcer to start bleeding, and
- Claimant's vomiting was a "contributing factor" for the pre-existing ulcer to begin bleeding on May 8, 2018.

Therefore, Dr. Tillquist opined that Claimant suffered a compensable work injury on May 8, 2018. Dr. Tillquist criticized Dr. Fishman for failing to address vomiting as a cause for bleeding and for opining that Claimant had a chronic ulcer.

22. The ALJ finds that Dr. Tillquist's opinions speak in terms of possibility, not medical probability. That ALJ also finds Dr. Tillquist's opinions less persuasive because that are premised on Claimant being dehydrated, a finding that the ALJ does not make.

23. Dr. Fishman testified at hearing on Respondents' behalf. While Dr. Fishman is not Level II Accredited with the Division of Workers' Compensation, and had not previously testified at a workers' compensation hearing, he is board certified in gastroenterology with decades of experience in that field, including the treatment of patients with gastric bypass surgery. The Judge accepted him as an expert in gastroenterology.

24. Dr. Fishman testified that Claimant's gastric ulcer, diagnosed in 2010, caused his 2018 gastric bleed. He explained that ulcers do not always heal after they bleed, but rather can become asymptomatic, as Claimant's did in 2010. Over time, the ulcer can become symptomatic again because of non-work factors such as smoking, use of aspirin or other over the counter pain relievers, and time. In this case, Claimant has a number of risk factors that would result in a non-healing ulcer becoming symptomatic, including smoking and taking aspirin.

25. Dr. Fishman explained that Claimant's ulcer was located near the anastomosis, the junction site between the old and new stomach. This ulcer was present in 2010 when a bleeding ulcer caused Claimant's hospitalization. Dr. Fishman explained that it was common for ulcers to become asymptomatic, but not actually "heal." Acid in the stomach typically prevents ulcers from healing completely, which is why doctors prescribe acid blockers for an extended time following a bleeding ulcer. Claimant's doctors did not prescribe a long-term acid blocker following his 2010 anastomotic ulcer bleed. Therefore, Dr. Fishman opined that Claimant had a non-healing gastric ulcer which was asymptomatic for approximately eight years following the 2010 bleed, and which never fully healed. Over time, the acid in Claimant's stomach, exacerbated by the gastric fistula, prevented the ulcer from healing. Claimant's routine smoking and use of aspirin further eroded the lining between the ulcer and the blood vessels underneath, until eventually, the ulcer began to bleed.

26. Dr. Fishman testified that dehydration does not typically cause vomiting; contrary to Dr. Tillquist's theory that Claimant's vomiting caused the ulcer to become symptomatic. Further, emergency room reports do not indicate that Claimant was dehydrated when admitted. Rather, Claimant's creatinine levels were normal, which suggests that he was not dehydrated when admitted.

27. Dr. Fishman opined that Claimant's vomiting resulted from the ulcer becoming symptomatic in the days prior to May 8, 2018. A symptomatic ulcer can cause nausea and vomiting, which is consistent with Claimant's reports that even after his air conditioner began working; he was still unable to eat without vomiting. Additionally, Dr. Fishman explained that a bleeding, symptomatic ulcer would not always immediately produce frank blood in the vomit.

28. Dr. Fishman conceded the possibility that Claimant's vomiting exacerbated the ulcer. However, he explained it was highly unlikely based on the ulcer's location, which was not in the "new" part of the stomach. Vomiting would not directly affect the ulcer site. Thus, Dr. Fishman concluded it was much more likely that Claimant's ulcer became symptomatic on or around May 4, 2018, which caused Claimant to become nauseous and vomit, which eventually resulted in Claimant's hospitalization due to the bleeding ulcer and its complications.

CONCLUSIONS OF LAW

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

The purpose of the Workers' Compensation Act of Colorado (Act), 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). A 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 Engineering, 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 to be assigned 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.

A claimant's right to compensation initially hinges upon a determination that "at the time of the injury, the employee is performing service arising out of and in the course of the employee's employment." C.R.S. § 8-41-301(1)(b). The "arising out of" test is one of causation which requires that the injury have its origins in an employee's work-related functions. There is no presumption that an injury, which occurs in the course of employment, arises out of the employment. *Finn v. Industrial Commission*, 165 Colo. 106, 437 P.2d 542 (1968). The evidence must establish the causal connection with reasonable probability, but it need not establish it with reasonable medical certainty. *Ringsby Truck Lines, Inc. v. Industrial Commission*, 30 Colo. App. 224, 491 P.2d 106 (Colo. App. 1971). A causal connection may be established by circumstantial evidence and expert medical testimony is not necessarily required. *Industrial Commission of Colorado v. Jones*, 688 P.2d 1116 (Colo. 1984); *Industrial Commission v. Royal Indemnity Co.*, 124 Colo. 210, 236 P.2d 293 (1951).

Whether a compensable injury has been sustained is a question of fact to be determined by the ALJ. *Eller v. Industrial Claim Appeals Office*, 224 P.3d 397 (Colo. App. 2009). The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the proximate causal relationship between an incident/injury and the need for medical treatment, plus entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. (2017). See *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000).

The fact that a claimant experiences symptoms while performing work does not require the inference there has been an aggravation or acceleration of a preexisting condition. See *Cotts v. Exempla, Inc.*, W.C. No. 4-606-563 (ICAP, Aug. 18, 2005). Rather, the symptoms could represent the logical and recurrent consequence of the pre-existing condition. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

As found, Claimant's testimony that he suffered from dehydration and that dehydration caused his vomiting symptoms is neither persuasive nor consistent with the medical evidence. Claimant testified at hearing that he had not been vomiting up blood before the May 8, 2018 incident. However, contemporaneous Northern Colorado Medical Evacuation records state that Claimant had been vomiting blood and "coffee ground" like emesis for three days prior to the alleged work injury. Further, Claimant's creatinine levels were within the normal range on the date of the admission, which suggests that Claimant was not dehydrated as Dr. Fishman explained. Finally, hospital physicians did not note that Claimant was suffering from dehydration during his hospital stay, but rather noted that Claimant had severe hypotension. Therefore, Claimant's testimony at hearing regarding the cause of his vomiting and his alleged dehydration are not persuasive.

Dr. Fishman testified credibly at hearing regarding the most likely cause of Claimant's gastrointestinal bleed. He explained that it was far more likely that Claimant's nausea symptoms in the days prior to the accident were caused by a newly symptomatic anastomotic ulcer. Further, he explained that based on the location of the anastomotic ulcer, vomiting in and of itself, would not have exacerbated the anastomotic ulcer. While vomiting is a physiologically disruptive event, in Claimant's case the new stomach would contract, causing the vomit to move up the esophagus. This would not affect the

anastomosis and anastomotic ulcer. Therefore, from a physiological standpoint, vomiting in and of itself would not have caused a gastrointestinal bleed as Dr. Tillquist described.

Dr. Richard Tillquist, M.D.'s opinion regarding the work-relatedness of Claimant's ulcer is not persuasive. Dr. Tillquist opined that Claimant's ulcer was symptomatic because of vomiting. He provided little further explanation, except that dehydration can cause vomiting, and that vomiting can exacerbate an ulcer. Dr. Fishman, by contrast, provided a more nuanced view of the facts, taking into account the ulcer's location, Claimant's history of smoking, and his long-term use of aspirin. Further, Dr. Fishman's opinion takes into account the contemporaneous note from the medical evacuation provider that states that Claimant had been vomiting fresh and dried blood for days, which demonstrates that Claimant's newly symptomatic ulcer caused the vomiting.

As found, Dr. Fishman's opinions are more persuasive than Dr. Tillquist's, and presents the most likely medical explanation for Claimant's anastomotic ulcer bleed on May 8, 2018. Thus, Claimant has failed to prove by a preponderance of the evidence that he suffered a work-related injury and therefore his claim for workers' compensation benefits is denied and dismissed.

ORDER

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

1. Claimant's claim for workers' compensation benefits is hereby denied and dismissed.
2. Any issues not determined in this decision 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 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 certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. ***For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.***

DATED: March 28, 2019

/s/ Kimberly Turnbow
Kimberly B. Turnbow
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 5-065-402-001

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

,

Claimant,

v.

,

Employer,

and

Self-Insured Respondent.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on March 7, 2019, in Denver, Colorado. The hearing was digitally recorded (reference: 3/7/19, Courtroom 1, beginning at 1:30 PM, and ending at 3:45 PM).

The Claimant was present in person and represented by -----, Esq. The Respondent WAS represented by -----, Esq.

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 11 were admitted into evidence, without objection. Respondent's Exhibits A through G were admitted into evidence, without objection.

At the conclusion of the hearing, the ALJ established a post-hearing briefing schedule. Claimant's opening brief was filed on March 14, 2019. Respondent's answer

brief was filed on March 21, 2019. No timely reply brief was filed and the matter was deemed submitted for decision on March 26, 2019.

ISSUES

The issues to be determined by this decision concern compensability of an episode of atrial fibrillation (hereinafter “a-fib”) on December 10, 2017. If the claim is found to be compensable, medical benefits and average weekly wage (AWW) are additionally designated issues.

The Claimant bears the burden of proof by a preponderance of the evidence on all issues.

FINDINGS OF FACT

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

The Incident

1. The Claimant is a 34-year employee of the Employer. On December 10, 2017, he had completed a workout routine at the fire station during one of his shifts. He had performed an exercise routine consisting of stretching, yoga, walking up and down stairs while wearing a weighted vest, as well as sets of push-ups, dips, and pull ups in between flights of stairs. The Claimant took a shower and shortly afterwards noticed that his heart was racing. This occurred approximately 30-minutes after the exercise. The Claimant hooked himself up to the EKG machine at the fire station and found that his heart was experiencing an episode of a-fib. Respondent argues, in its answer brief, that the time interval between the vigorous exercise and the episode of a-fib severs the causal link between the a-fib and the exercise. Respondent’s Independent Medical Examiner (IME), Mary R. Olsovsky, M.D., a cardiologist, rendered a more global opinion that exercise does not cause a-fib. She implies that the Claimant’s sleep apnea and waking with his heart racing could be a more likely cause. For the reasons specified herein below, the ALJ rejects this argument and Dr. Oslovsky’s opinion in this regard.

2. Upon the onset of the a-fib, the Claimant notified his supervisor of the situation and was taken to the hospital for treatment. The ALJ finds that Claimant reported his injury to an authorized Employer representative on December 10, 2017.

3. The incident cited as the cause of injury occurred in the course and scope of the Claimant’s employment. The Claimant was at work, during working hours, and had just finished a vigorous work-related workout routine when he realized something was wrong with his heart. The injury arose out of employment because the Claimant is

expected to maintain a requisite level of fitness to perform his duties as a fire fighter. The fire department expects employees to exercise while they are on shift and provides them equipment to do so. The Claimant's injury also satisfies the positional risk doctrine, because the conditions and obligations of his employment—training related to maintaining the requisite level of fitness to perform the duties expected of a firefighter—placed him in the position in which the injury occurred. Respondent argues that their IME's (Dr. Oslovsky) opinions do not support the arising out of" test. This opinion is in conflict with the opinion of William Chloe. M.D., a treating cardiologist, as supported by the opinion of the authorized treating physician (ATP), Hiep Leloudes Ritzer, M.D. and the Claimant's testimony. The ALJ resolves this conflict in favor of the opinions of Dr. Chloe, Dr. Ritzer, the testimony of the Claimant and against the opinions of Dr. Oslovsky for the reasons stated herein below.

4. The Claimant has not suffered an episode of a-fib prior to the incident of December 10, and it is more likely than not that this incident at work aggravated and accelerated any underlying heart problem, thus, making it dangerous for the Claimant to fulfill his duties as a firefighter without running the risk of experiencing another episode of a-fib, which could lead to even more serious consequences, as supported by the Claimant's medical restrictions as a result of the December 10 episode of a-fib.

Medical

5. The Claimant was first seen on December 10, 2017, when he was taken to Littleton Adventist Hospital. When he was released from the hospital he was told to see a cardiologist as soon as possible. The Claimant had an appointment with cardiologist, William Choe M.D. on December 11. Dr. Choe diagnosed the patient with paroxysmal a-fib/ flutter. He prescribed a blood thinner and a beta blocker for the Claimant and scheduled him for further testing. Dr. Choe, the Claimant's authorized treating cardiologist, also took the Claimant off line as a firefighter, meaning Claimant could not work as a line firefighter and he was restricted to light duty. Dr. Choe did not conduct a "causation analysis" as to the origin of the Claimant's injuries, however, Dr. Hiep did, taking Dr. Chloe's assessment into account.

6. On December 12, 2017, the Employer referred the Claimant to Dr. Ritzer, who became his authorized treating physician (ATP). Dr. Ritzer is not a cardiologist; she practices family medicine. Dr. Ritzer diagnosed the Claimant with recurrent supraventricular or atrial tachycardia, flutter, or fibrillation. Dr. Ritzer accepted Dr. Choe's findings related to the Claimant's condition and then conducted a "causation analysis" as to the origin of the Claimant's injuries and determined that the Claimant's symptoms were consistent with a work injury. Dr. Ritzer advised the Claimant that he should continue treatment with Dr. Choe. At this point, Dr. Choe became an ATP because he was within the chain of authorized referrals.

7. The Claimant has suffered from sleep apnea, which he was diagnosed with by a Dr. Smith in 2015. He was given a mouth piece to help with the condition. At the time of the incident on December 10, 2017, the Claimant's mouthpiece had a crack in it. Respondents argue that the sleep apnea, or the crack in the mouth piece **could** be an alternative cause of the Claimant's a-fib, but the ALJ does not find this explanation persuasive and rejects it.

8. The Claimant was released to perform regular duty by Dr. Ritzer, in consultation with Dr. Choe, on January 18, 2018.

Mary R. Olsovsky, M.D., Respondents' Independent Medical Examiner (IME)

9. Dr. Olsovsky, engaged by the Respondents to perform a medical records review, reviewed the Claimant's medical records. She did not examine the Claimant in person. Dr. Olsovsky disagreed with Dr. Ritzer's conclusion that the Claimant's a-fib was a result of work activities aggravating or accelerating an underlying problem. She listed risk factors such as age, physical condition, preexisting sleep apnea as factors that could have caused Claimant's a-fib. The ALJ infers and finds that anything is possible, but Dr. Olsovsky's opinion in this regard is speculative and is not proof of the causation of the Claimant's a-fib. She also explained that an episode of a-fib could be triggered by exercise. The ALJ finds Dr. Olsovsky's opinions and testimony insufficient to outweigh the opinion of Dr. Ritzer, supported and augmented by the findings of Dr. Choe, a cardiologist. Dr. Olsovsky's testimony does not convince the ALJ that the Claimant's a-fib was **not** aggravated and accelerated by his at work exercise routine on December 10, 2017. Stated in the affirmative, the ALJ finds that it is more likely than not that the incident of December 10, 2017, aggravated and accelerated the Claimant's underlying cardiac condition and caused the a-fib.

Ultimate Findings

10. The ALJ finds that the Claimant presented in straight-forward and credible manner. He was not impeached in any way. The ALJ finds his testimony convincing, credible and supporting the vigorous exercise as the precipitating cause of the a-fib on December 10, 2017.

11. The a-fib incident of December 10 was not just a temporary symptom-manifestation. It had consequences that necessitated medical treatment and physical restrictions that temporarily would not permit the Claimant to work as a firefighter.

12. The ALJ finds that ATP Ritzer's determination (supported and augmented by Dr. Chloe's opinion concerning the Claimant's medical condition) that the Claimant's a-fib constitutes a work injury is credible, persuasive, and outweighs the opinion of IME Dr. Oslovsky. Further, the ALJ finds that the Claimant's testimony is credible, persuasive and consistent with the fact that the cardiac episode on December 10, 2017 constituted a compensable injury.

13. Despite the fact that Dr. Oslovsky gave articulate and convincing testimony, the ALJ finds that the conclusion of Dr. Oslovsky is less credible than that of Dr. Ritzer. This is mainly due to the fact that Dr. Oslovsky never examined the Claimant in person, whereas Dr. Choe and Dr. Ritzer spent a substantial amount of time with the Claimant. Dr. Oslovsky was also unable to give a satisfactory explanation as to why she believed that the Claimant's episode of a-fib on December 10 was not caused by exercise and was instead caused by age, physical condition (the Claimant was physically fit prior to the December 10 incident) or sleep apnea. The ALJ further finds the generalized statements concern age, physical condition and sleep apnea as potential causes unpersuasive for the specific circumstances of this case. She made the statement that exercise is often recommended for individuals with cardiac problems. This statement is disassociated from a cause-and-effect analysis. Dr. Oslovsky also failed to convincingly explain why she thought the temporal connection (30-minutes) between exercise and the onset of the a-fib episode was not relevant to her conclusion. Under the circumstances, such an observation would be more convincing if the time gap was one or two weeks. The ALJ finds Dr. Oslovsky's opinions and testimony insufficient to outweigh the opinion of ATP Dr. Ritzer, supplemented with the findings of Dr. Choe and the testimony of the Claimant. Despite the fact that Dr. Oslovsky gave articulate testimony, the ALJ finds that the conclusion of Dr. Oslovsky is less credible than that of Dr. Ritzer as supported by Dr. Chloe's diagnosis. Despite the fact that Dr. Oslovsky gave articulate testimony, the ALJ finds that her conclusion is less credible than that of Dr. Ritzer as supported by the diagnosis of Dr. Chloe. This is mainly due to the fact that Dr. Oslovsky never examined the Claimant in person, whereas Dr. Choe and Dr. Ritzer spent a substantial amount of time with the Claimant.

14. It is not necessary for the Respondent to come up with a credible alternative explanation for the cause of the Claimant's a-fib. The Respondent may merely put the Claimant on his proof. Dr. Oslovsky was also unable to give a satisfactory explanation as to why she believed that the Claimant's immediate episode of a-fib on December 10 was not caused by exercise and was instead caused by age, physical condition, or sleep apnea. Underlying this alternative explanation is the proposition that the a-fib was an episode on its way to happen—as a result of the Claimant's dormant predisposition. She also failed to persuasively explain why she thought the temporal connection between exercise and the onset of the a-fib episode was relevant to her conclusion. Dr. Oslovsky's opinion may ultimately be summarized as the cause of the a-fib on December 10 was unexplained. The ALJ finds Dr.

Oslovsky's opinions and testimony insufficient to outweigh the opinion of Dr. Ritzer, supplemented with the findings of Dr. Choe and the Claimant's lay testimony.

15. Between conflicting testimonies and opinions, the ALJ makes a rational choice, based on substantial evidence, to accept the Claimant's testimony as a whole, and the supporting opinions of Dr. Ritzer and Dr. Choe, and to reject all opinions and testimony to the contrary.

16. The ALJ finds that the Claimant has proven by a preponderance of the evidence that he sustained a sufficient compensable injury, or aggravation and acceleration of his underlying and incipient cardiac condition that caused the a-fib on December 10, 2017.

17. The parties stipulated that the medical treatment of Dr. Ritzer and Dr. Choe was reasonably necessary and causally related if this claim was determined to be compensable, which it has been so determined. Therefore, the ALJ finds that the medical care and treatment that Claimant received for his a-fib, was authorized, causally related to the December 10 incident, and reasonably necessary to cure and relieve the effects of that injury.

18. The parties stipulated as follows if the claim was deemed compensable: the average weekly wage (AWW) is \$1,646.88, which yields a maximum temporary total disability (TTD) rate of \$948.15. Therefore, the ALJ finds that the Claimant's AWW is \$1,646.88 and his TTD rate is \$948.15.

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. *Arenas 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 Cleaner v. Indus. Claim Appeals Office*, 914 P.2d 501 (Colo. App. 1995). As found, the Claimant's testimony concerning lack of previous a-fib problems was credible and persuasive. Further, the medical opinion of Dr. Choe was credible and was used by Dr. Ritzer to conclude that there was a causal, work-related relation to the December 10, 2017 incident, which the ALJ also found to be credible and persuasive. Despite the fact that Dr. Oslovsky gave articulate testimony, the ALJ found that the conclusion of Dr. Oslovsky was less credible than that of Dr. Ritzer, as supported by Cardiologist Dr. Chloe's findings. This was due, in significant part, to the fact that Dr. Oslovsky never examined the Claimant in person whereas Dr. Choe and Dr. Ritzer spent a substantial amount of time with the Claimant. Dr. Oslovsky was also unable to give a satisfactory explanation as to why she believed that the Claimant's episode of a-fib on December 10 was not caused by vigorous exercise and was instead caused by age, physical condition, or sleep apnea. She also failed to persuasively explain why she thought the temporal connection between exercise and the onset of the a-fib episode was relevant to her conclusion. The ALJ finds Dr. Oslovsky's opinions and testimony insufficient to outweigh the opinion of Dr. Ritzer, supplemented with the findings of Dr. Choe and the Claimant's credible testimony.

b. Compensation can be awarded where there is competent evidence other than expert opinion. *Martin Marietta Corp. v. Faulk*, 158 Colo. 441, 407 P.2d 348 (1965). Such competent evidence includes lay testimony. See *Savio House v. Dennis*, 665 P.2d 141 (Colo. App. 1983); *Colorado Fuel & Iron Corp. v. Alitto*, 130 Colo. 130, 273 P.2d 725 (1954). Also see *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). As found, although Dr. Ritzer's opinion as supported by Dr. Chloe's assessment was an important factor in the credibility determination, the Claimant's testimony also played a significant role.

Substantial Evidence

c. 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 testimonies and opinions, the ALJ made a rational choice, based on substantial evidence, to accept the Claimant's testimony as a whole, the findings of Dr. Choe, the conclusion of Dr. Ritzer, and to reject opinions and testimony to the contrary.

Compensability

d. An "injury" referred to in § 8-41-301, C.R.S., contemplates a **disabling** injury to a claimant's person, not merely a coincidental and non-disabling insult to the body. See *Henderson v. RSI, Inc.*, 824 P.2d 91 (Colo. App. 1991). Also see *Gaudett v. Stationers Distributing Company*, W.C. No. 4-135-027 [Indus. Claim Appeals Office (ICAO), April 5, 1993]. A priori, the consequences of a work-related incident must require medical treatment or be disabling in order to be sufficient to constitute a compensable event. If an incident is not a significant event resulting in an injury, claimant is not entitled to benefits. *Wherry v. City and County of Denver*, W.C. No. 4-475-818 (ICAO, March 7, 2002). As found, the a-fib incident of December 10 required medical treatment for the Claimant and physical restrictions that would not permit him to work, temporarily, as a firefighter.

e. 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. This is the crucial question. If an industrial injury aggravates or accelerates a preexisting condition, the resulting disability and need for treatment is a compensable consequence of the industrial injury. Thus, a claimant's personal susceptibility or predisposition to injury does not disqualify the claimant from receiving benefits. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). An injured worker has a compensable new injury **if the employment-related activities aggravate, accelerate, or combine with the pre-existing condition to cause a need for medical treatment or produce the**

disability for which benefits are sought. § 8-41-301(1) (c), C.R.S. 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]. As found, the Claimant established an acceleration and aggravation of his underling condition which caused the episode of a-fib on December 10, 2017.

Medical

f. To be authorized, all referrals must remain within the chain of authorized referrals in the normal progression of authorized treatment. See *Mason Jar Restaurant v. Indus. Claim Appeals Office*, 862 P. 2d 1026 (Colo. App. 1993); *One Hour Cleaners v. Indus. Claim Appeals Office*, 914 P. 2d 501 (Colo. App. 1995); *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). As stipulated by the parties and found by the ALJ, the Claimant's medical treatment for his a-fib incident of December 10 was the result of a referral by the Employer and thereafter further treatment remained in the authorized chain of referrals.

g. 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 for his a-fib is causally related to the incident of December 10, 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 reasonably necessary to cure and relieve the effects of the a-fib.

Average Weekly Wage

h. 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 stipulated by the parties, the ALJ finds that the Claimant's AWW is \$1,646.88.

Burden of Proof

i. 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 his burden with respect to compensability; the authorization for medical treatment of the Claimant’s a-fib; and, for all causally related and reasonably necessary medical care and treatment therefore to cure and relieve the effects of the compensable a-fib of December 10, 2017..

ORDER

IT IS, THEREFORE, ORDERED THAT:

- A. The Claimant experienced a compensable episode of a-fib on December 10, 2017.
- B. Respondent shall pay the costs of all authorized, causally related and reasonably necessary medical care and treatment for the Claimant's compensable episode of atrial fibrillation on December 10, 2017, including the costs of treatment by Hiep Lelourdes Ritzer, M.D. and William Chloe, M.D., subject to the Division of Workers Compensation Medical Fee Schedule.
- C. The Claimant's average weekly wage is hereby established at \$1,646.88.
- D. Any and all issues not determined herein are reserved for future decision.

DATED this 25th day of March 2019.

DIGITAL SIGNATURE


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>.**