BROWN BAG SEMINAR

Thursday, December 19, 2013
(third Thursday of each month)
Noon - 1 p.m.

633 17th Street

2nd Floor Conference Room
(use elevator near Starbucks)

1 CLE (including .4 ethics)

Presented by

Craig Eley
Manager of Director’s Office
Prehearing Administrative Law Judge
Colorado Division of Workers’ Compensation

Sponsored by the Division of Workers' Compensation

Free

This outline covers ICAP and appellate decisions issued from
November 16, 2013 through December 13, 2013

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The respondent seeks review of an order of Administrative Law Judge Cannici (ALJ) dated July 24, 2013, that determined the claimant did not receive an overpayment of temporary total disability (TTD) benefits. We modify the order and as modified, affirm.

This matter previously was before us and has a protracted history. We recite those facts necessary to understand the posture of the case and the issue on review.

ALJ Cannici found that on March 12, 2007, the claimant was working as a ramp service employee for the employer when she sustained an admitted injury. The claimant was driving a tug vehicle that collided with a tug vehicle operated by another airline. The claimant sued the other airline for her injuries. In March 2010, the claimant and the respondent entered into a formal assignment agreement relating to the respondent’s subrogation claim under §8-41-203, C.R.S. Pursuant to the agreement, the respondent assigned its subrogation rights to the claimant in exchange for a percentage of the claimant’s net recovery from the lawsuit. The agreement also provided that it was not intended to apply to or limit the claimant’s right to receive future workers’ compensation benefits. In March 2010, the claimant settled her lawsuit, received her net recovery, and the respondent received a percentage of the claimant’s recovery.

Ultimately, the claimant underwent a Division Independent Medical Examination (DIME) with Dr. Gellrick, who opined that the claimant reached maximum medical improvement (MMI) as of September 20, 2010, with a 23% whole person impairment rating. On June 29, 2011, the respondent filed a final admission of liability (FAL) in accordance with the DIME opinion and admitted for medical benefits after MMI. The
worksheet accompanying the FAL indicated that the claimant received TTD benefits totaling $61,103.94. It further indicated that the claimant received Social Security Disability (SSDI) benefits from December 1, 2007 through July 31, 2010. The amount of $61,103.94 paid in TTD benefits reflected the amount the respondent paid after crediting the claimant’s lump sum payment to the respondent in the amount of $28,638.86 to account for the offset of SSDI benefits. The respondent also stated in the worksheet that the total amount of TTD benefits payable with the SSDI offset from December 1, 2007, through July 31, 2010, amounted to $59,417.47. In its FAL, the respondent stated that the amount of TTD benefits it overpaid to the claimant totaled $1,686.47. The respondent did not admit liability for any PPD payments by virtue of the statutory cap provisions under §8-42-107.5, C.R.S. The claimant objected and set the matter for hearing.

A hearing ultimately was held before ALJ Krumreich after which he ordered that the claimant was entitled to payment of PPD benefits. ALJ Krumreich found that the respondent’s actual TTD payments were reduced by the $28,638.86 payment from the claimant to account for her receipt of SSDI benefits, and that the respondent actually paid the claimant $61,103.94 for TTD benefits. ALJ Krumreich determined that the applicable statutory cap of $75,000 was not reached, and he calculated that the claimant was entitled to at least $13,896.06 in PPD payments. ALJ Krumreich was persuaded that the assignment agreement did not entitle the respondent to limit the claimant’s right to receive future workers’ compensation benefits.

The respondent appealed ALJ Krumreich’s order, arguing that the claimant was not entitled to receive PPD benefits after application of the $75,000 cap contained in §8-42-107.5, C.R.S. The Panel agreed with the respondent. The Panel reasoned that it was not clear from ALJ Krumreich’s findings whether the respondent received the benefit of the claimant's SSDI payments in determining whether the statutory cap had been reached. The Panel noted that the record included the respondent's FAL, which contained the worksheet reflecting differing amounts of TTD payments. The worksheet indicated that without accounting for the claimant's receipt of SSDI benefits, TTD would have been paid in the amount of $89,149.52, which exceeded the applicable $75,000 cap. In another set of calculations, the worksheet indicated some reduced TTD payments due to SSDI payments that were not expressly identified, and reflected total TTD payments in the amount of $59,417.47. In addition, the respondent asserted that it actually paid indemnity benefits totaling $61,103.94 and, therefore, overpaid TTD benefits by $1,686.47.

Relying on Flores v. Oregon Steel Mills, Inc., W.C. No. 4-608-694 (Dec. 14, 2009), aff’d, Case No. 11CA1696 (Colo. App. June 14, 2012) (NSOP), the Panel remanded, determining that in order to account for the SSDI offset, the respondent's TTD payments should be calculated to determine the length of time it would take to reach the
$75,000 cap and include in the periodic payments the appropriate offset for SSDI benefits to be paid until the cap is reached.

On remand, ALJ Cannici did not hold an additional hearing. In his order after remand, ALJ Cannici determined that the respondent’s TTD payments in conjunction with the claimant’s SSDI benefits exceeded the $75,000 statutory cap contained in §8-42-107.5, C.R.S. ALJ Cannici determined that the respondent paid the claimant indemnity benefits in the actual amount of $61,103.94. In ascertaining whether the respondent’s payments to the claimant exceeded the statutory cap set forth in §8-42-107.5, C.R.S., ALJ Cannici determined the amount of TTD benefits paid after taking the statutory offset for SSDI, through the date of MMI, totaled $59,417.47. Finding that the claimant was only entitled to receive TTD benefits in the amount of $59,417.47 after application of the cap, ALJ Cannici ordered that the respondent was entitled to recover an overpayment totaling $1,686.47 ($61,103.94 - $59,417.47).

Both the claimant and the respondent appealed ALJ Cannici’s order. On appeal, the claimant contended that the $75,000 cap contained in §8-42-107.5, C.R.S. had not been exceeded. Conversely, the respondent argued that while ALJ Cannici correctly determined that the claimant was overpaid, he erred in calculating such overpayment as being only $1,686.47. The respondent contended that without the SSDI offset, the claimant’s TTD benefits would have reached the cap of $75,000 on March 13, 2010, and should have been capped at $49,600.67. The respondent asserted that since the claimant has been paid $61,103.94 in indemnity payments, the overpayment instead was $11,503.27.

On March 11, 2013, the Panel issued an order affirming ALJ Cannici’s order to the extent he determined that the $75,000 cap in §8-42-107.5, C.R.S. was exceeded, but set aside his determination that the overpayment totaled $1,686.47. The Panel remanded for further findings and an order on the total amount of the overpayment that the respondent was entitled to recover.

The Colorado Court of Appeals subsequently issued its opinion in United Airlines v. Industrial Claim Appeals Office, 312 P.3d 235 (Colo. App. 2013), cert. denied October 28, 2013. In that case, the Court addressed the employer’s request for reimbursement of TTD benefits in excess of the $75,000 statutory cap in §8-42-107.5, C.R.S. The claimant had sustained a compensable injury in 2007, and the respondent admitted liability for TTD benefits. The claimant’s TTD benefits ceased when she was released to return to work in May 2011. At that time, the claimant had been paid TTD benefits totaling $99,483.14. A DIME was performed, and the claimant was placed at MMI with a whole person permanent impairment rating of five percent. The Court cited the definition of “[o]verpayment” in §8-40-201(15.5), C.R.S. as meaning the “money received by a claimant that exceeds the amount that should have been paid, or which the claimant was not entitled to receive. . . .” The Court explained that the phrase “money received”
contained in §8-40-201(15.5), C.R.S. limits overpayment to sums exceeding “the amount that should have been paid.” The Court held that since the claimant received only benefits to which she was entitled, the $24,483.14 she received above the cap did not constitute an “overpayment” under §8-40-201(15.5), C.R.S. The Court further held that §8-42-107.5, C.R.S. caps “combined” temporary and permanent payments at $75,000. The Court held that since the benefits the claimant received were solely for her temporary disability, she never received “combined” permanent and temporary benefits exceeding the cap. The Court therefore concluded that the claimant had not received an overpayment of TTD benefits, and the cap did not obligate her to repay the employer for the temporary benefits to which she was entitled.

The Panel subsequently issued a corrected order remanding the matter for ALJ Cannici to consider the parties’ arguments in light of the Court’s recent decision in United Airlines. After remand, ALJ Cannici held that the claimant’s TTD benefits ceased when she reached MMI on September 20, 2010, and that she did not receive temporary partial disability benefits. ALJ Cannici also held that the claimant received a permanent impairment rating of 23%, and that the statutory cap in §8-42-107.5, C.R.S. would apply. ALJ Cannici held, however, that based on the Court’s reasoning in United Airlines, the respondent is not entitled to recover an overpayment. ALJ Cannici held that regardless of whether the claimant’s receipt of TTD benefits in conjunction with SSDI benefits exceeded the statutory cap in §8-42-107.5, C.R.S., the claimant did not receive an overpayment of TTD benefits pursuant to the statutory cap in §8-42-107.5, C.R.S.

The respondent has petitioned to review ALJ Cannici’s latest order. The respondent now argues that the holding in United Airlines does not apply to its request for a second overpayment. This second overpayment consists of the TTD benefits that the claimant actually received totaling $61,103.94, and the amount of TTD benefits that the claimant actually was entitled to recover in the amount of $59,417.47. Consequently, the respondent argues that ALJ Cannici erred in failing to address its request for a second overpayment totaling $1,686.47. The claimant argues, on the other hand, that the respondent is precluded from recovering any overpayment because it filed a general admission of liability to pay such temporary indemnity benefits. The claimant further contends that the respondent is precluded from recovering this overpayment because it has to reopen the matter to request an overpayment, and the matter presently is time-barred from such a request. The claimant therefore contends that the respondent is “stuck” with its FAL and the contents thereof.

Initially, we conclude that ALJ Cannici properly held that pursuant United Airlines, the claimant did not receive an overpayment of TTD benefits in the amount of $11,503.27 under the statutory cap enunciated in §8-42-107.5, C.R.S. Consequently, we affirm ALJ Cannici’s order in this regard.
We next address the respondent’s argument that it is entitled to recover an overpayment in the amount of $1,686.47. Again, this second overpayment consists of the TTD benefits that the claimant actually received totaling $61,103.94, and the amount of TTD benefits that the claimant actually was entitled to recover in the amount of $59,417.47.

The term ‘overpayment’ is defined in § 8-40-201(15.5), C.R.S as follows:

(15.5) "Overpayment" means money received by a claimant that exceeds the amount that should have been paid, or which the claimant was not entitled to receive, or which results in duplicate benefits because of offsets that reduce disability or death benefits payable under said articles. For an overpayment to result, it is not necessary that the overpayment exist at the time the claimant received disability or death benefits under said articles.

Pursuant to §8-40-201(15.5), C.R.S., “three categories of possible overpayment are included in the statutory definition: one category is for overpayments created when a claimant receives money “that exceeds the amount that should have been paid”; the second category is for money received that a “claimant was not entitled to receive”; and the final category is for money received that “results in duplicate benefits because of offsets that reduce disability or death benefits” payable under articles 40 to 47 of title 8. §8-40-201(15.5).” Simpson v. Industrial Claim Appeals Office, 219 P.3d 354, 359 (Colo. App. 2009), rev’d in part on other grounds, Benchmark/Elite, Inc. v. Simpson, 232 P.3d 777 (Colo. 2010).

In her brief in opposition, the claimant attributes the $1,686.47 overpayment to ongoing payment of benefits by the respondent under its general admission of liability. The claimant does not appear to dispute that the amount she was overpaid in TTD benefits totals $1,686.47. Brief In Opposition at 4 ¶4. Instead, the claimant argues that the respondent is precluded from recovering the overpayment because it admitted for the payment of such temporary indemnity payments under its general admission of liability. As detailed above, pursuant to §8-40-201(15.5), C.R.S., two categories of overpayment include when a claimant receives money “that exceeds the amount that should have been paid” or money received that a “claimant was not entitled to receive.” Here, because the claimant received temporary benefits greater than what she was entitled to receive or greater than what she should have been paid, we conclude that the $1,686.47 she received in TTD benefits constitute an overpayment under §8-40-201(15.5), C.R.S. See Simpson v. Industrial Claim Appeals Office, supra (payment of TTD benefits under an admission of liability did not bar employee from seeking a recovery of overpayments). To the extent the claimant argues that retroactive reimbursement for an overpayment is
prohibited, this argument was rejected by the Court in *Simpson*. See also *Mattorano v. United Airlines*, W.C. No. 4-861-379 (July 25, 2013).

Moreover, to the extent the claimant argues that the respondent’s request for an overpayment is time-barred, we similarly are not persuaded. It is true, as the claimant argues, that a petition to reopen a claim for recovery of an overpayment is subject to time limitations and must be filed within six years of the date of injury, §8-43-303(1), C.R.S., or within two years of the last payment of benefits or compensation, §8-43-303(2), C.R.S. See *Calvert v. Industrial Claim Appeals Office*, 155 P.3d 474, 476-77 (Colo. App. 2006) (two-year statute of limitations begins to run from date of last disability payment); *Thye v. Vermeer Sales & Serv.*, 662 P.2d 188, 190 (Colo. App. 1983) (six-year statute of limitations for petitions to reopen workers' compensation claims begins to run from date of injury). Nevertheless, here, there is no dispute that the claimant’s date of injury was March 12, 2007, and the last disability payment was made on September 19, 2010. The respondent filed its FAL on June 29, 2011, requesting an overpayment of $1,686.47. Thus, we reject the claimant’s argument that the respondent’s request for an overpayment is time-barred.

We further note that ALJ Cannici previously found, with record support, that the respondent paid an actual amount of $61,103.94 in TTD benefits, when the claimant only was entitled to receive TTD benefits in the amount of $59,417.47. Tr. at 50-52. Thus, the claimant was overpaid TTD benefits in the amount of $1,686.47. Consequently, we modify ALJ Cannici’s order to reflect that the respondent is entitled to recover an overpayment totaling $1,686.47.

**IT IS THEREFORE ORDERED** that ALJ Cannici’s order dated July 24, 2013, is modified to reflect that the respondent is entitled to recover an overpayment of TTD benefits totaling $1,686.47, and as modified, affirmed.

**INDUSTRIAL CLAIM APPEALS PANEL**

[Signature]
David G. Kroll

[Signature]
Kris Sanko
CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on ________ 12/12/2013 ________ by _____ RP ________.

WENDY GRANDESTAFF, 474 BLACK FEATHER LOOP #410, CASTLE ROCK, CO, 80104 (Claimant)
ROBERT W. TURNER, LLC, Attn: ROBERT W. TURNER, ESQ., 8400 E. CRESCENT PARKWAY, SUITE 600, GREENWOOD VILLAGE, CO, 80111 (For Claimant)
RITSEMA & LYON, PC, Attn: LYNN P. LYON, ESQ., 999 18TH STREET, SUITE 3100, DENVER, CO, 80202 (For Respondents)
GALLAGHER BASSETT SERVICES, INC., Attn: JENNIFER GREEN, P O BOX 4068, ENGLEWOOD, CO, 80155-4068 (Other Party)
The claimant seeks review of an order of Administrative Law Judge Stuber (ALJ) dated June 18, 2013, that denied and dismissed his claim for whole person permanent partial disability (PPD) benefits. We affirm.

The claimant suffered an admitted industrial injury on October 1, 2005, when he was involved in a motor vehicle accident. The claimant suffered a pulmonary contusion and also reported neck, thoracic, and low back pain. After receiving conservative treatment, Dr. Ferstenberg placed the claimant at maximum medical improvement (MMI) on March 20, 2006, without permanent impairment. The respondent insurer filed a final admission of liability (FAL), denying any permanent disability or post-MMI medical benefits.

On June 1, 2007, Dr. Walsh examined the claimant, who reported left shoulder and thoracic spine pain. The claimant was referred to Dr. Jones, who performed left shoulder surgery on October 1, 2007. The respondent insurer voluntarily filed a general admission of liability to reopen the claimant’s workers’ compensation claim.

On March 5, 2008, Dr. Olson determined the claimant was at MMI with 11% impairment of the upper extremity due to the left shoulder surgery and slight loss of range of motion of the left shoulder. The respondent insurer filed a FAL for PPD benefits based upon 11% of the left upper extremity, and denied post-MMI medical benefits.
The claimant then sought care from his personal physician regarding low back pain and right leg symptoms. The claimant underwent a magnetic resonance image (MRI) of the lumbar spine, which showed a herniated disc at L5-S1. Dr. Jatana examined the claimant who reported a history of two years of symptoms in his low back after suffering the October 2005 motor vehicle accident. Dr. Jatana ultimately performed a three-level fusion surgery from L3-4 to L5-S1. This surgery was paid for by the claimant’s private health insurer.

The claimant ultimately filed a petition to reopen his workers’ compensation claim based upon a change of condition and error and/or mistake. After a hearing on the claimant’s petition, the ALJ entered an order determining the claimant proved he suffered a change of condition as a natural consequence of his admitted October 1, 2005, industrial injury. The ALJ found that the record evidence did not demonstrate the claimant had a chronic low back problem prior to his industrial injury, and also did not demonstrate that the claimant’s low back problem resolved after his industrial injury. The ALJ instead found the claimant continued to have low back pain, but suffered more significant neck and left shoulder problems. The ALJ determined the worsening was a natural consequence of the claimant’s industrial injury rather than a preexisting degenerative condition. The ALJ did not grant or deny any specific benefit and specifically ordered “[a]ll matters not determined herein are reserved for future determination.”

After the claimant’s claim was reopened, Dr. Olson recommended additional therapy. Dr. Olson opined that the claimant was at MMI on February 28, 2012. Dr. Olson determined that the claimant had excellent range of motion of the left shoulder, which resulted in 3% impairment of the left upper extremity. Dr. Olson combined the 3% rating with a 10% rating for the left shoulder distal clavicle resection to determine 13% impairment of the left upper extremity. He also determined a 24% whole person rating due to the lumbar spine. Dr. Olson converted the 13% upper extremity rating to 8% whole person rating, for a 30% total whole person impairment rating.

Dr. Janssen performed a Division Independent Medical Examination (DIME). He opined that the claimant was at MMI on February 28, 2012, with 24% whole person impairment of the lumbar spine. In his narrative report, however, Dr. Janssen stated he was struggling with how to relate the lumbar spine condition to the industrial injury due to a degenerative process in the claimant’s spine. Dr. Janssen stated that if the ALJ found the claimant had a degenerative condition and needed a multilevel fusion due to his lifestyle, then the claimant would have been at MMI for the work injury in January 2006 with no permanent impairment. Conversely, Dr. Janssen opined that if the ALJ found the claimant’s lumbar condition was due to the industrial injury, then the claimant would be at MMI on February 28, 2012, with 23% impairment for the lumbar spine only. Dr. Janssen concluded that more likely than not, however, the claimant’s fusion surgery was not due to the motor vehicle accident but instead was due to a degenerative process.
The respondents filed an application for hearing. The respondents listed the following as issues to be heard at the hearing: reasonably necessary; related to injury; PPD; causation; relatedness; “Respondents filing this Application in response to the Division IME of Dr. Janssen dated July 24, 2012”; and clarification of the DIME. The claimant then filed an opposed motion to strike the issue of causation and relatedness, arguing that the doctrines of issue and claim preclusion, and law of the case precluded the respondents from contesting such issues. The ALJ entered an order denying the claimant’s motion. The ALJ specifically ruled that the respondents shall have the opportunity to litigate the issues of causation and relatedness at the hearing.

After the hearing, the ALJ found that the claimant failed to prove by clear and convincing evidence that the DIME determination of no permanent impairment due to the lumbar spine condition was erroneous. Noting that the claimant could have had a work exacerbation of the spine condition, the ALJ nonetheless determined it was more likely that the claimant’s degenerative process was unrelated to the industrial injury. The ALJ also determined that to the extent his previous order on reopening made any findings of fact about relatedness of the claimant’s lumbar condition, those findings were demonstrated to be incorrect after the DIME process. The ALJ further ruled that his prior order on reopening was not a final order since it did not award or deny any benefits. Thus, the ALJ determined that the doctrines of issue and claim preclusion did not prohibit the respondents from challenging the relatedness of the lumbar impairment rating to the industrial injury. He also denied the claimant’s request to apply the law of the case doctrine. The ALJ denied and dismissed the claimant’s claim for whole person PPD benefits.

On review, the claimant argues the ALJ erred in denying and dismissing his claim for whole person PPD benefits. The claimant contends that the ALJ’s original finding of causation was conclusively litigated in his favor when his petition to reopen was granted. The claimant asserts that resolution of the issue of reopening was dependent upon a determination that the need for the surgical procedure was causally related to the work injury. The claimant therefore argues that based on the doctrines of issue and claim preclusion and law of the case, the respondents were precluded from relitigating the issue of causation of his lumbar condition. We are not persuaded that there is any error.

Under issue preclusion, often referred to as collateral estoppel, “once a court has decided an issue necessary to its judgment, the decision will preclude relitigation of that issue in a later action involving a party to the first case.” Youngs v. Industrial Claim Appeals Office, 297 P.3d 964, 974 (Colo. App. 2012)(quoting People v. Tolbert, 216 P.3d 1, 5 (Colo. App. 2007)); see also Sunny Acres Villa, Inc. v. Cooper, 25 P.3d 44, 47 (Colo. 2001). Issue preclusion completely bars relitigating an issue if the following four criteria are established: (1) the issue sought to be precluded is identical to an issue actually determined in the prior proceeding; (2) the party against whom issue preclusion is asserted has been a party to or is in privity with a party to the prior proceeding; (3) there
is a final judgment on the merits in the prior proceeding; and (4) the party against whom the doctrine is asserted had a full and fair opportunity to litigate the issue in the prior proceeding. *Sunny Acres Villa, Inc. v. Cooper*, 25 P.3d at 47. Issue preclusion applies to administrative proceedings, including those involving workers' compensation claims. *Id.*

Under claim preclusion, often referred to as res judicata, a judgment on the merits in a prior suit bars a second suit involving the same parties or their privies based on the same cause of action. *Pomeroy v. Waitkus*, 183 Colo. 344, 350, 517 P.2d 396, 399 (1973); see also *McLane Western, Inc. v. Dep't of Revenue*, 199 P.3d 752, 756–57 (Colo. App. 2008). A claim in a second judicial proceeding is precluded by a previous judgment where the following factors are satisfied: (1) finality of the first judgment; (2) identity of subject matter; (3) identity of claims for relief; and (4) identity of or privity between the parties to the two actions. *Loveland Essential Group, LLC v. Grommon Farms, Inc.*, 11CA0722 (Feb. 2, 2012), 2012 COA 22.


Initially, to the extent the claimant suggests that during the first hearing on reopening he requested an order for the respondent insurer to pay Dr. Jatana’s medical bills and any authorized and reasonably necessary treatment for his low back, the record shows the contrary to be true. During the first hearing, the following discussion took place between counsel and the ALJ on the issues to be considered and determined:

**THE COURT:** Okay. Well, are we -- I mean, are we litigating that issue today of – of the bills of Dr. Jatana?

[CLAIMANT’S COUNSEL]: Well, Judge, I don’t have any indication that there is a bill. All I know is that [the claimant] went through the surgery and the surgery was covered by his health insurance. Now, I assume that if there’s a reopening here, that is going to trigger, I guess, the third party recovery unit for [the claimant’s] health carrier to start sending requests for, you know, repayment. Now, I don’t have any bills, so I guess we could hold that in abeyance until we determine whether or not this claim is reopened. No objection to that.
[RESPONDENTS’ COUNSEL]: I have no objection to that.

THE COURT: All right. So, we’re just trying the issue of the reopening?

[CLAIMANT’S COUNSEL]: Then I’ll – that would – that would – is fine with me, Your Honor. Ex. 13 Tr. (March 24, 2011) at 186.

Generally, orders are not final if they do not fully dispose of the issue presented including the amount of benefits to be paid. *Bestway Concrete v. Industrial Claim Appeals Office*, 984 P.2d 680 (Colo. App. 1999); *United Parcel Service, Inc. v. Industrial Claim Appeals Office*, 988 P.2d 1146 (Colo. App. 1999). Here, therefore, the ALJ correctly determined that his order granting the claimant’s petition to reopen was not a final judgment because it did not award any specific medical benefits. Section 8-43-301(2), C.R.S.

Next, the claimant’s arguments notwithstanding, the ALJ did not err in ruling that the doctrines of issue and claim preclusion, and law of the case were inapplicable. At least two of the factors announced in *Sunny Acres Villa* and *Pomeroy* are absent for application of issue and claim preclusion. First, there was not a final judgment on the merits in the first proceeding. In his first order, the ALJ specifically noted that he did not grant or deny any specific benefit and he specifically stated “[a]ll matters not determined herein are reserved for future determination.” Ex. 9 at 71. As stated above, orders are not final if they do not fully dispose of the issue presented including the amount of benefits to be paid. Section 8-43-301(2), C.R.S.; *Bestway Concrete v. Industrial Claim Appeals Office*, supra; *United Parcel Service, Inc. v. Industrial Claim Appeals Office*, supra.

Second, the issue sought to be precluded in the second hearing was not identical to the issue actually determined in the first hearing and did not involve the same subject matter. The first hearing involved reopening based on a worsened condition, and the claimant bore the burden of proof by a preponderance of the evidence to establish such worsening. Section 8-43-201, C.R.S; §8-43-303, C.R.S.; *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000)(proof of causation is threshold issue, which the claimant must establish by a preponderance of the evidence). In the second hearing, the claimant bore the burden of proof, by clear and convincing evidence, to establish that the DIME physician’s determination of no impairment was erroneous. Section 8-42-107(8)(c), C.R.S.; *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995)(to overcome DIME report, there must be evidence which proves it is highly probable DIME physician's opinions are incorrect). We further note that in his second order, the ALJ also ruled that to the extent his previous order on reopening made any findings of fact about relatedness of the claimant’s lumbar condition, those findings were demonstrated to be incorrect after the DIME process. Conclusions of Law at 8 ¶2.
Our conclusion that distinct issues were involved in the hearings on reopening and overcoming the DIME physician’s determination of no impairment is consistent with relevant law. In Cordova, for instance, the Colorado Court of Appeals held that a DIME physician’s opinions that a claimant’s condition worsened, and that the worsening was caused by the industrial injury, were not entitled to presumptive weight when the issue concerned reopening rather than a direct attack on medical impairment. The Court noted that “the opinions of a DIME physician have only been given presumptive weight when expressly required by the statute,” and the Act contains no such requirement with respect to reopening based on worsened condition. Cordova v. Industrial Claim Appeals Office, 55 P.3d at 190; see also Faulkner v. Industrial Claim Appeals Office, supra (DIME finding regarding causation need not be overcome by clear and convincing evidence where dispute involved threshold issue of whether compensable injury occurred); Westerkamp v. Target Stores, W.C. No. 4-408-369 (December 26, 2001) (DIME physician’s assessment of medical impairment based on industrial injury did not require his opinion to be given presumptive weight concerning cause of a subsequent worsening of condition). Here, of course, the ALJ granted the claimant’s petition to reopen prior to the DIME taking place. Nevertheless, the weight given to a DIME physician’s opinions for purposes of reopening versus medical impairment highlights the distinct nature of the issues involved. We also recognize, as argued by the claimant, that during both hearings, the parties addressed the issue of causation of the claimant’s lumbar condition and submitted evidence and argument supporting their positions. There clearly was an overlap of evidentiary matters, as noted by the ALJ in his second order. Conclusions of Law at 7 ¶2. Nevertheless, the issues in both hearings were different with different burdens of proof, and the respondents, therefore, were not precluded from relitigating the issue of causation during the second hearing.

Moreover, to the extent the claimant argues that the ALJ erred in failing to apply the law of the case doctrine, we again are not persuaded that there is any error. It is true, as the claimant argues, that after the first hearing, the ALJ concluded the claimant sustained a worsening of his lumbar condition and that it was causally related to his original compensable injury. Again, however, this determination did not preclude the respondents from defending the DIME physician’s determination of no impairment on the basis that his lumbar condition was not causally related. Again, as detailed above, the issues of reopening based upon a worsening of condition and overcoming the DIME physician’s determination of no impairment are distinct issues. Further, the ALJ’s first order was not a final order. See Grant v. Avalon Construction, W.C. No. 4-532-029 (January 28, 2005); Wright v. U.S. Home Corporation, W.C. No. 4-312-835 (September 18, 1998). Consequently, we will not disturb the ALJ’s order on this ground.

Further, we do not view the holdings in City and County of Denver v. Industrial Claim Appeals Office, 02CA0322 (Sept. 26, 2003) (NSOP) and Grand County v. Industrial Claim Appeals Office, 07CA0424 (April 24, 2008) (NSOP) as dictating a
contrary result. First, in City and County of Denver the Court did not address the issues that are raised on review here. That is, the Court did not address whether issue and claim preclusion or law of the case precluded the respondents from contesting causation. In Grand County, the Court was not faced with the factual circumstances presented in this action. In that case, there was not a hearing on reopening for a worsened condition and then a subsequent hearing on overcoming the DIME of no impairment based on no causal relationship. We further note that unpublished opinions from the Colorado Court of Appeals have no precedential value. See C.A.R. 35(f); In the Matter of the Title and Ballot Title and Submission Clause for 2005–2006 # 55, 138 P.3d 273 (Colo. 2006).

IT IS THEREFORE ORDERED that the ALJ’s order dated June 18, 2013, is affirmed.
CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on ______________ 11/27/2013 ______________ by _______ RP ____________ .

RAUL SANCHEZ, 2711 HIGH, PUEBLO, CO, 81003 (Claimant)
AMERICAN FEDERATION OF STATE., Attn: WANDA STUBER/STEPHANIE HARRISON, C/O: COUNTY, AND MUNICIPAL EMPLOYEES, 1625 L ST, NW, WASHINGTON, DC, 20036-5665 (Employer)
TRAVELERS CASUALTY & SURETY COMPANY, Attn: TERESA MANSARDT, P O BOX 173762, DENVER, CO, 80217 (Insurer)
STEVEN U. MULLENS, P.C., Attn: KIMBERLY ROEPKE WHITING, ESQ., 1401 COURT STREET, PUEBLO, CO, 81003 (For Claimant)
THOMAS POLLART & MILLER, LLC, Attn: EMILY AHNELL, ESQ., 5600 SOUTH QUEBEC STREET, SUITE 220-A, GREENWOOD VILLAGE, CO, 80111 (For Respondents)
IN THE MATTER OF THE CLAIM OF
RICHARD WALLING,
Claimant,
v.
ASA ELECTRIC, INC.,
Employer,
and
TRUCK INSURANCE EXCHANGE,
Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Cain (ALJ) dated July 3, 2013, that ordered the respondents to provide the claimant a weight loss program, (SlimGenics) and assessed penalties against the respondents for unreasonably denying SlimGenics in violation of Workers’ Compensation Rule of Procedure (WCRP) 16-10(F). We affirm the ALJ’s order.

A hearing was held on the issue of medical benefits, specifically SlimGenics, and a CPAP machine. The ALJ also addressed the issue of penalties against the respondents for unreasonably denying the request for prior authorization of SlimGenics in violation of WCRP 16-10(F). After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The 48 year old claimant sustained a compensable right knee injury on April 25, 2008, while working for the respondent employer as an electrician. At the time the claimant underwent arthroscopic knee surgery in May 2009, the claimant weighed over 300 pounds. The claimant went on to have three total knee arthroplasties (TKA) on the right knee, the last of which occurred in July 2011. The TKA surgeries failed for various reasons and the claimant’s right knee pain is severe and continuing.

The claimant eventually began having pain in his left knee. The pain was determined to be the result of the “tricompartment arthritis” and “compensatory overuse” associated with the right knee injury. The respondents provided treatment for the claimant’s left knee under the auspices of the claim for the right knee injury.
Treating physician, Dr. Erikson, evaluated the claimant and stated that the claimant met the criteria for a right knee fusion and that such a surgery could produce a stable leg that would lessen the load on the left knee to the point a TKA would no longer be necessary. Dr. Erikson expressed great concern about the outcome of a left TKA noting that a significant factor in the severity of the claimant’s arthritis and failure of his joint replacements was his excessive weight. He recommended consultation with a bariatric surgeon and opined that the loss of 100 pounds would improve the claimant’s situation “in a big way.”

An independent medical examination was performed by Dr. Messenbaugh, who also recommended that the claimant undergo a right knee fusion, stating that if the fusion failed, the claimant would most likely be looking forward to an above-knee amputation.

On May 21, 2012, the claimant was seen by orthopedic surgeon, Dr. Hugate who previously performed a TKA on the claimant’s right knee in July 2011. Dr. Hugate stated that he was hesitant to replace the left knee because the claimant is young, he is heavy and he has a history of problems with the right knee. Dr. Hugate discussed the importance of weight loss and suggested the claimant see a weight loss surgeon and stated that if the claimant does not lose 75 to 100 pounds, or more, the knee “will need to be revised and he does not do well with surgeries.”

Dr. Gellrick became the authorized treating physician on June 21, 2012. Dr. Gellrick noted that the claimant was not necessarily interested in bariatric surgery but was interested in talking to a specialist in this area. Dr. Gellrick stated that the claimant needed dietary counseling and that the claimant should undergo a bariatric consultation. Dr. Gellrick also recommended a sleep apnea study because the claimant had been on opioids for a long period of time and there was a history of sleep dysfunction. Dr. Gellrick submitted the requests for authorization for the sleep study and the bariatric evaluation to the respondents. The respondents received the requests and asked Dr. Ramaswamy to review whether the requests were reasonable and necessary as related to the industrial injury that occurred on April 25, 2008. According to Dr. Ramaswamy, the need for bariatric surgery was not related to the industrial injury because the claimant was a candidate for the surgery prior to his injury and the industrial injury did not cause his weight gain. Dr. Ramaswamy also stated that it would be reasonable and necessary to conduct a sleep study to diagnose potential obstructive versus central sleep apnea. The insurance adjuster, Kari Mellin, sent a letter to Dr. Gellrick based on Dr. Ramaswamy’s letter denying the bariatric surgery evaluation as not related and approving the request for a sleep study. All of this was completed within the time constraints for denying a request for prior authorization under WCRP 16.
Dr. Gellrick then requested authorization for SlimGenics. According to Dr. Gellrick, SlimGenics would be beneficial because it would expedite maximum medical improvement (MMI) and “getting on with the need for surgery and taking the weight off the knees and avoid further delays in care.” The respondent insurer again submitted Dr. Gellrick’s request to Dr. Ramaswamy who stated that it did not appear that the referral to SlimGenics was related to the industrial injury because the work-related injury did not place the claimant in a more obese classification. The insurer sent a letter to Dr. Gellrick, denying the request for SlimGenics as unrelated. The denial was accomplished within the time constraints in WCRP 16.

In the meantime, the claimant underwent a sleep study which determined that he was suffering from severe obstructive sleep apnea. Dr. Gellrick prescribed a CPAP machine to treat the sleep apnea. Dr. Ramaswamy stated that the sleep apnea is not work related diagnosis and, therefore, would not be reasonable and necessary from a work-related standpoint. The insurer then denied the request for the CPAP machine.

On October 10, 2012, Dr. Gellrick noted that the claimant had been trying to diet on his own and that he weighed 266 on this date. However, Dr. Gellrick again recommended SlimGenics.

Dr. Ramaswamy testified by deposition and reiterated his opinion that the bariatric surgery would not be reasonable necessary and related to the injury because the claimant was obese prior to the injury and there did not appear to be any change in his weight after the injury and the claimant has recently lost a substantial amount of weight on his own. Dr. Ramaswamy further testified that under these circumstances, SlimGenics is not reasonable treatment for the claimant. Dr. Ramaswamy, however, acknowledged that the claimant “needs to lose a significant amount of weight to have a chance for a successful outcome.” He also stated that every time the claimant loses weight, “he’s going to become a better surgical candidate and both knees will be better.”

The ALJ credited the opinions of Dr. Erickson, Dr. Hugate, Dr. Messenbaugh and Dr. Gellrick and concluded that those opinions established that the claimant is a candidate for a right knee replacement fusion designed to relieve his injury related pain and restore function to the right knee and that claimant may also be a candidate for a left TKA. The ALJ was also persuaded by the opinions of these doctors that the claimant’s weight is a significant factor in his ongoing knee pain and arthritis and he needs to lose 100 pounds to improve his condition and to expedite MMI and speed up the decision on surgery. The ALJ also credited the claimant’s testimony that losing weight is difficult for him and that he does not believe he can lose the additional weight necessary to obtain surgery without participating in the SlimGenics program.
Based on these findings the ALJ concluded that the evidence persuasively established that the claimant cannot obtain optimal treatment for his injury related knee condition without treating his pre-existing obesity. The ALJ, therefore, held that the SlimGenics program is reasonable, necessary and related to the industrial injury.

The ALJ went on to deny the claimant’s request for a CPAP machine. On this issue, the ALJ was persuaded by Dr. Ramaswamy’s testimony that the claimant’s sleep apnea was caused by an obstruction of the airway that correlates with his non-industrial obesity. The ALJ determined that the claimant failed to prove that the need for a CPAP machine was proximately caused by the effects of the industrial injury.

The ALJ also determined that the insurer violated WCRP 16-10(F) by denying Dr. Gellrick’s request for prior authorization of the SlimGenics program. In this regard, the ALJ found that although the insurance adjuster complied with the time constraints of WCRP 16 for denying the request for prior authorization, the insurer did not act reasonably in denying the request. The ALJ determined that the insurance adjuster was aware of case law holding that medical treatment of a non-occupational condition is compensable if such treatment is reasonable and necessary to achieve optimum treatment of a compensable injury and that despite the adjuster’s awareness of this legal premise, Dr. Ramaswamy’s report did not address whether the SlimGenics program might be compensable as ancillary medical care designed to achieve optimum treatment of the compensable knee injuries. Moreover, the ALJ found that the record did not contain reliable or persuasive evidence that the insurer asked Dr. Ramaswamy to address the issue even though Dr. Gellrick, Dr. Erickson and Dr. Hugate indicated the importance of weight loss in the outcome of the claimant’s medical treatment.

The ALJ ruled that a reasonable insurer would not have denied prior authorization for the SlimGenics program without first obtaining the opinion of a qualified medical reviewer concerning whether or not the program was reasonably necessary to achieve optimum treatment of the compensable injury. The ALJ awarded penalties of $50 per day commencing July 10, 2012, through the date of the hearing, February 5, 2013, for a total of 211 days resulting in a penalty of $10,550.

On appeal the respondents contend that the ALJ erred in determining that SlimGenics is reasonable, necessary and related and in his assessment of penalties under Rule 16-10(F). We are not persuaded that the ALJ committed reversible error.

I.

The Workers' Compensation Act (Act) imposes upon every employer the duty to furnish such medical treatment “as may reasonably be needed at the time of the injury ...
and thereafter during the disability to cure and relieve the employee from the effects of the injury.” Section 8-42-101(1)(a), C.R.S. That duty includes furnishing treatment for conditions representing a natural development of the industrial injury, as well as providing compensation for incidental services necessary to obtain the required medical care. Employers Mutual Insurance Co. v. Jacoe, 102 Colo. 515, 81 P.2d 389 (1938); Country Squire Kennels v. Tarshis, 899 P.2d 362 (Colo. App. 1995). The duty has been construed to also include paying for treatment of unrelated conditions when such treatment is necessary to achieve optimum treatment of the industrial injury. Public Service Co. v. Industrial Claim Appeals Office, 979 P.2d 584 (Colo. App. 1999). In the Public Service Co. case, the court emphasized the factual nature of this determination. Id.

Here, the ALJ relied on the opinions of Dr. Erickson, Dr. Hugate, Dr. Messenger and Dr. Gellrick to conclude that SlimGenics is necessary to achieve optimum treatment of the industrial injury. This determination is amply supported by the evidence and therefore, we see no basis to disturb the ALJ’s determination on review. Section 8-43-301(8), C.R.S.

We reject the respondents’ contention that it was contradictory for the ALJ to deny the CPAP machine as unrelated to the industrial injury while finding the SlimGenics program related. Unlike the SlimGenics program, the ALJ did not find, nor did the claimant appear to allege that the CPAP machine was necessary to achieve optimal treatment for the industrial injury. Contrary to the respondents' argument, under the principles of Public Service Co., it is not necessary that there be a direct causal relationship in order for such treatment to be compensable. Rather, such treatment is compensable if it is necessary to achieve optimum treatment of the industrial injury, which the ALJ found to be the case here for the SlimGenics program.

The respondents also contend that this case is factually distinguishable from Public Service Co., because the claimant here is not a surgical candidate. The respondents’ arguments notwithstanding, the ALJ found that the claimant is a candidate for surgery. This is a reasonable inference from the evidence presented. Although the claimant's weight problem may not be causally connected to the industrial injury, such a direct causal relationship is not required in order for such treatment to be compensable under the theory espoused by Public Service Co.

The resolution of this case required the ALJ to determine the weight and credibility to be assigned to the expert opinions and testimony presented. This is a matter within the sole discretion of the ALJ. Cordova v. Industrial Claim Appeals Office, 55 P.3d 186 (Colo. App. 2002). The opinions Dr. Erickson, Dr. Gellrick, Dr. Hugate and Dr. Messenger, provide substantial evidence and valid support for the ALJ's conclusion.
that the SlimGenics program is reasonable, necessary and related medical treatment. Therefore, we may not disturb the order on review. Section 8-43-301(8), C.R.S.

II.

The respondents further contend that the ALJ erred in assessing penalties under the general penalty statute for violation of WCRP 16-10(F). Specifically, the respondents contend that they followed the WCRP 16-10 by timely denying the requests for prior authorization and that Dr. Ramaswamy’s opinion was sufficient to comply with the requirements of the rule. We disagree that the ALJ erred.

Section 8-43-304(1), C.R.S., allows an ALJ to impose penalties of up to $1000 per day against any party “who violates any provision of articles 40 to 47 of [Title 8], or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director or panel or any judgment or decree made by any court ....” The failure to comply with a procedural rule has been determined to be a failure to obey an “order” and failure to perform a “duty lawfully enjoined” within the meaning of §8-43-304(1), C.R.S.; Pioneers Hospital v. Industrial Claim Appeals Office, 114 P.3d 97, 98 (Colo. App. 2005); Diversified Veterans Corporate Center v. Hewuse, 942 P.2d 1312 (Colo. App. 1997).

The imposition of penalties under §8-43-304(1), C.R.S., is a two step process. The ALJ must first determine whether the disputed conduct constituted a violation of the Act, of a duty lawfully enjoined, or of an order. If the ALJ finds such a violation, he may impose penalties if he also finds that the actions were objectively unreasonable. City Market, Inc. v. Industrial Claim Appeals Office, 68 P.3d 601 (Colo. App. 2003); see also Jiminez v. Industrial Claim Appeals Office, 107 P.3d 965, 967 (Colo. App. 2003)(reasonableness of conduct in defense of penalty claim is predicated on rational argument based in law or fact); but see Pioneers Hospital v. Industrial Claim Appeals Office, supra (conduct examined to determine whether conduct was merely unreasonable without consideration of whether it was based on a rational argument).

In Fera v. Industrial Claim Appeals Office, 169 P.3d 231 (Colo. App. 2007), the court held that a violation of WCRP 16-10(F) constitutes a violation of an “order” within the meaning of §8-43-304(1), C.R.S. In Fera, the claimant requested prior authorization for physical therapy and steroid injections. This was denied after the insurer consulted with its medical advisor and concluded the need for treatment was related to a pre-existing condition. The claimant sought penalties for unreasonable denial of the treatment. The respondents moved for summary judgment alleging they had complied with the rules regarding prior authorization and there were no material issues of fact. The
ALJ granted the motion for summary judgment. The court of appeals set aside the ALJ’s order of summary judgment. The court of appeals noted that the record contained several medical reports supporting the claimant’s position that the requested treatment was related to his work injury and should have been covered and the existence of these medical reports created a question of fact as to whether the insurer acted unreasonably in denying the requests for prior authorization.

As the ALJ recognized in his order, under *Fera*, the insurer’s mere act of procuring a medical opinion under WCRP 16 does not excuse the insurer from acting reasonably with respect to the opinion when deciding whether to deny or approve a request for prior authorization. Rather, the insurer must act as a reasonable insurer would act with respect to the information obtained from the medical reviewer. *See also Miller v. Industrial Claim Appeals Office*, 49 P.3d 334 (Colo. App. 2001) (Insurer penalized for unreasonable denial of medical treatment).

Under the circumstances presented here, the ALJ determined that the insurer unreasonably denied Dr. Gellrick’s request for prior authorization of SlimGenics. The ALJ concluded that there was a “degree of reprehensibility” to the insurer’s conduct in this case because the insurer was admittedly aware that non-industrial conditions could be treated under the Act if necessary to obtain an optimum outcome for treatment of the compensable injury but the insurer denied prior authorization by relying on a medical report that did not even address this theory of compensability. The ALJ further found that the conduct delayed the implementation of a weight loss program and the claimant’s knee conditions continue to be painful and disabling and has delayed treatment necessary to relieve the claimant’s condition and assist him in reaching MMI. The ALJ thus determined that the claimant suffered actual harm as a result of the insurer’s conduct.

Because the issue of whether the insurer acted unreasonably is a factual question for the ALJ, we are bound to apply the substantial evidence test in determining whether the evidence supports the ALJ's findings of fact. *See Fera v. Industrial Claim Appeals Office, supra; Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). We must, therefore, uphold the ALJ's factual findings, if supported by substantial evidence and the plausible inferences drawn therefrom. Under this standard we must view the evidence as a whole and in the light most favorable to the prevailing party, and we must also defer to the ALJ's credibility determinations and resolution of conflicts in the evidence. *See Id.*

We have reviewed the record and conclude there is substantial evidence to support the ALJ’s finding of unreasonable conduct by the respondents. Although the ALJ could have drawn different inferences from the medical evidence, the question to be resolved was factual in nature. We conclude that the finding of unreasonableness made by the ALJ...
was supported by the opinions in evidence and in combination with the circumstances surrounding the refusal to authorize the SlimGenics.

We have considered the respondents’ remaining arguments and are not persuaded that the ALJ committed any error.

III.

The claimant has filed a motion requesting sanctions for the respondents’ alleged frivolous appeal. We decline to impose attorney fees pursuant to §8-43-301(14), C.R.S. Pursuant to this statute, attorney fees and costs may be awarded against an attorney who submits a petition to review or brief in support of a petition which is not well grounded in fact and warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law. Although we do not agree with the respondents' arguments, we do not consider the petition to review and appellate brief to be so lacking in merit that they it may be classified as not well grounded in fact or law. Therefore, we decline to award attorney fees. See BCW Enterprises, Ltd. v. Industrial Claim Appeals Office, 964 P.2d 533 (Colo. App. 1997); Brandon v. Sterling Colorado Beef Co., 827 P.2d 559 (Colo. App. 1991) (resort to judicial review is not considered frivolous or in bad faith as long as there is a reasonable basis for party to challenge the ALJ's order).

IT IS THEREFORE ORDERED that the ALJ’s order dated July 3, 2013, is affirmed.
CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on
________       12/10/2013             ______
by _____
RP        ________.

RICHARD WALLING, 11506 W. 102ND PLACE, WESTMINSTER, CO, 80021 (Claimant)
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