COLORADO
Department of Labor and Employment

Division of Workers' Compensation
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February Case Law Update

Presented by Judge Michelle Sisk and Judge David Gallivan

This update covers ICAO and COA decisions issued from January 5, 2019 to February 4, 2019

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COLORADO COURT OF APPEALS

DATE FILED: January 31, 2019
CASE NUMBER: 2018CA675

Court of Appeals No. 18CA0675
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-740-062

David M. Matus,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, David M. Matus and Pinnocol Assurance,

Respondents.

ORDER AFFIRMED

Division II
Opinion by JUDGE DAILEY
Furman and Lipinsky, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced January 31, 2019

David M. Matus, Pro Se

No Appearance for Respondent Industrial Claim Appeals Office

Harvey Flewelling, Denver, Colorado, for Respondent Pinnacol Assurance

¶ 1 In this workers' compensation action, claimant, David M. Matus, appearing pro se, seeks review of a final order of the Industrial Claim Appeals Office (Panel), which affirmed the decision of an administrative law judge (ALJ) denying and dismissing his petition to reopen. We affirm.

I. Background

¶ 2 Claimant sustained an admitted, work-related injury to his knee in May 2006. A physician who conducted a division-sponsored independent medical examination (DIME) of claimant determined claimant reached maximum medical improvement on June 28, 2010. Under the heading "Recommendations" in his report, the DIME physician indicated claimant would need "no specific further orthopedic treatment or surgery . . . at this point except that he needs to maintain strength in his quadriceps and hamstrings on a regular home exercise program. There is a possibility that his mild arthritic condition may progress and a knee replacement procedure might be needed in 15-25 years." The DIME physician assigned claimant a 32% permanent impairment rating for his lower extremity. On January 7, 2011, insurer, Pinnacol Assurance, filed a final admission of liability (FAL) based on the

DIME report, admitting to a 32% scheduled impairment of the "leg at hip."

¶ 3 Two months later, the parties entered into settlement negotiations. Claimant was represented by counsel, Robert Trigg, throughout the settlement process. The parties agreed to a "full and final settlement of all benefits, compensation, penalties and interest to which [c]laimant is or might be entitled as a result of these alleged injuries" for the sum of $29.477.19 plus Pinnacol's funding of a Medicare Set-Aside (MSA), which had to be approved by the Center for Medicare and Medicaid Services (CMS).

¶ 4 The parties disagreed about the MSA funding, though. Pinnacol recommended paying $110,111 to CMS to fully fund the MSA. Claimant wrote to CMS himself several times in July and August 2011 demanding that the MSA be funded in amounts totaling from $4,513,411.93 to $5,036,476.91. He calculated that this sum was necessary to cover his expenses and medical needs, including topical analgesic creams, massage therapy, monthly visits with a primary care physician, three physical therapy sessions per week, and multiple knee replacement surgeries. But, CMS determined that "$90,357.00, which is a combination of the

reviewed medical treatment and the future prescription drug costs that are noted in the submitted cover letter, adequately considers Medicare's interests." The settlement, incorporating both the direct payment to claimant and the funding of the MSA in the amount decreed by CMS, was approved by the director of the division of workers' compensation in December 2011.

¶ 5 Several years later, in 2015, CMS requested additional funding for the MSA. However, CMS quickly determined that its 2015 demand had been sent in error and acknowledged that because its request "post-dated the court approved settlement . . . those re-review requests cannot be considered. Once a court approves a settlement . . . no changes to a WCMSA [Workers' Compensation Medicare Set-Aside Arrangement] can be made."

¶ 6 In 2017, claimant petitioned to reopen the settlement on the bases of fraud and mutual mistake of material fact. He alleged that the settlement and, in particular, the MSA fund, failed to incorporate costs for, among other things: (1) an adequate monthly supply of prescription narcotics; (2) a sufficient number of physical therapy sessions; (3) a topical analgesic gel; and, (4) knee replacement surgery. He estimated that "the actual total for [his]

future medical costs is $428,059.68." He argued that Pinnacol's failure to include these costs in the MSA constituted fraud and a material mistake of fact.

¶ 7 After conducting a hearing — a transcript of which is not included in the record before us — the ALJ found that claimant "knew what MSA funding CMS was requiring and what funding was provided in the Settlement Agreement prior to signing [it] on December 19, 2011." The ALJ noted that admitted medical records supported Pinnacol's and CMS's calculations and exclusions of certain treatments. And further that, even if true, claimant's allegations of errors did not amount to fraud because claimant "did not prove that Pinnacol was aware of the 'falsity' of their alleged error or omissions." Nor could claimant establish his undue reliance on these allegedly false statements because he agreed to the amounts in the settlement, signed the agreement, had "full knowledge" of the agreement's content and bases, and was represented by counsel throughout the negotiation process. The ALJ therefore concluded claimant could not establish fraud on Pinnacol's part.

¶ 8 Likewise, the ALJ concluded claimant failed to establish any mistake of fact in the settlement because claimant

> understood that [certain treatment or funding] was not included [in the MSA] when he entered into the Settlement Agreement. Regardless of how the final amount of the MSA was reached, it was the final amount of the MSA that was material to the settlement. Both parties understood what the final finding amount of the MSA would be at the time of the settlement, and agreed to it.

As both claimant and Pinnacol were fully aware of the contents of the settlement agreement, which were supported by admitted medical records, the ALJ held there could not have been a mutual mistake of material fact. Having found neither fraud nor mutual mistake of material fact, the ALJ denied and dismissed claimant's request to reopen the settlement.

¶ 9 On review, the Panel held that because substantial evidence supported the ALJ's findings, it was bound by them and could not set them aside. It therefore affirmed the ALJ's decision. Claimant now appeals.

II. Analysis

¶ 10 Claimant contends that Pinnacol intentionally or negligently miscalculated the costs of his future medical expenses to its benefit.

He argues that Pinnacol "lowered most numbers, they made up numbers, they entered numbers by mistake and left them in the tally and they eliminated numbers." Pinnacol's allegedly fraudulent actions and the parties' mutual mistake about his medical needs, he argues, warrant reopening the settlement he and Pinnacol reached in 2011. In support of his claims of fraud and mutual mistake, claimant points to an "unsigned, unedited letter" he calls "the deceitful document" drafted by one of his treating physicians and contends that the ALJ erroneously relied upon it and mischaracterized it as a medical "report." He implies that because the document was not a medical "report," the ALJ should not have relied upon it to determine the MSA funding amount. He also contends that Pinnacol's counsel "falsely represented the content of a key document," which we understand from the opening brief to be the previously-described "deceitful" medical report. Finally, he asserts that Pinnacol's counsel made allegedly false statements that constituted a "fraud upon the court."

¶ 11 We are not persuaded by any of these arguments.

A. Law Governing Reopening and Standard of Review

¶ 12 The Workers' Compensation Act (Act) expressly limits this court's review of a Panel's decision. The Act states:

> Upon hearing the action, the court of appeals may affirm or set aside such order, but only upon the following grounds: That the findings of fact are not sufficient to permit appellate review; that conflicts in the evidence are not resolved in the record; that the findings of fact are not supported by the evidence; that the findings of fact do not support the order; or that the award or denial of benefits is not supported by applicable law. If the findings of fact entered by the director or administrative law judge are supported by substantial evidence, they shall not be altered by the court of appeals.

§ 8-43-308, C.R.S. 2018. To the extent the grounds for reversal claimant enumerates in his opening brief diverge from the bases set forth in section 8-43-308, they are inapplicable.

¶ 13 Rather, we must adhere to well-settled standards of review governing our examination of the grant or denial of a reopening petition. Once a claim is closed, as here, it is not subject to further litigation unless it is reopened under section 8-43-303, C.R.S. 2018; *Berg v. Indus. Claim Appeals Office*, 128 P.3d 270, 272 (Colo. App. 2005). And, a party seeking to reopen a settled workers'

compensation claim can do so only upon "the ground of fraud or mutual mistake of material fact." § 8-43-204(1), C.R.S. 2018; *see Loper v. Indus. Comm'n,* 648 P.2d 1092, 1094 (Colo. App. 1982) (workers' compensation settlement agreement may be set aside on ground of mutual mistake). In harmony with the requirements set forth in section 8-43-204(1), section 8-43-303(1) reiterates that a party seeking to reopen a claim must show "fraud, an overpayment, an error, a mistake, or a change in condition." § 8-43-303(1).

¶ 14 The party attempting to reopen a claim "shall bear the burden of proof as to any issues sought to be reopened." § 8-43-303(4). Thus, to reopen the settlement, claimant bore the burden of demonstrating either that Pinnacol had engaged in fraud or that the parties had been mutually mistaken about a material fact when the settlement agreement was reached. *See Jarosinski v. Indus. Claim Appeals Office*, 62 P.3d 1082, 1084 (Colo. App. 2002) (claimant bears the burden of proof on reopening).

¶ 15 An ALJ has broad discretionary authority to determine if a claimant has met his or her burden of proof warranting reopening. *See Renz v. Larimer Cty. Sch. Dist. Poudre R-1*, 924 P.2d 1177, 1181 (Colo. App. 1996). Indeed, section 8-43-303 states simply that an

ALJ "may" reopen a claim. The statutory reopening authority granted ALJs is thus "permissive, and whether to reopen a prior award when the statutory criteria have been met is left to the sound discretion of the ALJ." *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186, 189 (Colo. App. 2002). An ALJ's decision to grant or deny a petition to reopen may therefore "be reversed only for fraud or clear abuse of discretion." *Wilson v. Jim Snyder Drilling*, 747 P.2d 647, 651 (Colo. 1987); *see also Heinicke v. Indus. Claim Appeals Office*, 197 P.3d 220, 222 (Colo. App. 2008) ("In the absence of fraud or clear abuse of discretion, the ALJ's decision concerning reopening is binding on appeal.").

B. Fraud

¶ 16 Claimant first asserts that the settlement agreement should have been reopened because Pinnacol engaged in fraud. Specifically, he argues that Pinnacol's counsel committed a "fraud upon the court" by misrepresenting "the content of a key document." We disagree.

¶ 17 To reopen a settled claim based on fraud, a claimant must establish that Pinnacol made false representations upon which he relied:

> The constituents of fraud, though manifesting themselves in a multitude of forms, are so well recognized that they may be said to be elementary. They consist of the following: (1) A false representation of a material existing fact, or a representation as to a material existing fact made with a reckless disregard of its truth or falsity; or a concealment of a material existing fact, that in equity and good conscience should be disclosed. (2) Knowledge on the part of the one making the representation that it is false; or utter indifference to its truth or falsity; or knowledge that he is concealing a material fact that in equity and good conscience he should disclose. (3) Ignorance on the part of the one to whom representations are made or from whom such fact is concealed, of the falsity of the representation or of the existence of the fact concealed. (4) The representation or concealment made or practiced with the intention that it shall be acted upon. (5) Action on the representation or concealment resulting in damage.

Morrison v. Goodspeed, 100 Colo. 470, 477-78, 68 P.2d 458, 462 (1937); *see also, e.g., City of Colorado Springs v. Andersen Mahon Enterprises, LLP*, 260 P.3d 29, 35 (Colo. App. 2010) (citing to *Morrison v. Goodspeed* as "setting forth the elements of fraud").

¶ 18 "Whether a person seeking rescission of a contract has a right to rely on the misrepresentation is a question of fact and is binding

on appeal if supported by the evidence." *M.D.C./Wood, Inc. v. Mortimer*, 866 P.2d 1380, 1382 (Colo. 1994).

¶ 19 Here, we perceive no basis for setting aside the ALJ's determination that no fraud occurred because the decision is supported by substantial evidence in the record. The ALJ found that claimant failed to establish a crucial element of his claim. Specifically, the ALJ found that claimant introduced no evidence establishing that Pinnacol knew it was making false statements and thus did not prove this element. Having failed to establish a critical element of his fraud claim, the ALJ concluded claimant could not establish fraud on Pinnacol's part. *See Morrison*, 100 Colo. at 477-78, 68 P.2d at 462. Because claimant has not provided a transcript of the hearing, we must presume that this finding is supported by the record. *See Nova v. Indus. Claim Appeals Office*, 754 P.2d 800, 801 (Colo. App. 1988).

¶ 20 Even without a transcript, though, the evidence that is included in the record before us substantially supports the ALJ's decision. Notably, the DIME physician opined that claimant would not require additional, causally-related surgery, contrary to claimant's representation that he will need knee replacement

surgery and his implication that any such surgery would be related to his work injury. To be sure, the DIME physician indicated claimant may need a knee replacement because of his arthritis in "15-25 years," but the DIME physician did not opine that such surgery, should it become necessary, would be work-related. Thus, it was not fraud to omit funding for knee replacement from the MSA.

¶ 21 Likewise, Dr. Kahn reported that claimant's prescriptions were "reduced 55%." Claimant insists that this medical record is a "deceitful document," and that the ALJ and Panel erred in relying upon it. He argues that the document is "not a report" and, as we understand his argument, consequently lacked the credibility given it by the ALJ and Panel, even though Dr. Khan titled the document "Update Assessment/Narrative Report."

¶ 22 But, regardless how the document is characterized or labeled — as a report, medical record, letter, summary, or generic document — it is an expression of Dr. Khan's medical opinion. No legal authority in Colorado of which we are aware mandates that only medical "reports" merit consideration and evidentiary weight, and claimant has not pointed us to any authority supporting his

position. Indeed, another title of Colorado statutory law includes the following broad, sweeping definition of "medical record" illustrating that many documents fall under this rubric:

> (3)(a) "Medical record" means the written or graphic documentation, sound recording, or computer record pertaining to medical, mental health, and health care services, including medical marijuana services, performed at the direction of a physician or other licensed health care provider on behalf of a patient by a physician, dentist, nurse, service provider, emergency medical service provider, mental health professional, prehospital provider, or other health care personnel.
>
> (b) "Medical record" includes diagnostic documentation such as X rays, electrocardiograms, electroencephalograms, and other test results and data entered into the prescription drug monitoring program under section 12-42.5-403, C.R.S.

§ 24-72-601(3), C.R.S. 2018. As this definition makes plain, any document generated by a physician may constitute a medical record or report.

¶ 23 To the extent claimant's objection to Dr. Khan's opinion lies in the absence of Dr. Khan's signature on the document, we know of no law mandating a signature on medical records. Here, too, claimant has not identified any legal authority in support of his

position. And, contrary to claimant's assumption, many of the documents included in the definition of "medical record" — such as medical images — are unlikely to be signed. Indeed, the appellate record in this case contains other unsigned medical reports pertaining to claimant — such as the June 5, 2015, letter and report drafted by Dr. Barry L. Veazey of Orthopedic Associates in College Station, Texas, recommending total knee replacement — suggesting that the practice of leaving documents unsigned is common in the medical profession and not evidence of "deceit" as claimant suggests.

¶ 24 Moreover, it was within the ALJ's discretion to consider Dr. Khan's narrative report and the ALJ's prerogative to accord the document its due weight. As "[i]t is solely within the ALJ's discretionary province to weigh the evidence and determine the credibility of expert witnesses," we may not disturb this decision. *Youngs v. Indus. Claim Appeals Office*, 2012 COA 85M, ¶ 46. Rather, we are required to defer to the ALJ's credibility determinations and resolutions of any conflicts in the evidence. Therefore, we may not substitute our judgment for that of the ALJ and cannot reweigh the allegedly "deceitful document." *See Metro*

Moving & Storage Co. v. Gussert, 914 P.2d 411, 415 (Colo. App. 1995).

¶ 25 Finally, to the extent claimant asserts that Pinnacol's counsel committed "fraud upon the court" by making false statements to the ALJ, we note that claimant has neither identified the false statements Pinnacol's counsel made nor provided a transcript to enable us to review the hearing proceedings. Where a transcript is not included in the record, we must presume that the ALJ's resolution of the issue is supported by the evidence. *See Nova*, 754 P.2d at 801. Therefore, we must presume that the ALJ's finding of no fraud on Pinnacol's part is amply supported by the record.

¶ 26 Because substantial evidence supports the ALJ's finding that no fraud was committed in the negotiation and execution of the settlement documents, and because neither we nor the Panel can ascertain whether any fraud was committed during the hearing in the absence of a transcript, we conclude that the Panel properly affirmed the ALJ's denial of claimant's request to reopen based on fraud. *See Wilson*, 747 P.2d at 651; *Morrison*, 100 Colo. at 477-78, 68 P.2d at 462; *Heinicke*, 197 P.3d at 222.

C. Mutual Mistake of Material Fact

¶ 27 We next address claimant's contention that the settlement agreement should be reopened based on a mutual mistake of material fact.

¶ 28 "The doctrine of mutual mistake provides that 'an agreement founded in a mutual mistake of facts that are the very basis of the contract will void the contract.'" *England v. Amerigas Propane*, 2017 CO 55, ¶ 19 (quoting *Carpenter v. Hill*, 131 Colo. 553, 557, 283 P.2d 963, 965 (1955)). Therefore, in cases involving an alleged mutual mistake of material fact, rescission of a settlement agreement "is available for mistakes relating to the nature of known injuries but not for mistakes as to the future course and effects of those injuries." *Gleason v. Guzman*, 623 P.2d 378, 383 (Colo. 1981).

¶ 29 "A mutual mistake is one which is reciprocal and common to both parties to an agreement, and both parties must share the same misconception as to the terms and conditions of the agreement." *Cary v. Chevron U.S.A., Inc.*, 867 P.2d 117, 118 (Colo. App. 1993). A fact is material if it is "sufficient in importance to influence and govern a man of ordinary intelligence." *Hailpern v.

Dryden, 154 Colo. 231, 236, 389 P.2d 590, 593 (1964) (quoting *McNeely v. Philadelphia Nat'l Bank*, 172 A. 111, 112 (Pa. 1934)).

> The doctrine of mutual mistake has three primary criteria. First, the mistake must be mutual, meaning "both parties must share the same [factual] misconception." [*Cary*, 867 P.2d at 118.] Second, the mistaken fact must be material, meaning that it is a fact which goes to "the very basis of the contract." *Carpenter*, [131 Colo. at 557,] 283 P.2d at 965. In other words, the mistake of fact must relate to a material aspect of the contract such that, but for the mistake, the party seeking rescission would not have entered the contract. . . . Third, the mistaken fact must be a past or present existing one, as opposed to "a fact to come into being in the future." [*Hailpern*, 154 Colo. at 236, 389 P.2d at 593.]

England, ¶ 20 (citations omitted).

¶ 30 As pertinent here, when reviewing a settlement for an alleged mistake of mutual fact, the factfinder looks to the parties' knowledge at the time they entered into the agreement. The parties' knowledge and understanding of the factual situation at the time they entered into the settlement agreement is a question of fact for the ALJ to determine. *See Cary*, 867 P.2d at 118. Thus, an ALJ's factual determination of these issues will be upheld if supported by substantial evidence in the record. *See id.* (upholding the ALJ's

factual determination that the claimant knew and understood she was settling "her claims regarding carpal tunnel syndrome and other job-related claims").

¶ 31 Here, the ALJ found, with record support, that both claimant and Pinnacol knew the total amount that the MSA would be funded and agreed to that sum. Claimant was represented throughout the negotiation and settlement process and signed both the settlement agreement and the MSA addendum. Claimant voiced his concerns that the amount of the MSA was inadequate — in fact, he asked that the amount be fifty times higher than that recommended by Pinnacol — in a series of letters to the CMS. But, in the end, claimant signed the settlement agreement. To the extent he claimed that "he thought he had to sign the Settlement Agreement because his claim was 'closed,'" the ALJ expressly rejected this contention finding it neither credible nor persuasive. As with all credibility determinations, we cannot disturb the ALJ's finding that claimant's testimony was not credible unless the evidence is "overwhelmingly rebutted by hard, certain evidence" to the contrary. *See Arenas v. Indus. Claim Appeals Office*, 8 P.3d 558, 561 (Colo.

App. 2000) ("[W]e may not interfere with the ALJ's credibility determinations. . . .").

¶ 32 For these reasons, we conclude that substantial evidence supported the ALJ's finding that the parties were not mutually mistaken about any material fact when they entered into the settlement agreement. The Panel thus properly affirmed the ALJ's order denying claimant's request to reopen based on mutual mistake and we cannot set it aside on this ground. *Wilson*, 747 P.2d at 651; *Heinicke*, 197 P.3d at 222.

III. Due Process

¶ 33 Last, we note that claimant has asserted a due process claim in his enumerated list of issues on appeal. However, he does not discuss or address the due process claim beyond listing it at the beginning of his opening brief. Because this argument is not developed further, we decline to address it. *See Meza v. Indus. Claim Appeals Office*, 2013 COA 71, ¶ 38; *Antolovich v. Brown Grp. Retail, Inc.*, 183 P.3d 582, 604 (Colo. App. 2007) (declining to address "underdeveloped arguments").

IV. Conclusion

¶ 34 The order is affirmed.

JUDGE FURMAN and JUDGE LIPINSKY concur.

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-679-322-05

IN THE MATTER OF THE CLAIM OF:

MANUEL GARCIA,

Claimant,

v.

SWIFT FOODS COMPANY,

Employer,

and

ZURICH AMERICAN INSURANCE CO.,

Insurer,
Respondents.

FINAL ORDER

The respondents seek review of an order of Administrative Law Judge Nemechek (ALJ) dated April 23, 2018, that granted the claimant's petition to reopen and ordered the respondents to pay the claimant permanent partial disability (PPD) benefits based on the Division Independent Medical Examination (DIME) physician's 19 percent whole person rating. We affirm the ALJ's order.

This matter was previously before us. The claimant sustained an admitted injury to his back on April 5, 2005. The respondents filed a final admission of liability on July 7, 2006, admitting for permanent partial disability benefits based upon a five percent whole person rating and denying liability for maintenance medical benefits. On December 7, 2007, the parties entered into a written stipulation to reopen the claim. The stipulation was approved by an ALJ order dated December 7, 2007. The claimant underwent additional medical treatment and was again placed at maximum medical improvement (MMI) with no additional impairment. The respondents filed an amended final admission of liability on March 27, 2008, based on the report of the DIME physician, Dr. Aschberger, and denying liability for maintenance medical benefits.

The claimant filed a petition to reopen on March 28, 2011, alleging a "[c]hange in medical condition." The claimant also filed an application for hearing listing the issue of petition to reopen the claim. On December 22, 2011, the parties entered into a signed stipulation. Paragraph one of the stipulation stated that the claimant filed a petition to

reopen the claim for the April 8, 2005, injury as well as a new claim listing the date of injury as July 27, 2010, and that these claims had been consolidated for the purposes of a hearing. Paragraph two of the stipulation stated that the claimant filed a timely petition to reopen the 2005 claim and that the parties stipulate and agree that the claimant will continue to receive reasonable and necessary and related medical care to maintain MMI from the authorized treating physician. Paragraph three of the stipulation specified that the parties stipulated and agreed that the evidence does not support a new injury to the lumbar spine on July 27, 2010, and the claimant agreed to withdraw the claim for that alleged injury. The stipulation also provided that, "[a]ll other issues are hereby reserved." The stipulation was approved by order dated January 5, 2012. (Hereinafter referred to as the “2012 Stipulation”). ALJ Nemechek further noted that the stipulation did not state that the claimant was withdrawing the petition to reopen.

The claimant filed an application for hearing and notice to set on July 23, 2012, listing the issue of PPD. The respondents alleged that the issue was closed and the claimant had to establish a right to reopen before the court could address PPD. ALJ Broniak conducted a hearing and by order dated February 8, 2013, concluded that she lacked authority to resolve the issue of PPD because the claimant had not obtained a DIME to challenge the impairment rating. ALJ Nemechek determined that this was an interlocutory order because it did not award or deny benefits.

The claimant subsequently filed an application for a DIME. The respondents filed a motion to strike contending that the claim was closed by the March 27, 2008, final admission of liability. The claimant responded citing to ALJ Broniak's Order arguing that the claim had been reopened. A pre-hearing administrative law judge (PALJ) granted the respondents' motion to strike and noted in her July 10, 2013, order that the 2012 stipulation affirmed that the claimant was at MMI as of that date and was receiving maintenance benefits but that the claim was closed. The PALJ order also concluded that the claimant abandoned the petition to reopen by canceling the hearing.

Despite the PALJ order striking the application for the DIME, the DIME was conducted by Dr. Shea. The DIME physician concluded that the claimant reached MMI on February 28, 2006, and that he sustained a 19 percent whole person impairment.

The respondents filed an application for hearing endorsing the issues of PPD, petition to reopen, and overcoming the DIME. The claimant filed a response endorsing the issues of PPD, issue preclusion, and appeal of the PALJ July 10, 2013, order. Another PALJ issued an order on October 24, 2013, concluding that the issues should be bifurcated. The first issues to be determined were whether the 2012 stipulation of the

parties included an agreement to reopen the claim and, (2) whether ALJ Broniak's order confirmed that the matter was reopened as opposed to only ruling that a DIME would be jurisdictionally required if the matter had been reopened.

The case was submitted to ALJ Cain on stipulated facts and position statements. In an order dated December 12, 2013, ALJ Cain determined that the stipulation was ambiguous as to whether the parties agreed to reopen the claim and did not unequivocally establish that they intended to do so. ALJ Cain ultimately concluded that the claim was not reopened by the 2012 stipulation, nor did ALJ Broniak's February 8, 2013, order reopen the claim. Thus, the claim remained closed pursuant to the March 27, 2008, final admission of liability.

A hearing was held on May 16, 2014, before ALJ Broniak on the issues of whether the workers' compensation claim remained open, closed, or whether it was reopened. The issues of whether the claimant was entitled to additional permanent partial disability benefits and penalties against the claimant for failure to comply with PALJ Purdie's order were also listed for hearing. In an order dated February 5, 2015, ALJ Broniak determined that the claim was not open and has never been reopened. The ALJ denied the request for penalties against the claimant. The order also stated that the claimant had not properly filed a petition to reopen and did not address whether his condition worsened. The ALJ stated, "the issue of whether claimant should receive an increase in his PPD award cannot be determined at this time." There was no appeal of the ALJ's order.

The claimant then filed an application for hearing on April 23, 2015, listing as the issues to be determined: medical benefits, petition to reopen claim, PPD, and *Grover* medicals. The respondents filed a response to the application for hearing listing the statute of limitations, waiver, estoppel, and res judicata. The respondents filed a motion for summary judgment contending that there were no issues of material disputed fact with regard to the claimant's petition to reopen. The respondents stated that the claim remained closed by the March 27, 2008, final admission of liability as determined by ALJ Cain's order and indemnity benefits had not been paid for more than seven years. In response, the claimant asserted that the petition to reopen filed on March 28, 2011, was timely filed and that the issue of whether the claimant sustained a worsening of condition has never been litigated so the claimant is entitled to a hearing on that issue.

In an order dated October 19, 2015, ALJ Nemechek granted the motion for summary judgment citing to three reasons. First, the ALJ stated that the prior orders addressed whether the claim was closed and concluded it was. Specifically pointing to

ALJ Cain's prior order, the ALJ stated that ALJ Cain implicitly concluded that the claim was not reopened by the March 28, 2011, petition to reopen and the claimant failed to present any evidence to show that the claim was actually reopened. Second, the ALJ found that ALJ Cain's order constituted the law of the case. Finally, the ALJ held that the doctrine of issue preclusion applied here because the parties had already litigated the issue and ALJ Cain had concluded that the claim remained closed by the March 27, 2008, final admission of liability. The ALJ therefore, denied and dismissed the claimant's petition to reopen and the claim for additional permanent partial disability benefits.

The claimant appealed to the Industrial Claim Appeals Office (Panel) arguing that the ALJ misconstrued the issue before him and that the March 28, 2011, petition to reopen was timely filed and preserved the right to litigate a worsening of condition. The claimant contended because no order addressed whether the claimant's condition worsened, the claimant was entitled to a hearing on this issue. In an order dated February 16, 2016, the panel agreed that there was a dispute of material fact and remanded the matter to the ALJ for further proceedings.

In an order dated April 23, 2018, ALJ Nemechek determined that the claimant’s March 28, 2011, petition to reopen was timely filed within the statute of limitations period specified by §8-43-303(1), C.R.S. The ALJ further determined that the 2012 Stipulation did not constitute a waiver of the claimant’s right to seek adjudication of the petition to reopen concluding that there was nothing in the record that indicated a knowing, voluntary, unequivocal waiver on the part of the claimant to have his right to proceed to hearing on the petition to reopen. The ALJ further found that that the prior orders of ALJ Cain, Broniak, and PALJ Purdie did not make a factual determination on the issue of whether the claimant met his burden of proof for the March 28, 2011, petition to reopen. Therefore, the claimant was not precluded from pursuing the 2011 petition to reopen.

ALJ Nemechek further concluded that the claimant met the burden of proof to show he sustained a worsening of condition. The ALJ evaluated the claimant’s change of condition based on the evidence as of the time the petition to reopen was filed in March 2011. The ALJ was persuaded by the medical evidence of increased symptoms and treatment for those symptoms by the claimant’s authorized treating physicians. The ALJ also credited Dr. Hughes’ opinion from a June 20, 2011, examination that the claimant sustained a natural progression of injury related degenerative changes in his lumbar spine at the L4-L5 level which were related to his initial work injury of April 8, 2005. The claimant also testified that his symptoms had increased since 2008, he had a lot of pain in his back as well as on one side. The claimant stated his pain was stronger and he took

more Advil. The evidence persuaded the ALJ that the claimant proved that his condition was worse than in 2008**.**

The ALJ also found that the claimant had the right to a further DIME pursuant to ALJ Broniak's February 8, 2013, order and that the respondents failed to overcome the DIME physician's 19 percent whole person impairment rating. The ALJ found that the rating was supported by Dr. Hughes' opinion and objective findings in the 2011 MRI. The ALJ, therefore, awarded additional permanent disability benefits pursuant to the DIME's physician's 19 percent whole person rating.

The respondents now appeal. The respondents assert that the ALJ made legal and factual errors in his determinations and request that the order be overturned in its entirety. We are not persuaded the ALJ committed reversible error.

I. Issue Preclusion

The respondents first contend that the prior orders from ALJ Broniak, ALJ Cain, and PALJ Purdie denied the claimant the right to go forward on his claim for additional permanent disability benefits because of the doctrine of issue preclusion.

Under the issue preclusion doctrine, "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." *People v. Tolbert*, 216 P.3d 1, 5 (Colo. App. 2007). Issue preclusion is less "flexible" than the law of the case doctrine, because it completely bars re-litigating 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 44 (Colo. 2001). Issue preclusion applies to administrative proceedings, including those involving workers' compensation claims. *Id.; Youngs v. Industrial Claim Appeals Office*, 297 P.3d 964, 973-974 (Colo. App. 2012).

We agree with the ALJ's conclusion that the prior orders did not address whether the claimant sustained a worsening of condition to establish a basis for his petition to reopen. Moreover, ALJ Broniak's and ALJ Cain's orders were not final orders on the issue of permanent partial disability benefits because they did not award or deny permanent partial disability benefits. Section 8-43-301(2), C.R.S; *see Bestway Concrete*

v. Industrial Claim Appeals Office, 984 P.2d 680 (Colo. App. 1999)(under this statute an order must be one that finally disposes of the issue presented.)

In the February 8, 2013, order, ALJ Broniak determined that she lacked jurisdiction to determine PPD and explicitly stated that the order assumed the claim is reopened for the purposes of determining whether the claimant is entitled to additional PPD benefits. The ALJ ultimately concluded that she was deprived of jurisdiction to determine PPD in the absence of a DIME.

ALJ Cain's December 12, 2013, order was limited to procedural issues and only resolved the effect of the 2012 stipulation. ALJ Cain specifically stated that a "reasonable interpretation of the stipulation is that the parties reached partial agreement on limited issues but wished to reserve the right to litigate other matters including whether or not the claim could be reopened."

ALJ Broniak's February 5, 2015, order, only determined that the claim was not open and has never been reopened. Although the ALJ found that ALJ Broniak found that there was no petition to reopen before her, ALJ Nemechek determined that ALJ Cain's 2013 order constitutes law of the case concerning the effect of the 2012 Stipulation, in which the parties agreed that the claimant filed a timely petition to reopen. ALJ Broniak did not address whether the claimant's condition worsened and did not award or deny additional PPD benefits, noting that the issue "could not be determined at this time."

Although PALJ Purdie determined that the claimant abandoned the petition to reopen by cancelling the hearing, a PALJ's order is interlocutory and subject to appeal at a hearing before a merits ALJ. Section 8-43-207.5(3), C.R.S.; *Industrial Claim Appeals Office v. Orth*, 965 P.2d 1246 (Colo. 1998).

We therefore conclude that the claimant was not barred from pursuing the 2011 petition to reopen by the doctrine of issue preclusion.

II. Statute of Limitations

The respondents contend that because more than six years have passed since the date of injury and more than two years have passed since the last indemnity payment, the claimant is barred from reopening his claim pursuant to the statute of limitations in §8-43-303(1), C.R.S. We perceive no error.

As found by the ALJ, the petition to reopen was timely filed and preserved the right to litigate a worsening of condition. Filing the petition to reopen within six years of injury tolls the statute of limitations even if not adjudicated within six years of the date of injury. *Federal Express v. Industrial Claim Appeals Office*, 51 P.3d 1107 (Colo. App. 2002). Although the respondents contend that the 2012 Stipulation intended to resolve all issues, the terms of the stipulation itself stated that "all other issues were reserved." Moreover, ALJ Nemechek determined that the law of the case doctrine applied with regard to the findings of ALJ Cain 2013 order concerning the effect of the 2012 Stipulation. ALJ Cain specifically stated that a "reasonable interpretation of the stipulation is that the parties reached partial agreement on limited issues but wished to reserve the right to litigate other matters including whether or not the claim could be reopened." We, therefore, perceive no error in ALJ Nemechek's determination that the petition to reopen was timely filed and the claimant did not waive his right to pursue litigation on the petition to reopen.

III. Worsening of Condition

The respondents argue that the claimant failed to prove a worsening of condition because his permanent restrictions remained the same as they were in 2007, the claimant remains at MMI and does not require any additional medical benefits beyond those admitted as maintenance benefits in the respondents' final admission of liability. We perceive no error.

In order to reopen a claim pursuant to § 8-43-303(1), C.R.S., the claimant must prove a worsening of his condition that is causally related to the industrial injury. Moreover, the worsened condition must warrant further benefits. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Richards v. Industrial Claim Appeals Office*, 996 P.2d 756 (Colo. App. 2000). The determination whether to reopen a claim is discretionary with the ALJ and, absent fraud or a clear abuse of that discretion, we may not disturb the ALJ's order. *Osborne v. Industrial Claim Appeals Office*, 725 P.2d 63 (Colo. App. 1986). An abuse of discretion is only shown where the order exceeds the bounds of reason, such as where it is unsupported by substantial evidence or is contrary to law. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993).

Further, the findings of fact upon which the ALJ bases his determination must be upheld if supported by substantial evidence in the record. §8-43-301(8), C.R.S. In applying the substantial evidence test, we must defer to the ALJ's resolution of conflicts in the evidence, his credibility determinations, and the plausible inferences that he drew

from the evidence. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003). To the extent medical evidence is presented, it is solely the ALJ's responsibility to assess the weight of that evidence and resolve any conflicts or inconsistencies. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990).

The respondents initially denied maintenance benefits in the March 27, 2008, final admission of liability. In making his determination of a worsening of condition the ALJ relied on the treatment notes from July 2010 through March 9, 2011. The ALJ credited the claimant's testimony of his worsening symptoms and Dr. Hughes' opinion concerning causation. We perceive no abuse of discretion. Although other findings were possible, substantial evidence supports the ALJ's finding that reopening was appropriate because of the claimant's worsened condition and the ALJ's determination that the worsened condition caused an increase in permanent impairment. *See Richards v. Industrial Claim Appeals Office,* 996 P.2d 756 (Colo. App. 2000)*; Dorman v. B & W Construction Co.,* 765 P.2d 1033 (Colo. App. 1988).

IV. Claimant Precluded from DIME

The respondents contend that the claimant was required to go back to Dr. Aschberger for a follow-up DIME and that the ALJ should have struck the DIME report from Dr. Shea. We agree with the claimant that this issue was not raised before the ALJ and, therefore, we do not consider the issue on appeal. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 884 P.2d 1131 (Colo. App. 1994); *Robbolino v. Fischer-White Contractors*, 738 P.2d 70 (Colo. App. 1987).

V. Overcoming the DIME

Finally, the respondents contend that the ALJ erred in his determination that the respondents failed to overcome the DIME physician's 19 percent rating. We again perceive no error.

A DIME physician's medical impairment rating must be overcome by clear and convincing evidence. §8-42-107(8)(c), C.R.S.; *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186, 189 (Colo. App. 2002); *Qual-Med, Inc. v. Indus. Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998); *see also Leprino Foods Co. v. Indus. Claim Appeals Office*, 134 P.3d 475, 482 (Colo. App. 2005) ("DIME physician's opinions concerning MMI and permanent medical impairment are given presumptive effect . . . [and] are binding unless overcome by clear and convincing evidence"). "Clear and convincing evidence means evidence which is stronger than a mere 'preponderance' ; it is evidence

that is highly probable and free from serious or substantial doubt." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App. 1995). Therefore, the party challenging a DIME physician's conclusion must demonstrate that it is "highly probable" that the DIME physician's impairment rating is incorrect. *Qual-Med*, 961 P.2d at 592. Whether a party has met the burden of overcoming a DIME by clear and convincing evidence "is a question of fact for the ALJ's determination." *Metro Moving & Storage*, 914 P.2d at 414. We must uphold the factual determinations of the ALJ if the decision is supported by substantial evidence in the record. § 8-43-301(8), C.R.S.

The ALJ here found that the DIME physician's opinion was supported by the medical evidence. The DIME physician determined that the claimant remained at MMI but assessed a higher medical impairment rating based upon the range of motion testing after the claimant had experienced an increase in symptoms and required additional treatment. The ALJ also cited to Dr. Hughes' opinion and the objective findings in the MRI report as support for his determination. The ALJ specifically rejected the opinions of Dr. Smith and Dr. Wunder that the claimant's increased symptoms were due to the degeneration of his lumbar spine rather than the industrial injury. The ALJ found that these opinions were mere differences of opinions and did not rise to the level of clear and convincing evidence necessary to overcome the DIME physician's impairment rating.

To the extent the ALJ's decision is supported by substantial evidence in the record, we may not substitute our judgment by reweighing the evidence in an attempt to reach inferences different from those the ALJ drew from the evidence. *See Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31, 32-33 (Colo. App. 1990). The ALJ's findings here are supported by the evidence and those findings, in turn, support his conclusions. We, therefore, see no basis to disturb the ALJ's order. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated April 23, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on

___________1/8/19_______ by _____TT_________ .

KAPLAN MORRELL LLC, Attn: BRITTON JESS MORREL ESQ, 6801 W 20TH STREET SUITE 201, GREELEY, CO, 80634 (For Claimant)
POLLART MILLER LLC, Attn: BRAD J MILLER ESQ, 5700 S QUEBEC STREET SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-931-411

IN THE MATTER OF THE CLAIM OF:

DYLLON KARDISCO,

Claimant,

v.

RED SKY CONSTRUCTION INC,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

FINAL ORDER

The respondents seek review of an order of the Director of the Division of Workers' Compensation (Director) dated September 6, 2018, insofar as it granted the claimant temporary total disability (TTD) benefits from March 27, 2018, to April 19, 2018, totaling $1,035.00. We affirm.

The Director made the following pertinent findings of fact. The claimant suffered a compensable injury on October 9, 2013. The respondents filed a Final Admission of Liability (FAL) on February 17, 2017, indicating a maximum medical improvement (MMI) date of December 18, 2015. The respondents admitted to a 30% whole person impairment with a total value of $125,779.15.

The claimant filed an application for hearing on the issue of permanent total disability (PTD) benefits, which was held in abeyance by stipulation of the parties.

The claimant then signed a vocational rehabilitation plan on May 16, 2017. Two days later, the parties stipulated that the respondents would pay all remaining permanent partial disability (PPD) benefits in a lump sum, without discount. On June 5, 2017, the respondents filed a general admission of liability (GAL) admitting for temporary total disability (TTD) benefits from February 14, 2017, ongoing.

The claimant participated in the vocational rehabilitation plan, which was directed primarily at obtaining a GED. The claimant completed the GED program in early 2018. The respondents then notified the claimant on March 27, 2018, that they no longer would provide vocational rehabilitation services. The respondents filed a GAL dated April 5, 2018, which purported to terminate TTD benefits as of March 26, 2018.

The parties subsequently attended a prehearing conference to address the validity of the respondents' GAL. On May 1, 2018, a prehearing ALJ concluded the admission improperly terminated temporary benefits and declared it void. The same day the prehearing order was issued, the respondents filed an FAL indicating that temporary disability benefits terminated March 26, 2018, upon termination of vocational rehabilitation and a pleading captioned "NOTICE RE: C.R.S. §8-42-105(1)." The respondents contended the April 5, 2018, GAL was sufficient to provide notice of termination.

The claimant then filed a motion seeking an order from the Director compelling the respondents to continue paying TTD benefits until a hearing could be held regarding the claimant's entitlement to any additional benefits. The respondents argued that the statutory cap on combined TTD and PPD benefits enunciated in §8-42-107.5, C.R.S. barred any further payment of TTD benefits and that the termination of TTD benefits via a GAL was appropriate.

On June 12, 2018, the Director entered his order denying the claimant's motion. While the Director held that there was no authority to grant the requested relief sought by the claimant, he nevertheless held that the respondents had improperly terminated TTD benefits by failing to provide the required 14 days' written notice set forth in §8-42-105(1), C.R.S. before terminating such benefits. In his order, the Director explained that vocational rehabilitation is permitted by §8-42-111(3), C.R.S., which allows the respondents to offer such benefits in lieu of PTD benefits. He further explained that in cases where vocational rehabilitation is offered, the injured worker is obligated to accept, and the failure to accept vocational rehabilitation results in the denial of PTD benefits. Additionally, the Director explained that once vocational rehabilitation commences, an injured worker becomes entitled to TTD benefits, and these benefits are paid despite the injured working having reached MMI and otherwise not being eligible. According to the Director, for pre-MMI temporary benefits, termination is only possible with an order or upon the occurrence of events specifically listed in §8-42-105(3), C.R.S. He held that benefits being paid due to participation in vocational rehabilitation are instead governed by a different section, §8-42-105(1), C.R.S. That is, under §8-42-105(1), C.R.S., vocational rehabilitation may be terminated at any time upon 14 days' written notice to

all parties and the Director. The Director stated that once notice is given, the parties are returned to the positions they held prior to the commencement of vocational rehabilitation.

With regard to the respondents' argument that the statutory cap had been reached and the claimant was therefore not legally entitled to any further TTD benefits, the Director held that once an injured worker accepts vocational rehabilitation, he is again considered temporarily disabled. The Director held that for purposes of the cap, this is akin to a reopening which may entitle the claimant to additional temporary disability benefits, even if the cap has been exceeded. The Director therefore ruled that the claimant was entitled to receive TTD benefits until vocational rehabilitation was terminated in accordance with the 14 days' written notice requirement set forth in §8-42-105(1), C.R.S. Using the respondents' April 5, 2018, GAL, which provided written notice that vocational rehabilitation benefits would terminate, the respondents were permitted to terminate TTD benefits as of April 19, 2018, or 14 days after written notice was provided.[1] The Director therefore ordered the respondents to pay $1,035.00 in TTD benefits for the 14 days' written notice period.

The respondents subsequently petitioned to review the Director's order, arguing that pursuant to the statutory cap enunciated in §8-42-107.5, C.R.S. for combined TTD and PPD benefits, the award of additional TTD benefits was not supported by applicable law. Citing to *Grogan v. Lutheran Medical Center, Inc*., 950 P.2d 690 (Colo. App. 1997), the respondents contended that since the claimant was at MMI and had reached the statutory cap on combined PPD and TTD benefits, he was not entitled to additional TTD benefits regardless of whether the respondents continued or terminated vocational rehabilitation under §8-42-111, C.R.S. While a briefing schedule subsequently was issued, neither party filed briefs.

In response to the arguments raised in the respondents' petition to review, the Director issued another order on September 6, 2018. In his order, the Director found that the respondents paid the claimant a total of $39,955 in TTD benefits prior to reaching MMI and permanent benefits of $125,779.15 pursuant to a stipulation of the parties. Thus, the total benefits the respondents paid prior to commencement of vocational rehabilitation totaled the cap of $161,734.15.[2] The Director further held that the

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[1] The Director held that to the extent his holding regarding the GAL conflicted with the May 1, 2018, prehearing order which held that the respondents' GAL improperly terminated temporary benefits and was void, that prehearing order was overruled.

respondents voluntarily filed a GAL on June 5, 2017, admitting liability for ongoing TTD benefits. According to the Director, from that moment onward, the respondents were obligated to comply with all statutory requirements for termination of those benefits, including the requirement set forth in §8-42-105(1), C.R.S. to provide 14 days' written notice before termination of such benefits. Since the respondents failed to do this, however, the Director held that the termination of TTD benefits on March 26, 2018, was in violation of the statute and directed that TTD benefits be continued until properly terminated. The Director further distinguished the holding in *Grogan,* concluding it did not dictate a contrary result. The Director held that in *Grogan*, the claimant had accepted an offer of vocational rehabilitation and subsequently filed an application for hearing, arguing she was entitled to the payment of benefits while the rehabilitation program was ongoing. However, the Director concluded that the *Grogan* case was distinguishable because the insurer there did not file an admission of liability, as was done in this case. The Director therefore ordered the respondents liable to pay the claimant TTD benefits for the 14 days between March 27, 2018, and April 19, 2018, which totaled $1,035.00.

The respondents have petitioned to review the Director's September 6, 2018, order. The respondents argue the Director erred in determining they are liable for $1,035.00 in TTD benefits for the 14 days between March 27, 2018, and April 19, 2018. They contend the claimant is not entitled to TTD benefits in excess of the cap enunciated in §8-42-107.5, C.R.S. The respondents argue that the 14 days' written notice provision in §8-42-105(1), C.R.S. for terminating temporary benefits does not mandate the ongoing payment of such benefits when the statutory cap on combined TTD and PPD benefits is reached, as it was here. We are not persuaded the Director erred.

Section 8-42-105, C.R.S. provides, in pertinent part, as follows regarding the payment of TTD benefits when vocational rehabilitation is offered and accepted:

> (1) . . . Except where vocational rehabilitation is offered and accepted as provided in section 8-42-111 (3), temporary total disability payments shall cease upon the occurrence of any of the events enumerated in subsection (3) of this section. *If vocational rehabilitation is offered and accepted, any party may at any time terminate vocational rehabilitation upon fourteen days' written notice to the other parties and the director.* For purposes of this section, termination of vocational rehabilitation shall be the same as if vocational rehabilitation had never been offered and accepted, and the employer or insurance carrier shall not be entitled to recover any temporary

[2] Effective July 1, 2013, the limits on combined temporary and permanent partial payments for an impairment rating greater than 25% whole person totaled $161,734.15.

> total disability benefits paid during the period that vocational rehabilitation was provided. (Emphasis added.)

Additionally, pursuant to §8-42-107.5, C.R.S., the applicable cap on combined temporary disability and PPD benefits provides in pertinent part as follows:

> No claimant whose impairment rating is greater than twenty-five percent may receive more than one hundred fifty thousand dollars from combined temporary disability payments and permanent partial disability payments. . . For injuries sustained on and after January 1, 2012, the director shall adjust these limits on the amount of compensation for combined temporary disability payments and permanent partial disability payments on July 1, 2011, and each July 1 thereafter, by the percentage of adjustment made by the director to the state average weekly wage pursuant to section 8-47-106.

Here, we agree with the Director that the respondents were required to comply with the statutory requirement under §8-42-105(1), C.R.S. of providing 14 days' written notice to all parties and the Director before terminating the claimant's TTD benefits, even though the cap enunciated in §8-42-107.5, C.R.S. was reached. As found by the Director, the respondents filed a GAL on June 5, 2017, admitting liability for paying ongoing TTD benefits. Since vocational rehabilitation was offered and accepted, then the provisions of §8-42-105(3), C.R.S., which require TTD benefits to cease, do not apply. *See Larimer County v. Sinclair*, 939 P.2d 515, 516 (Colo. App. 1997)("when an offer and acceptance of vocational rehabilitation occur, the provisions of §8-42-105(3) do not apply"). Instead, under the clear language of §8-42-105(1), C.R.S., the only way the respondents may terminate TTD benefits is by virtue of providing 14 days' written notice of the termination of such benefits to all parties and the Director.

When the respondents admit liability, they are bound by that admission and must pay accordingly. Section 8-43-203(2)(d), C.R.S. (if any liability is admitted, payments shall continue according to admitted liability). This is true even if the admission of liability was improvidently filed. *See Cibola Constr. v. Industrial Claim Appeals Office*, 971 P.2d 666, 667 (Colo. App. 1998)(respondents bound to pay benefits consistent with erroneous admission). Moreover, W.C. Rule of Procedure 6-1(A)(1), 7 CCR 1101-3, specifically states that the provision for allowing unilateral termination because of MMI does not apply where vocational rehabilitation services have been offered. Thus, when a general admission is filed admitting to TTD benefits for vocational rehabilitation, then the respondents must continue to pay temporary disability benefits until an order or §8-42-105(1), C.R.S., permits them to cease. The respondents here voluntarily filed a GAL

admitting for TTD benefits for vocational rehabilitation after the statutory cap had been reached. Once the respondents admitted for TTD benefits, the 14 days' written notice provision enunciated in §8-42-105(1), C.R.S. was implicated and required the continued payment of TTD benefits until properly terminated under the express statutory requirements. Thus, under the particular circumstances presented here, §8-42-107.5, C.R.S. does not allow the respondents to unilaterally terminate TTD benefits by filing a GAL without complying with the 14 days' written notice provision set forth in §8-42-105(1), C.R.S.

The respondents contend that the holding in *Grogan* requires a contrary result. However, we agree with the Director that the holding in *Grogan* is distinguishable. As explained by the Director in his order, the insurer in *Grogan* did not file a GAL to pay temporary benefits after the claimant had accepted the offer of vocational rehabilitation. Consequently, the *Grogan* Court did not address the statutory requirement that TTD benefits may only be terminated by complying with the 14 days' written notice provision under §8-42-105(1), C.R.S. Conversely, here, the respondents filed a GAL on June 5, 2017, to pay ongoing TTD benefits while vocational rehabilitation was provided, even though the statutory cap already had been reached. Consequently, the statutory requirement of paying TTD benefits until properly terminated under §8-42-105(1), C.R.S. applies even though the statutory cap of §8-42-107.5, C.R.S. has been reached.

IT IS THEREFORE ORDERED that the Director's order dated September 6, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Kris Sanko

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on

_________1/15/19______ by _____TT________ .

PINNACOL ASSURANCE, Attn: HARVEY D FLEWELLING ESQ, 7501 E LOWRY BLVD, DENVER, CO, 80230 (Insurer)
THE FRICKEY LAW FIRM, Attn: JANET L FRICKEY ESQ, 940 WADSWORTH BLVD SUITE 400, LAKEWOOD, CO, 80214 (For Claimant)
RUEGSEGGER SIMONS SMITH & STERN LLC, Attn: KEVIN M CARLOCK ESQ, 1700 LINCOLN ST SUITE 4500, DENVER, CO, 80203 (For Respondents)
DIVISION OF WORKERS COMPENSATION, Attn: TAYLOR DURAN, 633 17TH STREET SUITE 400, DENVER, CO, 80202 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-057-220-001

IN THE MATTER OF THE CLAIM OF:

PATRICIA P HERNANDEZ CHAIREZ,

Claimant,

v.

EMPLOYBRIDGE HOLDING COMPANY,

Employer,

and

XL INSURANCE AMERICA INC,

Insurer,
Respondents.

FINAL ORDER

The respondents seek review of an order of Administrative Law Judge Cayce (ALJ) dated July 31, 2018, that determined the claimant sustained a compensable injury and ordered the respondents to authorize the proposed labral repair surgery for the claimant's right shoulder as requested by Dr. Shah. We affirm the ALJ's order.

This matter went to hearing on the issues of compensability and, if determined compensable, whether the "surgery recommended by Dr. Shah is reasonable, necessary and causally related to the compensable injury." After hearing the ALJ entered factual findings that for purposes of appeal can be summarized as follows. The claimant works as a production assistant assembling parts for firearms. The ALJ determined that the claimant sustained a compensable injury to her right shoulder on May 25, 2017, while working on an arbor press machine. The claimant reported the injury to her employer and was eventually referred to Dr. Otten. Dr. Otten diagnosed the claimant with a repetitive strain of the right shoulder, performed a steroid injection and released the claimant to modified duty. The claimant continued to see the Physician's Assistant, Donald Downs, complaining of pain in her shoulder.

The claimant underwent an MRI on August 9, 2017, which showed labral degeneration and a probable superimposed labral tear.

Dr. Shah performed an orthopedic consultation on August 17, 2017, upon referral from Dr. Otten. He diagnosed the claimant with a right shoulder labral tear, arthritis of the right acromioclavicular joint and recommended surgical treatment to improve the claimant's pain and function.

Dr. Douthit performed a Rule 16 medical record review for the respondents. Dr. Douthit diagnosed the claimant with work-related aggravated tendinitis/bursitis of the right shoulder and determined that the MRI findings were not causally related to the June 8, 2017, work injury.

Dr. Shah re-evaluated the claimant on October 26, 2017, and again recommended surgical intervention. Dr. Shah specifically recommended right shoulder arthroscopy, extensive debridement, subacromial decompression, labral repair and distal clavicle excision.

Dr. Ridings performed an independent medical examination. In his opinion there was no mechanism of injury at work that would be expected to cause any significant injury to the claimant's shoulder. Dr. Ridings also recommended against surgery.

Dr. Otten received a copy of Dr. Ridings' report and stated that the MRI confirmed a labral tear and the claimant needed surgical repair. Dr. Otten testified at hearing and explained how the claimant's pre-existing degenerative changes made the claimant predisposed to injury. Dr. Otten further testified that he recommended the claimant undergo a limited surgical procedure focusing on the work-related labral tear, which he believed to be the most likely cause of the claimant's problems.

The ALJ credited the opinions of Dr. Shah and Dr. Otten over the conflicting opinions of Dr. Douthit and Dr. Ridings on the claimant's work-related diagnosis and recommended treatment. ALJ Order at 7 ¶ 29. The ALJ then found that the claimant proved by a preponderance of the evidence that she suffered a compensable injury in the form of a right shoulder labral tear. ALJ Order at 7 ¶ 30. The ALJ went on to find that the "[c]laimant proved by a preponderance of the evidence that the surgical procedure recommended by Dr. Shah is reasonable, necessary and related to the claimant's compensable injury. Id. at ¶ 31.

In paragraph (I) of the "Order" section, the ALJ found the claim compensable. In paragraph (II), the ALJ specifically ordered the insurer to authorize the proposed labral repair surgery for the right shoulder as "requested by Dr. Shah." ALJ Order at 9.

The respondents do not appeal the ALJ's determination of compensability. The only argument on appeal is the respondents' contention that paragraph II of the ALJ's order is ambiguous and unsupported by the findings of fact. We are not persuaded there is any error in the ALJ's order.

We note initially that the claimant states in her Brief in Opposition that she filed a motion to dismiss the respondents' petition to review because it was not timely served on the Office of Administrative Courts. Although ALJ Cayce had not ruled on the motion at the time the claimant filed her brief, there is now an order from ALJ Cayce dated October 26, 2018, denying the claimant's motion to dismiss the petition to review. We do not address the motion here.

Our review is limited by statute and we may only correct, set aside, or remand an order if the findings of fact are not sufficient to permit appellate review, if conflicts in the evidence are not resolved, if the findings of fact are not supported by the evidence, if the findings of fact do not support the order, or if the award or denial of benefits is not supported by the applicable law. §8-43-301(8), C.R.S. We have no basis to disturb the ALJ's order in this case.

We disagree with the respondents' contention that the ALJ's order is ambiguous. A statement is ambiguous when it is reasonably susceptible to more than one meaning. *Public Service v. Meadow Island Ditch Co. No. 2*, 132 P.3d 333 (Colo. 2006). In determining whether there is an ambiguity in a writing, the reviewing body should evaluate it as a whole and construe the language in harmony with the plain meaning of the words employed. *Canal Insurance Co. v. Nix*, 7 P.3d 1038 (Colo. App. 1999).

We do not view the ALJ's order here as ambiguous in any respect. Before the hearing began the claimant highlighted the differences between Dr. Otten's surgery recommendation and Dr. Shah's recommendation. Tr. at 16-17. The respondents also requested that the ALJ find that the surgery suggested by Dr. Shah was not reasonably necessary. Tr. at 19. The ALJ's order clearly states that the issue for hearing was Dr. Shah's surgery recommendation. ALJ Order at 1. The ALJ also explicitly found the procedure recommended by Dr. Shah reasonable, necessary and related to the claimant's compensable injury. ALJ Order at 7 ¶ 31. Thus, the ALJ's findings support the order for the insurer to authorize the surgery recommended by Dr. Shah.

Moreover, the ALJ's factual findings are supported by the evidence. In his report dated October 26, 2017, Dr. Shah detailed the claimant's need for a right shoulder arthroscopy, extensive debridement, subacromial decompression, labral repair and distal

clavicle excision. Dr. Shah stated that the MRI showed findings of subacromial bursitis and labral tear with parallel labral cyst. Dr. Shah further noted that the claimant has not improved with conservative treatment. Thus, given the claimant's symptoms and structural pathology, Dr. Shah recommended this surgical intervention. Claimant's Exhibit 2. Dr. Shah's opinion provides substantial evidence and valid support for the ALJ's order. It is the ALJ's sole prerogative to evaluate the credibility of the witnesses and the probative value of the evidence. In this regard, it is for the ALJ to determine the weight and credibility of expert medical opinion and we may not reweigh the evidence based upon the respondents' argument that the expert evidence was not credible. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990).

The respondents' argument notwithstanding, we find no uncertainty in the ALJ's order to require the insurer to authorize the surgical procedure recommended by Dr. Shah. The ALJ's findings are supported by the evidence in the record and those findings, in turn, support the order. We, therefore, have no basis to disturb the ALJ's order on appeal. §8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated July 31, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on

___________1/16/19________ by _______TT_________ .

CAMERON W TYLER AND ASSOCIATES PC, Attn: CAMERON W TYLER ESQ, 3223 ARAPAHOE AVE SUITE 300, BOULDER, CO, 80303 (For Claimant)
RITSEMA & LYON PC, Attn: RICHARD A BOVARNICK ESQ, 999 - 18TH ST SUITE 3100, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-069-072-001

IN THE MATTER OF THE CLAIM OF: JOHN T SATTERFIELD, Claimant, v. RM WEISS CONTRACT SALES d/b/a ALTITUDE RESOURCES, Employer, and SENTINEL INSURANCE COMPANY LTD, Insurer, Respondents.	FINAL ORDER

The respondents seek review of a supplemental order of Administrative Law Judge Margot Jones (ALJ) dated December 13, 2018, that determined the claim compensable and ordered the reimbursement to the claimant of out of pocket medical expenses. We affirm the order of the ALJ.

The claimant works for the respondents as a sales associate in its commercial furniture business. The claimant services a sales territory encompassing Colorado and Wyoming. He works out of his home office in Aurora and routinely conducts sales calls by phone and in person. On February 1, 2018, after completing sales visits in Greeley and Ft. Collins, the claimant returned to his home office. The next day he had a sales presentation scheduled in Colorado Springs.

To make the presentation the claimant required a set of three ring binders featuring fold outs and clear covers. He made plans to drive to the local Office Depot store to obtain the binders. The claimant left his home office shortly before 3:00 p.m. and, traveling south, approached the intersection of Quincy Avenue and Smoky Hill Road. He determined that to avoid traffic congestion and save time, he would proceed south along Smoky Hill Road and then to Parker Road. On the way to the Office Depot store he would pass a dry cleaner where he could retrieve several white dress shirts for use at the next day's presentation. As the claimant proceeded across the intersection at Quincy he

was hit from his left side by a speeding automobile. The collision caused the claimant significant injuries to his left hip, his right wrist and several other joints.

The respondents denied liability for the claimant's injuries contending he was on a personal errand to pick up his clothes from the dry cleaners. The claimant asserted his trip was designed to secure binders for the work related sales presentation. He also noted the shirts he planned to pick up at the laundry included a set of starched white dress shirts, one of which he planned to wear to the sales presentation. His experience suggested such a shirt presented a professional appearance and assisted his chances of success at completing a sale.

The claimant requested an expedited hearing pertinent to the issues of compensability and medical benefits. At the May 15, 2018, hearing, the claimant testified concerning the need to acquire binders for the sales presentation as well as the reasons he had for choosing to wear starched white dress shirts. The claimant described the route he planned to take to arrive at the Office Depot store. He pointed out that while this route would allow him to arrive at the store on Parker Road, it was longer insofar as distance was concerned. Nonetheless, the route was still faster because it allowed him to avoid heavy south bound traffic on Parker Road in favor of a faster drive achieved by approaching the store going north on Parker. To do so, he planned to first proceed south on Smoky Hill Road. He would stop at the cleaners on the way and then continue on the same route to the Office Depot store. Tr. at 20, 43, 51-52, 55. "Because the traffic is less heavy coming down Parker Road going north at that time of the day. That's why I chose the time at the – the way I went, because it would cause less aggravation and save me time." Tr. at 43. Accordingly, the claimant was driving south on Smokey Hill Road through the intersection with Quincy Avenue when he was hit by the speeding car.

Notwithstanding the respondents' assertion the claimant was pursuing a deviation from his work related trip to the Office Depot store when the accident occurred; the ALJ ruled the claimant was in the course and scope of his work when he was injured. The ALJ reasoned any deviation "was not a substantial deviation" and the stop at the dry cleaners was in the cause of providing service to the respondent employer. The ALJ ruled the claimant's injuries were compensable. The ALJ ordered the respondents to reimburse the claimant for $347.53 in out of pocket medical expenses and to provide other medical benefits that are reasonable and related to the compensable injuries.

On appeal, the respondents argue the claimant's injuries did not "arise out of" his employment as required by § 8-41-301(1)(b) C.R.S. The respondents explain the claimant was hurt while engaged in a personal errand to retrieve his laundry. The fact

that the claimant planned to wear a newly cleaned shirt to work the next day was said to not be required by any request or direction of the employer and originated solely in the claimant's personal desire to dress as he did.

A review of the record made at the hearing indicates the debate over the relationship of the claimant's shirts to the employer's work is not significant to the compensability of the claim. The respondents insist there is no evidence to demonstrate the claimant's injuries arose out of his job functions. The respondents maintain the only task the claimant sought to accomplish had to do with picking up his laundry. They also argue the ALJ made no finding of any work connection to the claimant's automobile trip because retrieving laundry is not a work related activity. However, the respondents ignore the several explanations the claimant gave for the trip which included the need to arrive at an Office Depot to pick up binders to complete a sales presentation. The fact that the need for the three ring binders was required for a presentation mandated by the claimant's job is not contested. The ALJ made the finding "Claimant planned to go to the dry cleaner and [Office] Depot." Finding of Fact ¶ 7. The ALJ also determined:

> Claimant was retrieving laundered shirts needed for an early morning business meeting. The ALJ cannot find this deviation to be so substantial as to take Claimant outside of the course and scope of his employment. It is uncontested that Claimants work required extensive driving and that his duties required sales presentations to customers and prospective customers. … Claimant established by a preponderance that his injury in the MVA occurred in the course and scope of his employment and any deviation taken was insubstantial. Conclusions of Law ¶¶ 7 & 8.

In *Kelly v. Industrial Claim Appeals Office*, 214 P.3d 516 (Colo. App. 2009), the Court reviewed a claim that a claimant's trip was compensable as it was in the quasi-course of employment involved in traveling to obtain medical care. The ALJ ruled the trip was not compensable due to a deviation taken by the claimant. The decision observed that: "As a general rule, substantial deviations curtail coverage, while minor deviations do not." *Id*. at 518. "Accordingly, whether a deviation from covered employee travel is substantial enough to break the chain of causation is generally a question of fact for the ALJ."

> The general test for deviation from employment in Colorado is whether the deviation is substantial. *See Phillips*

> *Contracting, Inc. v. Hirst*, 905 P.2d 9, 12 (Colo. App. 1995)("When a personal deviation is asserted, the issue is whether the activity giving rise to the injury constituted a deviation from employment so substantial as to remove it from the employment relationship."). This test mirrors that used in the out-of-state cases cited above for deviations from travel for work-related medical treatment. *Id*. at 519.

The opinion referenced several cases featuring examples of circumstances determined by different courts to represent insubstantial deviations from otherwise compensable travel:

> *Preway, Inc. v. Davis*, 22 Ark. App. 132, 736 S.W.2d 21, 22-23 (Ark. Ct. App. 1987)(fact that claimant intended to drop off her son while in route from home to treating physician did not sever chain of causation), *and Laines v. Workmen's Comp. Appeals Bd*., 48 Cal. App. 3d 872, 122 Cal. Rptr. 139, 143 (Cal. Ct. App. 1975)(fact that journey to authorized medical treatment began from claimant's attorney's office did not sever chain of causation where claimant was injured in a motor vehicle accident while in route; benefits awarded because it would be "too narrow" a rule to limit compensability to "only ... trip[s] from the jobsite, where the injury occurred, to the doctor's office for the first treatment"), *and Taylor v. Dixie Plywood Co*., 297 So. 2d 553, 555-56 (Fla. 1974)(compensation not precluded where claimant, while in route from work to authorized treatment on the same day the underlying industrial injury occurred, first went to his home, and after leaving home for the doctor's office was in an automobile accident; benefits awarded because "the deviation, if any, was insubstantial under the circumstances" and there was no "unreasonable or extraneous deviation for a personal purpose"), *and Taylor v. Centex Constr. Co*., 191 Kan. 130, 379 P.2d 217, 217-18, 222-23 (Kan. 1963)(where claimant, upon leaving the doctor's office after authorized treatment, stopped at a service station to call his wife, had his

> truck serviced, ate lunch, and then proceeded to a tavern to buy a bottle of soda, causation was not severed; claimant entitled to benefits for injury that occurred in motor vehicle accident while returning to his jobsite from the tavern). *Id*. at 517-18.

This case is not unlike the examples cited above in *Kelly*. The testimony of the claimant described a similar situation concerning his stop at the dry cleaners. He explained that he would proceed to the Office Depot store: "After I stopped at the cleaners because I was going to be driving right by it." Tr. at 43. Here, the ALJ deemed the deviation in the trip to pick up three ring binders caused by the retrieval of the dry cleaning was not only 'insubstantial' but also could be seen as related to the next day's sales presentation. The ALJ's characterization of that deviation as sufficiently insubstantial so as not to remove the trip from the employment relationship is supported by substantial evidence in the record.

The respondents' contention the claimant was injured due to an unrelated trip to the dry cleaners is not supported by the record. This is regardless of whether the retrieval of dry cleaning not required by the employer can be seen as an activity arising out of employment. That portion of the trip was not characterized as a substantial part of the journey that otherwise was aimed at work necessities.

II.

A review of the record indicates the debate over the relationship of the claimant's shirts to the employer's work is not germane to the compensability of the claim. The uncontested evidence revealed a stop at the dry cleaners did not change the route the claimant planned to take to arrive at the Office Depot. The claimant would have found himself traveling south through the intersection of Quincy and Smokey Hill Road at precisely the same moment as was the speeding car regardless of whether or not he planned to pick up dry cleaning. That is because, as he testified, the route to the Office Depot required him to proceed in that fashion. The uncontested evidence demonstrates that any deviation represented by picking up dry cleaning had not been initiated at the point the MVA occurred. The fact that he was also going to pass by the cleaners therefore becomes a moot point.

As noted above, the claimant chose the route he took to the Office Depot store because "… it would cause less aggravation and save me time." Tr. at 43. "Why did you want to use the faster route? [ANS:] I needed the time to put together the packages that I

thought I needed for the following day with the potential customer." Tr. at 52. "I chose it because it was less traffic going the way I was going to go and took less time." Tr. at 55. Accordingly, even if the claimant had no laundry at the dry cleaners waiting to be picked up, he still would have crossed the Quincy Avenue intersection in the same manner as he did. Therefore, any deviation in his trip caused by the dry cleaner would not have begun until he traveled several blocks past Quincy. That deviation presented no causal relationship to the accident leading to the claimant's injuries.

The resolution of the disagreement concerning the connection of dress shirts to the work performed for the employer is not an issue required to be addressed in this matter. We therefore decline to do so.

IT IS THEREFORE ORDERED that the ALJ's supplemental order issued December 13, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

John A. Steninger

CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on

2/4/19 by TT .

FRANKLIN D AZAR & ASSOCIATES PC, Attn: RYAN J HOOVER ESQ, 14426 EAST EVANS AVENUE, AURORA, CO, 80014 (For Claimant)
LAW OFFICES OF SCOTT TESSMER, Attn: MATTHEW C HAILEY ESQ, 6430 S FIDDLERS GREEN CIRCLE SUITE 410, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-907-620-002

IN THE MATTER OF THE CLAIM OF:

DANIEL LANGE,

Claimant,

v.

FINAL ORDER

KERN USA,

Employer,

and

FEDERAL INSURANCE COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Edie (ALJ) dated September 10, 2018, that ordered penalties assessed against the claimant for failing to abide by an order directing him to repay the respondents an overpayment and for failing to attend a scheduled medical appointment. We affirm the penalties pertinent to the repayment and correct the amount of the penalties related to the medical appointment.

The claimant injured his groin and lower abdomen in a work related incident on December 27, 2012. After considerable treatment and missed time from work, the claimant was placed at maximum medical improvement (MMI) on September 6, 2016. The respondents filed a Final Admission of Liability (FAL) on October 28, 2016, admitting for a 17% permanent impairment rating leading to an award of $91,836.60 in combined temporary and permanent indemnity benefits. The FAL awarded maintenance medical benefits after MMI.

The claimant challenged the FAL by submitting an application for a hearing requesting permanent total disability benefits. In an order of June 29, 2017, a previous ALJ denied the request for permanent total benefits. The ALJ's order was affirmed on appeal to the Industrial Claim Appeals Office in a decision dated October 11, 2017. There were no further appeals related to the indemnity benefits awarded by the FAL.

The respondents made a claim for an overpayment premised on § 8-42-107.5 C.R.S. which limits the amount of combined temporary and permanent partial disability benefits that may be awarded to a claimant. The combined benefits cap applicable for the claimant's date of injury is $78,482. Following a hearing on November 7, 2017, ALJ Lamphere determined the claimant had been overpaid $13,354.60. In an order of December 1, 2017, the claimant was ordered to repay this overpayment to the respondents at the rate of $50 per month. Despite requests from the respondents, the claimant made no payment.

The respondents also complained that the maintenance medical benefits provided the claimant, which consisted entirely of narcotic pain medications, were not reasonable and necessary. In the same order of December 1, ALJ Lamphere agreed the maintenance medications were not reasonable. The ALJ required the respondents to pay only for the medical expenses "associated with weaning claimant from the opioid medication". Those medical benefits were ordered, "conducted through Dr. Polanco and continue in duration and include all treatments which are reasonable and necessary to safely withdraw claimant from opioids." The respondents notified the claimant he was required to attend a medical appointment with Dr. Polanco they had arranged for December 18, 2017. The claimant declined to attend the appointment. The respondents set a second appointment with Dr. Polanco for January 4, 2018. A prehearing order was obtained from PALJ Steninger compelling the claimant to attend the January 4 appointment. The claimant again refused to participate in the appointment.

The respondents requested a hearing to seek penalties related to an asserted failure by the claimant to comply with the orders of ALJ Lamphere concerning repayments and PALJ Steninger pertinent to attending scheduled medical appointments. The respondents also sought to extinguish the claimant's eligibility for further medical maintenance benefits.[1]

A hearing was held before ALJ Edie on September 5, 2018. The claimant testified but no copy of the transcript was ordered to be included in the record on appeal. The respondents submitted documents consisting of various ALJ and PALJ orders, as well as

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[1] The ALJ also denied the respondents' request for an 8% penalty to be assessed pursuant to § 8-43-401. The ALJ ruled that by its terms the section only allowed a penalty to be imposed on insurers or employers who delay specified payments. However, the respondents state in their position statement submitted at the September 5 hearing that they are requesting "interest at a rate of 8% per annum … under Section 8-43-401." It appears the citation to § 8-43-401 was a typographical error and was intended to reference § 8-43-410 which does provide for interest at the rate of 8% per annum. Nonetheless, the ALJ's reasons for denying relief pursuant to § 8-43-401 applies equally to § 8-43-410. Paragraph (2) of that section indicates employers or insurance carriers are to pay 8% interest. It does not contain a similar provision relating to claimants.

correspondence exchanged between the unrepresented claimant and respondents' counsel. At the conclusion of the hearing, on September 10, the ALJ found the claimant failed to comply with the order to repay the overpaid benefits and the order to attend medical appointments with Dr. Polanco.

The ALJ invoked § 8-43-304(1) and concluded the claimant had been ordered by ALJ Lamphere on December 1, 2017, to repay the respondents $13,354.60 at the rate of $50 per month. The ALJ observed the respondents had notified the claimant in written electronic correspondence that the respondents expected the first $50 payment by January 15, 2018. The address to send the payment was included. The ALJ recited the claimant's testimony that his funds were severely constrained. However, the ALJ also noted the claimant did not present this circumstance in reply to the respondents and he failed to not only pay the $50, but he did not endeavor to pay anything at all. The ALJ resolved an appropriate penalty would be $2.00 per day. The daily penalty was determined to start on January 15 and ran for the 233 days concluding on the date of the September 5 hearing. The total penalty assessed was $466.

Insofar as the claimant did not attend medical appointments with Dr. Polanco, the ALJ determined the doctor was an authorized physician and that the claimant was ordered by ALJ Lamphere to attend the medical examination to wean the claimant off his opioid medication. The ALJ found the respondents initially notified the claimant an appointment with Dr. Polanco had been arranged for December 18, 2017. When the claimant did not appear, the respondents made a second appointment for him to see the doctor on January 4, 2018. On January 2, PALJ Steninger entered an order, compelling the claimant to attend the January 4 evaluation. The claimant sent the respondents' counsel an email message on December 20 advising her that he would not attend the January 4 appointment. The claimant testified at the hearing he had discontinued the use of opioid medications on his own approximately two months previously. The ALJ found the statement credible. The ALJ deemed the claimant's refusal to submit to an appointment with Dr. Polanco to have been unreasonable and willful. Accordingly, the ALJ directed the claimant to pay a daily penalty of $100 for the 18 days between December 18 and January 4, totaling $1,800.

Finally, the ALJ ruled that because ALJ Lamphere had adjudged the only remaining medical treatment recommended for the claimant consisted solely of the opioid medication found to be unnecessary and unreasonable, and in light of the claimant's successful abandonment of the medications, it was appropriate to terminate maintenance medical benefits in their entirety.

On appeal, the claimant contends he should not be required to reimburse the overpayment while he still has symptoms of disability from his work injury. The claimant details his monthly income and compares it to the more extensive sum of his living expenses. He asserts his constitutional rights have been abridged, but does not specify which rights are involved. He explains the respondents were to blame for mistakenly paying too much in benefits. The claimant argues he was not obligated to attend appointments with Dr. Polanco and retained the ability to wean himself from the opioid medications. He argues his refusal to attend the appointments was made known to the respondents in advance and his failure to attend did nothing to lengthen the duration of his case.

The claimant's contention that he has not completely recovered from his injuries is not germane to the issue of the overpayment in this case. It is not disputed the claimant was provided with a permanent impairment rating. The issue is solely whether the combined benefits cap in § 8-42-107.5 applies such that it limits the amount of permanent disability benefits owed the claimant. To the extent the claimant had a disagreement with the overpayment amount, that contest was required to be adjudicated through an appeal of ALJ Lamphere's December 1, 2017, order, made within 20 days of that date. That issue therefore, will not to be considered in this appeal.

Insofar as the claimant recites the details of his income and his living expenses, we infer he is challenging the amount of the daily penalty assessed due to his failure to pay the required $50 per month to retire the overpayment. The standards to measure the reasonableness of a penalty applied pursuant to § 8-43-304(1) have been set forth in *Associated Business Products v. Industrial Claim Appeals Office*, 126 P.3d 323 (Colo. App. 2005), and in *Dami Hospitality LLC v. Industrial Claim Appeals Office*, _P.3d _, 2017COA21 (Colo. App. 2017)(Cert. granted).

> In *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 575, 580, 583, 116 S. Ct. 1589, 134 L. Ed. 2d 809 (1996), the Supreme Court first articulated factors that should be considered when weighing the "reasonableness of a punitive damages award." In deciding whether the constitutional line for an excessive fine "has been crossed," the Court later condensed these factors by instructing lower courts to "focus on the same three criteria: (1) the degree of the defendant's reprehensibility or culpability; (2) the relationship between the penalty and the harm to the victim caused by the

> defendant's actions; and (3) the sanctions imposed in other cases for comparable misconduct." *Cooper Indus.*, 532 U.S. at 425. (*Dami Hospitality*, Id. at 13).

Dami Hospitality also directs the court to consider the ability of the party to pay the fine assigned. *Id*. at 17.

To the extent this matter features a penalty assessed against a claimant these factors suggest significant limits to the quantity of a penalty. The claimant had missed eight monthly payments of $50 each, or $400. A daily penalty of $2.00 was assessed, a total of $466. The ALJ observed the claimant had expressed as his reason for noncompliance the presence of judicial bias and unspecified abridgement of his constitutional rights. It was noted the respondents incurred the expense of the hearing that prolonged the course of litigation in the claim. The claimant was deemed to have failed to communicate to the respondents the presence of any financial hardship. These findings describe a degree of reprehensibility. The harm to the respondents in being without $400 in repayments is illusory. There is no evidence in the record or the case law to allow for a useful comparison to sanctions imposed in other cases for comparable misconduct. However, the ALJ had available to him a penalty range of from 1¢ to $1,000 per day. Choosing to set the daily penalty at $2.00 appears to be a reasonable exercise of discretion aimed at penalizing the claimant's disobedient conduct while acknowledging the minimal harm to the respondents. Concerning the claimant's ability to pay the fine, the claimant will clearly have trouble with any fine at all. Nonetheless, because the daily fine has been set at a de minus amount, it is seen as reasonable since the only alternative would be virtually no fine at all.

The claimant's assertion he was not required to attend appointments with Dr. Polanco applies to the first, December 17 appointment, but not to the subsequent appointment on January 4.

The ALJ ruled the claimant had failed to obey a lawful order of ALJ Lamphere that he be treated by Dr. Polanco to rid himself of opioid dependence. Section 8-43-304(1) provides an employer, insurer, employee or any person involved in a violation of "articles 40 to 47 of this title 8, … for which no penalty has been specifically provided, or fails, … to obey any lawful order made by … the director or … any court … shall also be punished by a fine of not more than one thousand dollars per day …". However, ALJ Lamphere in his December 1, 2017, order specified:

> 2. Respondents shall pay for all reasonable, necessary and related medical expenses associated with weaning claimant from the opioid medication used to treat the pain caused by his industrial injury. The weaning program shall be coordinated through Dr. Polanco and continue in duration and include all treatments which are reasonable and necessary to safely withdraw Claimant from opioids.

The order is directed at the respondents. It serves, in conjunction with the ALJ's other findings, to grant their request to cease paying for medical benefits for the claimant. The order allows them to restrict their liability to the costs of Dr. Polanco's weaning program. It does not require the claimant to use this one remaining medical benefit. The respondents made it available to the claimant but he had the option to decline the benefit. The ALJ was in error in concluding the claimant had violated an order of an ALJ when he did not abide by the respondent's demand to attend an appointment with Dr. Polanco on December 18.

Section 8-43-404(1) does equip the respondents with the authority to make a written request to a claimant to submit to an examination by a physician. However, the failure to comply with such a demand is remedied through the penalty described in § 8-43-404(3). That section suspends the recalcitrant claimant's ability to collect compensation until he complies. A penalty pursuant to § 8-43-304(1) is not available where a claimant is alleged to have violated the statute (as opposed to an ALJ's or director's order) when a "… penalty has been specifically provided…" *Pena v. Industrial Claim Appeals Office*, 117 P.3d 84, 86 (Colo. App. 2004), *Barbieri v. Helzberg Diamond Shops*, W.C. No. 4-679-315 (September 25, 2008). The claimant is not eligible for additional compensation in this claim. Nonetheless, the presence of this penalty provision in § 8-43-404(3) precludes a monetary fine from being assessed through the application of § 8-43-304(1) when a claimant ignores the request to submit to a requested examination. The claimant therefore, has violated neither an order made by a court nor a requirement of articles 40 to 47 title 8, made subject to a penalty by § 8-43-304(1).

The second requested appointment with Dr. Polanco on January 4 was the subject of an order from a PALJ. The order of a PALJ is an order of the director. § 8-43-207.5(3). The availability of an alternative penalty has no implication for penalty sanctions premised on the violation of a director's order. *Kennedy v. Industrial Claim Appeals Office*, 100 P.3d 949, 951 (Colo. App. 2004). Therefore, the ALJ had the

authority to assess a penalty for the claimant's failure to abide by PALJ Steninger's order when he was absent from the January 4 appointment. In *Crowell v. Industrial Claim Appeals Office*, 298 P.3d 1014, 1017 (Colo. App. 2012), the court expressed its view that the failure of a party "to attend medical examination scheduled for particular date" is an example of a violation subject to a penalty for a single day's duration. Accordingly, here, the ALJ did not assess a continuing penalty for any days subsequent to the appointment on January 4.

The penalty imposed was $100. In *Kennedy*, *supra*, a penalty of $500 was applied when a claimant failed to attend an examination by a Division sponsored Independent Medical Examiner (DIME) following the order of a PALJ. Given the increased significance to a claim represented by a DIME determination, a lower amount, such as the $100 fine here, is reasonable for the claimant's obstruction of an examination whose purpose would be solely to extend medical benefits for a few months at most (and end them entirely when the claimant did not attend the Dr. Polanco appointment). We therefore modify the penalty assessed due to the avoidance of appointments with Dr. Polanco by decreasing that amount from $1,800 to $100.

IT IS THEREFORE ORDERED that the ALJ's order issued September 10, 2018, is affirmed to the extent the claimant was penalized $466 for his refusal to make monthly payments for overpaid benefits and the order is corrected to assess the claimant a penalty of only $100 for the failure to attend the doctor's appointment on January 4, 2018.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on

__________1/18/19_______________ by _________TT__________ .

DANIEL LANGE, 1245 JANES LANE, COLORADO SPRINGS, CO, 80909 (Claimant)
RITSEMA & LYON PC, Attn: KRISTIN A CARUSO ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-978-452-06

IN THE MATTER OF THE CLAIM OF:

KORENA HENRY,

Claimant,

v. FINAL ORDER

KAISER FOUNDATION HEALTH PLAN,

Self-Insured Employer,
Respondent.

The claimant seeks review of an order of Administrative Law Judge Cayce (ALJ) dated May 25, 2018, and served to the parties on May 29, 2018. The ALJ determined that the claimant had not overcome the opinion of the physician selected to perform the Division independent medical examination (DIME) regarding maximum medical improvement (MMI) and permanent physical impairment; that the claimant did not sustain any permanent physical impairment; that denied any post-MMI medical maintenance care; that denied disfigurement benefits; and that deferred the issue of temporary disability. We affirm.

The claimant was injured on August 13, 2014, when the heel of her left shoe caught in the sidewalk causing her to fall forward.

The hearing took place over three sessions on August 3, 2017; October 13, 2017; and January 22, 2018. The issues before the ALJ were whether either party overcame the opinion of Dr. Sacha (the DIME physician) as to MMI and permanent medical impairment; whether the scheduled permanent medical impairment should be converted to a whole person impairment; whether the claimant is entitled to temporary total disability benefits; whether the claimant requires post-MMI medical care; whether the claimant is entitled to an award of disfigurement; and average weekly wage. The ALJ established findings of fact that are summarized below.[1]

[1] There are fundamental and significant disagreements about the extent of the claimant's injuries, especially regarding a diagnosis of chronic regional pain syndrome, thus necessitating a lengthy summarization of the ALJ's 79 findings of fact. We regret the length of what follows, but a full examination of the ALJ's order is necessary.

The claimant has a pre-existing history of Systemic Lupus Erythematous. In 2006, a physician noted that due to this condition, claimant had severe arthritis of the hip, fingers, knees and hands, in addition to severely decreased circulation, which caused coldness and weakness in her hands.

The claimant was involved in a motor vehicle accident on September 4, 2012, with immediate complaints of headache and diffuse spine pain from her neck to lower back. Back pain continued with reports of such on October 10, 2012; January 3, 2013; February 6, 2013; March 23, 2014; and from January 2014 through April 17, 2014.

On August 13, 2014, claimant suffered an admitted industrial accident when the heel of her left shoe became caught in a sidewalk. The claimant reported falling forward onto outstretched wrists/hands and landing on her computer bag. The claimant was seen on the date of injury by Dr. Ramaswamy, who was designated as the authorized treating physician (ATP). Claimant was diagnosed with a left ankle sprain, left knee sprain, and left hip/sacroiliac joint strain.

The ATP reexamined the claimant on August 15, wherein she complained of left knee pain, along with swelling and coldness in her left ankle. X-rays taken on August 13 revealed "a questionable nondisplaced pathologic fracture through the proximal tibia." X-rays of the left ankle were negative for fracture. A CT Scan of the left knee on August 15 was negative for any abnormalities. A venous duplex study was negative for deep venous thrombosis. A left ankle MRI on August 26 revealed a mild high ankle sprain, a mild deltoid sprain, and mild acute sprains of the collateral ligaments, with no ruptured ligaments or fractures. A left foot MRI on August 26 revealed medial hallux sesamoiditis with suspected stress fracture and reactive MTP joint effusion. A left knee MRI was negative. On September 2, the ATP opined that the secondary left hip and SI joint dysfunction was likely due to her altered gait. She was referred for orthopedic consultation to Dr. Myers. Dr. Myers found no pathology in the left knee. He noted that the left foot MRI revealed inflammation and the left ankle MRI revealed fluid around multiple ligaments. Dr. Myers diagnosed a high ankle sprain and recommended that claimant wear a brace and undergo physical therapy.

On September 18, the ATP noted swelling, coolness, discoloration, and tenderness on physical examination. He recommended a vascular ultrasound. On the same day, claimant went to Castle Rock Adventist emergency department with complaints of swelling, discoloration and coolness in her left leg, along with "shock waves" up the leg. No duskiness or discoloration was observed on physical examination. Claimant was diagnosed with leg pain. Dr. Myers reevaluated claimant on September 19 and indicated

diffuse tenderness and hypersensitivity, and subjective autonomic complaints including coldness.

On October 2, the ATP noted the presence of some elements of complex regional pain syndrome (CRPS). He recommended CRPS testing. Claimant was seen by Dr. Schakaraschwili on October 13. He noted no swelling or discoloration, no skin, hair or nail changes, no hyperhidrosis, and temperatures equal to touch. Claimant reported some hyperesthesia in the foot and decreased pin sensation in the leg. He noted that claimant could have sustained injuries to the saphenous or common peroneal nerves which could be causing symptoms suggestive of CRPS. He stated, "I see few clinical signs consistent with [CRPS] and would only pursue workup for this if electrodiagnostic studies are negative. An EMG of the lower extremity on October 21 was normal.

Dr. Schakaraschwili reexamined the claimant on October 21. He noted no changes in his physical findings but remarked that claimant's description of pain was consistent with CRPS, but the physical examinations did not reveal strong clinical signs of CRPS. An infrared thermogram test and QSART test were recommended. A CT scan of the left lower extremity on November 10 was normal.

The claimant was seen by additional treaters, including Drs. Anderson and Gerhold, who suggested a possibility of CRPS.

Dr. Schakaraschwili reexamined the claimant on January 5, 2015, and noted multiple symptoms. He opined that the findings were "consistent with although not strongly diagnostic for [CRPS]." He recommended an autonomic testing battery, stating if the findings were abnormal, claimant would meet the criteria for CRPS with two abnormal diagnostic tests.

The ATP noted on January 8, the claimant declined QSART testing for fear the test would aggravate her fibromyalgia/lupus. CRPS was continued as a possible diagnosis.

A MRI of the left knee on January 28, revealed an isolated high-grade transverse chondral fissure with no evidence of ligament or meniscal injury. Concurrent X-rays were negative to suggest CRPS, as well as no acute or chronic fractures in left foot, ankle, and tibia/fibula.

On February 4, claimant was seen by Dr. Ogin. The doctor noted no obvious swelling, redness, atrophic or dystrophic changes, marked discomfort to superficial palpation, and full knee range of motion. Dr. Ogin remarked, "She has a paucity of

objective pathology. The thermographic study was somewhat positive, but this could be influenced by other factors. It is certainly possible that she may have underlying CRPS, but that her pain conditions may also be highly influenced by anger, stress, anxiety or other psychological barriers." Dr. Ogin recommended claimant see a pain psychologist, and noted that claimant was "surprisingly incredibly resistant" to doing so. The doctor offered to perform a sympathetic nerve block, which claimant declined. Dr. Ogin recommended a QSART.

On March 5, the ATP noted, "possible CRPS based on allodynia, discoloration and temperature changes. Thermogram testing was positive and bone scan study was suggestive of CRPS. It is reasonable for the patient to undergo a nerve block (sympathetic block) for diagnostic and hopefully therapeutic purposes."

On or about April 28, Dr. Ring performed a medical records review at the behest of the respondent. He was unable to perform an examination as claimant cancelled the appointment alleging increased pain from a recent intervention. Dr. Ring questioned whether the claimant sustained a fracture, as the more recent CT scan did not reveal a fracture. The doctor remarked that claimant had persistent subjective complaints with inconsistent objective clinical findings. He noted that the EMG was negative for a peripheral nerve injury or other findings, and the knee MRI revealed only minor, non-surgical changes, which could be compatible with age and body habitus. Dr. Ring opined that a CRPS diagnosis was questionable, based on the thermogram results which could have been influenced by claimant's history of deep vein thrombosis and lupus. He noted the bone scan and x-rays were non-diagnostic. Dr. Ring recommended claimant see a pain psychologist prior to consideration of any further treatment.

On April 30, a lumbar spine MRI revealed mild joint arthritis and a synovial cyst at L4-5.

On May 1, the claimant returned to Dr. Ramaswamy reporting significant lower back pain. She reported improvement in her left leg after the sympathetic block, but continued to complain of knee pain. The doctor noted that claimant had a diagnostic response to the sympathetic block. He stated, "Therefore, the diagnosis of CRPS appears to have been established—positive bone scan, x-rays, and thermogram—along with diagnostic block." Claimant continued to complain of pain in the lumbar spine and left hip. On May 8, Dr. Bainbridge performed a right L4-5 facet joint block and aspirated the facet cyst. By May 22, claimant reported to her ATP improved lower back pain but increased discomfort in her left lower extremity.

On August 25, claimant returned to the ATP and reported progressively worsening symptoms. The doctor noted that the sympathetic block helped with claimant's symptoms for approximately 3 ½ months. He listed symptoms of allodynia, swelling, purple coloration, and coldness in the left leg. He referred the claimant for another sympathetic block.

On September 8, the ATP authored a report in disagreement with Dr. Ring's April 28 report. He noted his understanding that the bone scan was suggestive of CRPS, the x-rays were suggestive of CRPS, and the sympathetic block was diagnostic and therapeutic.

On October 6, the claimant continued to report worsening symptoms to the ATP. The doctor again reviewed the efficacy of the sympathetic block and also noted he was "unable to link a lower back diagnosis to this claim."

Dr. Parry conducted an IME at claimant's request on October 9. Dr. Parry opined that claimant had CRPS, stating, "While the bone scan and thermogram are not 'textbook' positive, they are consistent with the diagnosis and meet the criteria for the workers' compensation guidelines. Her response to sympathetic blockade was unequivocal with a significant positive response and prolonged duration of the response." Dr. Parry assessed a total 36% whole person impairment, consisting of 15% for CRPS, 27% lower extremity impairment (11% whole person) for knee range of motion and chondromalacia, and 15% lumbar spine impairment for range of motion and specific disorders. She opined that claimant required maintenance treatment in the form of topical medication, access to a pool and personal trainer, follow-up appointments with Dr. Ramaswamy, and orthopedic access for her knee.

On December 3, the claimant reported to the ATP as having "no sensation to her left leg whatsoever." The doctor believed she needed to undergo additional blocks and gym/therapy for three to four months before being placed at MMI.

Dr. Ramaswamy referred the claimant to Dr. Faulkner, an orthopedist. Dr. Faulkner diagnosed chondromalacia and joint pain of the left knee. He recommended orthotics, PT, and possible intraarticular steroid injection if the pain did not improve with PT.

Dr. Ring reviewed additional records and opined on June 23, that the claimant had reached MMI. He opined that limited conservative therapy was reasonable along with sympathetic blocks if substantial long-term benefits were documented. Dr. Ring

concluded lumbar spine injections were not work-related and there were no indications for surgery, orthopedic care or PT.

On June 28, the ATP opined that claimant's myofascial low back pain was related to her altered gait and recommended orthotics.

On July 6, Dr. Ramaswamy placed claimant at MMI as of that date and assigned 15% whole person impairment for station and gait abnormalities associated with claimant's CRPS diagnosis. He recommended orthotics, land/pool PT, a gym pass, Lidoderm patches, and sympathetic blocks as maintenance treatment.

Dr. Lesnak performed an IME on September 27 at the request of the respondent. Dr. Lesnak noted claimant was uncooperative and refused to complete certain paperwork, provide certain information, and perform certain maneuvers. The doctor noted claimant exhibited several pain behaviors and nonphysiologic findings during the exam. He opined that other than a left high ankle strain/sprain, "there is absolutely *no medical evidence to suggest that she sustained any other type of injury as a result of this occupational incident of 08/13/2014."* Dr. Lesnak concluded there were no clear clinical findings or diagnostic criteria to support a CRPS diagnosis. Dr. Lesnak opined the bone scan possibly suggested some subtle abnormalities, but was not conclusive of a CRPS diagnosis, and the thermogram also suggested a possible diagnosis of "subtle CRPS," but "did not meet any type of 'strong' diagnostic criteria." He questioned whether the nerve blocks resulted in any significant benefit. He concluded that claimant had no permanent impairment, opining that claimant did not have CRPS or any impairment of the left ankle, knee, hip or low back.

A DIME was requested and performed by Dr. Sacha on November 28. Dr. Sacha noted claimant's history of lupus, chronic low back pain, and stroke with left-sided symptoms. He noted that claimant was in a prior MVA with low back, head and neck complaints and ongoing symptoms at the time of the work injury. Dr. Sacha incorrectly noted the date of the MVA as 9/4/2010. (The MVA was 9/4/2012.) He also erroneously reported that the claimant had a QSART test when in fact she did not. He erroneously reported that the claimant had been treated by Dr. Failinger and had received an injection therefrom. The claimant had not treated with Dr. Failinger. Dr. Sacha did not reference the claimant's thermogram. He further noted that the triple-phase bone scan was negative, specifically stating, "It showed some uptake in the left foot consistent with chronic degenerative changes, but no evidence of sympathetic-mediated pain." He noted that the lumbar sympathetic block from Dr. Bainbridge, "had a diagnostic response with partial temporary relief and lasting relief for a couple of months but had increased low

back pain postprocedure." Dr. Sacha remarked that claimant had severe marked pain behaviors.

Dr. Sacha gave the following impression: (1) history of dorsiflexion injury to the left ankle, (2) knee complaints with a negative MRI, (3) history of a diagnosis of CRPS with no evidence of sympathetic-mediated pain, (4) lumbar radiculopathy, non-work related, and (5) delayed recovery.

Dr. Sacha opined the lumber radiculopathy did not fit the mechanism of injury and was "clearly" related to her MVA. Dr. Sacha further opined there was no evidence of CRPS, stating, "She does not meet any of the criteria and does not have any findings on exam consistent with this." He remarked claimant is high risk for delayed recovery and overutilization of resources.

Lastly, Dr. Sacha opined claimant reached MMI on July 6, 2016, with no need for further interventions, surgery, lumbar sympathetic blocks, or a spinal cord stimulator. As maintenance treatment, he recommended follow-ups with Dr. Ramaswamy, six pool therapy sessions, and a pool pass for two years. Dr. Sacha concluded that claimant had no work restrictions. He assigned an 18% lower extremity impairment rating (7% whole person), consisting solely of range of motion deficits in the hind foot and knee. He did not establish a Table 40 diagnosis for the knee because the MRI was negative, but relied on clinical findings.

Dr. Basse performed an IME for the respondent on January 24, 2017. She noted that the claimant refused to complete the health history questionnaire and would not answer certain questions. On exam, the doctor noted diffuse tenderness in the left lower extremity, no increased symptoms to light touch, very minimal color changes in the knee and ankle with overall symmetric appearance of the legs, no color, temperature, sweat, swelling, hair, or nail changes in the foot or toes. Dr. Basse noted claimant's history of arthritis in her knees and low back pain. She opined that the temporal relationship needed to establish causality of the low back pain was not present. She also opined there were "no objective fall-related, traumatically acquired findings that can explain claimant's current left knee symptoms," and no traumatically acquired injury to the foot or toe related to the work injury.

Dr. Basse further opined that there was no objective evidence of confirmed CRPS, noting she looked at the "actual objective study results" for the CRPS analysis, including the stress thermogram, bone scan and x-rays. She opined the studies "are all negative and do not support the possibility of chronic CRPS, but stated the findings were nonspecific

and "highly atypical of the usual findings in ACUTE CRPS." She further explained that the bone scan findings are "more likely representative of her decreased weight bearing with associated decreased bone metabolism/turnover." Dr. Basse further stated the stress thermogram noted a normal sympathetic response, and x-rays did not reveal CRPS. Dr. Basse noted claimant's positive short-term response to the sympathetic blockade was subjective and unreliable. She noted that her exam findings, along with those of Drs. Schakaraschwili, Anderson, and Ogin did not identify clinical symptoms. She explained that the temperature asymmetry, color changes, and swelling could be due to claimant's use of a walking boot, or other non-work related conditions.

Lastly, Dr. Basse opined that claimant had suffered a high ankle sprain and her continued diffuse left ankle symptoms are non-traumatic and not work related. She concluded "[t]here was no objective evidence of any ongoing traumatically related problems that can be attributed to the 08/13/2014 fall." She concluded that claimant has some type of pain disorder, somatoform disorder, or other psychological diagnosis.

On February 13, 2017, respondent filed a final admission of liability (FAL) admitting for 18% lower extremity rating as per the DIME, Dr. Sacha. Claimant objected to the FAL and requested a hearing on the issues presented to the ALJ, as listed above.

At hearing, the claimant testified that she experienced significant pain relief from the sympathetic blocks, but that her symptoms ultimately returned. Claimant stated she continues to experience pain, discoloration, weakness, temperature asymmetry, burning sensations, swelling, tenderness, and loss of sensation in her left lower extremity. She testified that her symptoms are different from the symptoms she experiences from lupus flare-ups. She admitted the following: she had chronic low back pain prior to the accident, she suffered a brown recluse spider bit on the left leg prior to the work injury, she received treatment for arthritis in both knees in 2006, and she testified at a deposition in February 2017 that a lupus flare can cause pain all over her body, including in her knees and ankles, and she sometimes has coldness in the upper extremities due to the lupus. She testified that neither Dr. Sacha nor Dr. Lesnak measured the temperature of her lower extremities.

Dr. Lesnak also testified at the hearing as an expert in physical medicine and rehabilitation. He testified that the work injury caused mild high ankle and deltoid ligament sprains. He further opined that claimant's ongoing symptoms are inconsistent with the original mechanism of injury and these injuries typically resolve within a couple of months. Dr. Lesnak agreed with the DIME physician that claimant is at MMI. Dr. Lesnak explained claimant has undergone at least 17 diagnostic studies, which in unusual

in a non-surgical case, and the sole objective findings were the mild sprains identified by the original MRI. He reiterated his opinion that the claimant does not have CRPS. He explained the timeframe for developing CRPS is inconsistent with the timing of claimant's symptoms, as CRPS takes at least several weeks or months to develop, but claimant reported knowing something was significantly wrong just days following the accident. He also testified that CRPS does not cause loss of sensation. He stated that his physical exam was negative for any color changes, temperature changes, swelling, or other hallmark signs of a CRPS diagnosis. He testified that none of the objective tests confirmed CRPS. He acknowledged the bone scan had some subtle findings that could be consistent with chronic CRPS, he indicated that the bone scan was taken just four months after the injury, and chronic CRPS takes several years to develop.

Dr. Lesnak agreed with the DIME that claimant should not receive a lumbar spine impairment rating, as there is no evidence claimant sustained a work-related low back injury, the lumbar spine MRI was negative for any trauma-related problems, and that claimant had preexisting low back pain. He opined that claimant did not sustain any permanent impairment of the left knee or ankle, as the mechanism of injury is inconsistent with a knee injury and claimant's preexisting arthritis may better explain her symptoms.

Dr. Lesnak further testified that Dr. Sacha erred by assigning a rating for knee range of motion loss without a supporting Table 40 diagnosis. Further, Dr. Sacha did not compare the range of motion for the other knee as a baseline before assigning a range of motion deficit for the left knee. As to the ankle, Dr. Lesnak explained sprains are not permanent conditions and the mild sprains which the claimant sustained have clearly resolved after three years.

Lastly, Dr. Lesnak testified that no further medical benefits are reasonable or necessary for the resolved work-related injury.

The ALJ specifically credited the opinions of Drs. Sacha, Lesnak, Basse, and Ramaswamy as to the claimant's MMI status and concluded that claimant reached MMI on July 6, 2016. The ALJ concluded that claimant had failed to overcome the DIME's opinion by clear and convincing evidence that claimant reached MMI on July 6, 2016. Likewise, the respondent failed to overcome the DIME that the claimant reached MMI on January 5, 2015, an earlier date contended by the respondent (but not raised here).

The ALJ specifically credited the opinions of Drs. Sacha, Lesnak, and Basse over the conflicting opinion of Dr. Ramaswamy as to the lumbar spine and CRPS diagnoses

and found the claimant does not have CRPS and did not sustain any work-related injury to her lumbar spine. The ALJ concluded that claimant failed to overcome Dr. Sacha's opinion on the lumbar spine and CRPS by clear and convincing evidence.

The ALJ specifically credited the opinions of Drs. Lesnak and Basse as to the claimant's permanent medical impairment and found that claimant did not sustain any permanent impairment as the result of the work injury. The ALJ found that respondent proved by a preponderance of the evidence that the 18% scheduled impairment rating assigned by Dr. Sacha (and admitted to by the respondent) is incorrect.

The ALJ specifically credited the opinions of Drs. Lesnak and Basse as to post-MMI medical care and concluded that claimant failed to prove by a preponderance of the evidence that she is entitled to post-MMI treatment as recommended by Dr. Faulkner.

The ALJ found that the evidence was insufficient to determine whether or not the claimant was entitled to temporary disability benefits. The ALJ deferred any decision and left it to the parties to proceed further. (This issue has not been appealed to the Panel).

As to disfigurement benefits, the ALJ determined that there was insufficient persuasive evidence that the claimant's altered gait was the result of the work injury. Accordingly, the ALJ found that claimant failed to prove entitlement to a disfigurement award.

The ALJ ordered that the claimant reached MMI on July 6, 2016. It was further ordered that claimant sustained no permanent medical impairment. The ALJ denied any post-MMI medical treatment. The ALJ ordered that the respondent is entitled to an overpayment for any PPD benefits previously paid. The ALJ denied disfigurement benefits. The issue of temporary disability benefits was reserved for future determination.

The claimant appeals the ALJ order's asserting the following grounds of error:

1. The findings of fact, conclusions of law, and order are not sufficient to permit appellate review.
2. The findings of fact, conclusions of law, and order are not sufficient to warrant a dismissal or denial of previously admitted PPD.
3. Conflicts in the evidence are not properly resolved and the evidence of record is inadequate to support the ALJ's conclusions of law, findings of fact, and the order.

4. The parties purportedly reached a stipulated agreement in a third party claim satisfying respondent's subrogation lien in full. Thus, claimant argues that no "overpayment" has occurred.
5. In the alternative, if the "court" finds an "overpayment" has occurred, respondent should be barred from double recovery.
6. The findings of fact are not supported by the evidence.
7. The findings of fact are not supported by substantial evidence.
8. The findings of fact do not support the order.
9. The denial of benefits is not supported by applicable law.
10. The ALJ misapplied the Medical Treatment Guidelines and medical evidence.
11. Overpayments should not be applied to claims where the respondent has taken a position on a DIME in a Final Admission of Liability and have not pled or filed a petition to reopen the FAL.
12. Upholding portions of the DIME is a perversion of the intent and purpose of the DIME process.
13. The overpayment statute as applied to this case places a chilling effect on the DIME process and should be void as applied.
14. The finding of overpayment in this case amounts to punitive action taken against the claimant for exercising her due process rights.

In her brief, the claimant arduously takes issue with the ALJ's interpretation of the evidence. Of her 52 enumerated contentions of factual error, the claimant revisits dozens of medical records in the record and contends that the ALJ "misconstrued," "mischaracterized," "failed to note," "omitted," "did not explain," "was unclear," "makes no reference," "ignored," and wrongfully "relied," as to those medical records. Claimant argues that out of 27 medical appointments with Dr. Ramaswamy, the ALJ did not notate the contents of each and every medical report—most of which would favor the claimant's estimation of the facts. Instead the ALJ relied on representative samples of the medical reports. The claimant highlights and pinpoints portions of the medical records that would tend to support a finding of a diagnosis of CRPS and tend to support a finding of no pre-existing lower back pain (at least in 2013 and early 2014) (e.g.-the claimant asserts that the lower back pain in 2013 and early 2014 was due to urinary tract infections and possible kidney stones and not due to muscular, skeletal, or neurological problems).

All of the medical records that the claimant believes were omitted or misconstrued by the ALJ are in the record, and nearly all of them were referred to by the claimant in her post-hearing position statement. Thus, we must presume that the ALJ considered all of the records and those that were not mentioned in the ALJ's findings of fact were either non-dispositive or repetitive of those that were dispositive. The ALJ is not held to

crystalline standard in articulating her findings of fact. Rather, the ALJ's findings are sufficient if the basis for ALJ's order is apparent from the findings, and we are able to discern from the order the reasoning that underlies the conclusions. *Magnetic Engineering, Inc. v. Indus. Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). The ALJ's findings here are sufficient and we are able to discern the reasoning underlying her conclusions.

Essentially, the claimant uses her brief as a vehicle to reargue the merits of the claim as if to a fact-finder. Restating a merits argument with additional vigor does not give it extra weight in the substantial evidence equation. We, of course, are not the fact-finding agency; such is the exclusive prerogative of the ALJ. We view the bulk of the brief as a request that we reweigh the evidence. However, the Panel has no authority to reweigh the evidence. *See Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31 (Colo. App. 1990)(reviewing court bound by resolution of conflicting evidence regardless of existence of evidence which may support contrary result). Likewise, we have no authority to substitute our judgment for that of the ALJ concerning the sufficiency and probative weight of the evidence. *See Arenas, supra.*

The claimant argues that the DIME is supposed to be a "fair review of medical care that has been determined and controlled by a doctor employed by the respondent." The claimant asserts that when a DIME physician commits so many errors (as are contended here), the claimant has not been accorded an exam that comports with the statute, rules, or the AMA Guidelines.

Specifically, the claimant contends that the DIME physician, Dr. Sacha, made the following errors:

- He reported that Dr. Ramaswamy felt the low back condition was a pre-existing condition.
- He reported the claimant did physical therapy for six weeks.
- He reported the claimant did massage therapy and acupuncture with Dr. Bondi for nine visits, but the claimant never saw Dr. Bondi.
- He reported that the claimant had a QSART exam and that it revealed essentially normal findings, but the claimant never had a QSART exam.
- He reported that the triple phase bone scan was negative.
- He reported the chronology of the doctors that the claimant saw out of sequence.

- He reported that the claimant refused a lumbar sympathetic block from Dr. Ogin, when the refusal was only because Dr. Ogin was not willing to discuss doing one without steroids.
- He reported that Dr. Bainbridge got an MRI of the lumbar spine before the claimant had a lumbar sympathetic block, when the chronology was reversed.
- He reported that Dr. Failinger performed a knee injection and recommended PT and orthotics. The claimant never saw a Dr. Failinger.
- He reported that the claimant was in a motor vehicle accident on September 4, 2010. (The actual date of the MVA was September 4, 2012.)
- He indicated that he performed a cutaneous exam and found equal temperature in both lower extremities. The claimant testified that the doctor performed no temperature measurements of the lower extremities.
- He reported that the claimant had an IME with Dr. Ring, when Dr. Ring only performed a medical record review and never examined the claimant.
- He reported that Dr. Schakaraschwili performed a CT scan of the claimant's leg, an MRI of the left knee, and an MRI of the left foot, when that care was recommended by Dr. Ramaswamy.
- He reported that the claimant had a right Achilles surgery. Claimant denies ever having such surgery.
- Claimant testified that Dr. Sacha used no other equipment during his examination other than a reflex hammer.
- He determined range of motion measurements without using measuring devices and based his conclusion by eyeballing her lower extremity.
- He omits any mention of the results of the thermogram as noted by Dr. Schakaraschwili.
- He fails to address Dr. Ramaswamy's findings that the lower back problems were due to an altered gait.
- He did not address any of the findings of Dr. Ramaswamy and other doctors that reported findings of discoloration, swelling, and temperature changes during physical examinations.
- He stated the claimant's sensation was decreased in patchy non-dermatomal distribution in both legs, although the claimant testified the he did not perform any sensation testing.

Claimant argues that due to these defects, Dr. Sacha's report is so deficient in its entirety that it is highly probable that his report is incorrect. In her order, the ALJ noted that these inaccuracies were pointed out to her by the claimant in her argument and in her

post-hearing position statement. ALJ's Order at 11 ¶ 52, 19. The ALJ concluded that the claimant failed to meet her burden to overcome Dr. Sacha's opinion based on a totality of the evidence and that the inaccuracies did not render his ultimate opinions highly probably incorrect. We perceive no error in the ALJ's determination in this regard. Section 8-43-301(8), C.R.S.

The claimant further complains that the ALJ failed to explain why she found "one-time" respondent's IMEs to be more persuasive that Dr. Ramaswamy, who saw the claimant 27 times over two years. Further, the claimant complains that the ALJ failed to explain why she "ignored" (failed to mention) medical reports from nine of the ATP's evaluations. And of the 18 Dr. Ramaswamy reports that were notated by the ALJ, the ALJ omitted certain (favorable) sentences or findings from the notation. However, the ALJ is not required to articulate the basis for her credibility determinations. Wells v. Del Norte School District C-7, 753 P.2d 770 (Colo. App. 1987). Rather, the ALJ's credibility determinations must merely be sufficient to adequately inform a reviewing authority how the ALJ resolved conflicts in the evidence, which was done here. Regional Transportation District v. Jackson, 805 P.2d 1190 (Colo. App. 1991).

In its brief in opposition, respondent argues that the claimant failed to sign her petition to review and therefore the petition should be stricken under CRCP 11 and § 8-43-301(14), C.R.S. We disagree. These separate provisions are inconsistent with one another. Subsection 14 departs from Rule 11 by redacting the following sentence: "If a pleading is not signed, it shall be stricken unless it is signed promptly after the omission is called to the attention of the pleader." If there is a conflict or inconsistency, the civil procedure rules are disregarded. *Renaissance Salon v. Indus. Claim Appeals Office,* 994 P.2d 447 (Colo. App. 1999); *Powderhorn Coal Co. v. Weaver,* 835 P.2d 616 (Colo. App. 1992); *Nova v. Indus. Claim Appeals Office,* 754 P.2d 800 (Colo. App. 1988). Accordingly, we consider the claimant's petition to review to be properly filed and the lack of a signature on the petition to review is of no consequence to this appeal.

Respondent further argues that substantial evidence supports the ALJ's order and that the ALJ properly determined that the respondent is entitled to an overpayment.

We note that the claimant requested that only her testimony be transcribed from the August 3, 2017 hearing. Thus, we are not informed as to any other portions of that hearing that may have dealt with procedural issues, substantive issues that were to be heard by the ALJ, or other testimony that may have been presented.

The respondent contends that claimant did not raise the subrogation agreement from a third party claim at the hearing. The respondent also contends that the claimant did not raise an estoppel argument so as to prevent the respondent from claiming an overpayment. The record that is before us is devoid of any mention of the purported subrogation agreement, or of an estoppel argument until after the ALJ entered her order.

We are not in a position, nor is it within our authority, to determine whether payments under the purported subrogation agreement may serve as satisfaction of the overpayment. The argument was not raised at hearing before the ALJ, and thus may not be considered on appeal. *Kuziel v. Pet Fair, Inc.*, 948 P.2d 13 (Colo. App. 1997); *Pacheco v. Roaring Fork Aggregates*, 897 P.2d 872 (Colo. App. 1995) (a party may not raise issues on appeal which were not first raised before the ALJ). Consequently, the claimant's contentions related to the purported subrogation agreement and the corresponding affirmative defenses and equitable arguments regarding satisfaction of the overpayment, estoppel, and double recovery are not properly before us and will not be considered herein.

However, we review the ALJ's order—not as to whether the overpayment has been satisfied—but as to whether the order of overpayment is supported by the evidence.

Section 8-40-201(15.5), C.R.S. defines "overpayment" as "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 would result in duplicate benefits because of offsets that reduce disability or death benefits under said articles." Here, the ALJ concluded that claimant did not sustain any work-related impairment. Therefore the ALJ did not err in determining that the respondent is entitled to an overpayment for PPD benefits which claimant previously received.

The Panel previously addressed the overpayment issue in *Haney v. Shaw, Stone, and Webster,* W.C. No. 4-796-763 (ICAO July 28, 2011). The Panel stated:

> In 1997, the General Assembly amended subsections (1) and (2)(a) of § 8-43-303 to permit reopening of an award on grounds of "fraud" and "overpayment," in addition to the traditional grounds of error, a mistake, or change in condition. The 1997 amendments also provide that "no such reopening shall affect the earlier award as to moneys already paid except in cases of fraud or *overpayment*." (Emphasis added). Further, the 1997 amendments added § 8-40-201(15.5), defining "overpayment" as:

> [M]oney 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 [articles 40 to 47 of title 8]. For an overpayment to result, it is not necessary that the overpayment exist at the time the claimant received disability or death benefits….

The 1997 legislation is designated as an act "concerning the recovery from claimants of workers' compensation benefits to which such claimants are not entitled." *Ashley v. King Soopers*, W. C. Nos. 4-573-332, 4-584-481 (October 28, 2004). In our view, the statute contemplates that in the case of overpayment such as that here, the ALJ has authority to remedy the situation. *Stroman v. Southway Services*, Inc. W. C. No. 4-366-989 (August 31, 1999).

Whether the respondent has shown an overpayment requires a factual determination which is exclusively the authority of the ALJ. Because the issue is factual in nature, we must uphold the ALJ's determination if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires us to consider the evidence in a light most favorable to the prevailing party, and defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Wilson v. Indus. Claim Appeals Office,* 81 P.3d 1117 (Colo. App. 2003).

In this regard, the ALJ's assessment of the probative value of the evidence and her credibility determinations are matters solely within her province. We may not set aside a credibility determination unless the testimony of a particular witness, although direct and unequivocal, is "so overwhelmingly rebutted by hard, certain evidence directly contrary" that a fact finder would err as a matter of law in believing the witness. *Halliburton Services v. Miller,* 720 P.2d 571 (Colo. 1986); *Johnson v. Industrial Claim Appeals Office,* 973 P.2d 624 (Colo. App. 1997). Consequently, the ALJ's credibility determinations are binding except in extreme circumstances. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d. 558 (Colo. App. 2001). We will neither reweigh the evidence nor substitute our judgment for that of the ALJ regarding the credibility of the competing witnesses.

Here, the fact of the overpayment is essentially uncontroverted. The claimant does not dispute that she received payment for permanent impairment under the respondent's

final admission. As a result of the ALJ's determination that the claimant did not sustain any permanent impairment, the respondent's earlier payment became an overpayment.

The claimant raises other tangential issues related to the overpayment such as:

1. Overpayments should not be applied to claims where the respondent has taken a position on a DIME in a Final Admission of Liability and have not pled or filed a petition to reopen the FAL.
2. The overpayment statute as applied to this case places a chilling effect on the DIME process and should be void as applied.
3. The finding of overpayment in this case amounts to punitive action taken against the claimant for exercising her due process rights.

However, the claimant does not develop these arguments further, never articulating precisely what facts or law support them. Without adequately developed legal argument, we are unpersuaded as to the claimant's assertions of inequity. *See Vogel v. Carolina Int'l, Inc.,* 711 P.2d 708, 715 (Colo. App. 1985) (The burden is upon the party asserting error to establish it…); *see also Rego Co. v. McKown-Katy,* 801 P.2d 536, 540 (Colo. 1990) (The burden is on the party asserting error to show reversible error).

A DIME physician's opinion as to MMI and as to a medical impairment rating must be overcome by clear and convincing evidence. §8-42-107(8)(c), C.R.S.; *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186, 189 (Colo. App. 2002); *Qual-Med, Inc. v. Indus. Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998); *see also Leprino Foods Co. v. Indus. Claim Appeals Office*, 134 P.3d 475, 482 (Colo. App. 2005) ("DIME physician's opinions concerning MMI and permanent medical impairment are given presumptive effect . . . [and] are binding unless overcome by clear and convincing evidence"). "Clear and convincing evidence means evidence which is stronger than a mere 'preponderance' ; it is evidence that is highly probable and free from serious or substantial doubt." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App. 1995). Therefore, the party challenging a DIME physician's conclusion must demonstrate that it is "highly probable" that the DIME physician's impairment rating is incorrect. *Qual-Med*, 961 P.2d at 592. Whether a party has met the burden of overcoming a DIME by clear and convincing evidence "is a question of fact for the ALJ's determination." *Metro Moving & Storage*, 914 P.2d at 414. We must uphold the factual determinations of the ALJ if the decision is supported by substantial evidence in the record. § 8-43-301(8), C.R.S.

Although one may vociferously disagree with the opinions of the various

physicians involved in this claim, including the DIME, these opinions serve as substantial evidence upon which the ALJ properly relied. The existence of evidence which, if credited, might support a determination contrary to that reached by the ALJ does not afford us grounds to grant appellate relief. *Colorado Fuel and Iron Corp. v. Industrial Commission*, 152 Colo. 25, 380 P.2d. 28 (1963). The ALJ is not required to cite or discuss every piece of evidence before crediting evidence to the contrary. *Crandall v. Watson-Wilson Transportation System, Inc.*, 171 Colo. 329, 467 P.2d 48 (1970). Rather, as expressly recognized by the ALJ, evidence not cited is implicitly rejected as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000). To the extent that a witness's testimony was inconsistent, the ALJ was free to rely on those portions she found persuasive and to reject other portions. *See Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968). The substantial evidence standard of review does not permit a reviewing forum to reweigh the evidence with a view toward determining whether, given the evidence as a whole, "a mistake has been committed" in the weighing of the evidence. Rather, the existence of substantial evidence supporting a factual finding precludes the reviewing forum from disturbing it and renders it binding. Section 8-43-301(8), C.R.S.

We have considered all of the claimant's remaining arguments and contentions and are not persuaded that they are sufficient to disturb the ALJ's order.

IT IS THEREFORE ORDERED that the ALJ's order issued May 29, 2018 is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

John A. Steninger

Kris Sanko

CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on

______________1/25/2019_________ by _________KG____________ .

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RUEGSEGGER SIMONS & STERN LLC, C/O: MICHELE STARK CAREY (#27225), 1700 LINCOLN STREET SUITE 4500, DENVER, CO, 80203 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-007-076-001 and
5-066-360

IN THE MATTER OF THE CLAIM OF:

ALEXANDER MARTINEZ,

Claimant,

v.

LKQ HOLDING CORPORATION,

Employer,

and

INDEMNITY INSURANCE COMPANY OF NORTH AMERICA,

Insurer,
Respondents.

ORDER OF REMAND

The claimant seeks review of an order of Administrative Law Judge Cannici (ALJ) dated August 3, 2018, that denied and dismissed the claimant's workers' compensation claim for an alleged injury dated December 14, 2017. We set aside the ALJ's denial of the claim and remand the matter for further findings.

The matter went to hearing on consolidated claims. In W.C. No. 5-007-076 (date of injury February 8, 2016), the respondents sought to overcome the Division Independent Medical Examination (DIME) physician's 18 percent whole person impairment rating. In W.C. No. 5-066-360, the claimant filed a new claim alleging an injury date of December 14, 2017.

The claimant works as a delivery driver for this employer. The claimant's job duties involved delivering automobile and RV parts throughout Colorado. The claimant sustained an admitted injury on February 8, 2016, when he was involved in an automobile accident. The claimant sustained a lumbar strain and underwent conservative treatment that included injections and physical therapy. The claimant's authorized treating physician, Dr. Hemler, diagnosed the claimant with spondylosis, radiculopathy and intervertebral disc degeneration in the lumbar region. Dr. Hemler placed the claimant at maximum medical improvement (MMI) on June 22, 2016, and gave the claimant a 10 percent whole person rating. Dr. Hemler released the claimant to return to

regular employment with a 50 pound independent lifting restriction. The claimant objected and requested a DIME.

The claimant returned to work and prior to attending the DIME purportedly sustained a new injury on December 14, 2017. The ALJ found that on this date the claimant was performing his regular duties for the employer "when he re-injured his back." ALJ Order at 3 Finding of Fact ¶4. The claimant testified that he was pushing a "grill guard" or bumper" out of a truck when he felt a pop and experienced pain in his low back. The claimant returned to Dr. Hemler for a follow-up examination. Dr. Hemler noted that the claimant was "generally doing well with persistent low back pain and occasional leg pain." Dr. Hemler also noted that the claimant "has sustained one additional flare-up but does not feel that there was a new injury." Dr. Hemler prescribed a short course of chiropractic care and recommended a few days off work.

The claimant then went to Dr. Peveto at Concentra on January 9, 2018, and reported continued, radiating low back pain since his December 14, 2017, work accident. Dr. Peveto diagnosed the claimant with a lumbar strain and radiculopathy.

On January 10, 2018, the claimant underwent a DIME with Dr. Hall for the February 8, 2016, injury. The DIME physician agreed with the MMI date of June 22, 2016, but stated that the impairment rating was a "bit tricky" due to the claimant's December 14, 2017, injury. The DIME physician assigned the claimant an 18 percent whole person rating explaining that the claimant's range of motion had increased from Dr. Hemler's rating and that this was likely related to the intervening event.

On February 6, 2018, the claimant was evaluated by Dr. Jones from Concentra. Dr. Jones commented that the December 14, 2017, incident "has a component of exacerbation" of the February 8, 2016, injury. The claimant then saw Physical Assistant Prochino at the Star Spine and Sport. Prochino noted that the claimant had a flare-up at work on December 15, 2017, when he was delivering a rear bumper. Prochino recommended chiropractic treatment. The claimant saw Dr. Deonarain on March 9, 2018. Dr. Deonarain stated that the claimant exacerbated his symptoms in December 2017 when he was pushing the bumper.

Dr. Fall testified at hearing. At the respondents' request, Dr. Fall conducted an independent medical examination on April 5, 2017, and also performed a records review and issued a written report on May 22, 2018. Dr. Fall agreed that the claimant reached MMI on June 22, 2016, for the February 8, 2016, injury. Dr. Fall also agreed with Dr. Hemler's 10 percent whole person impairment rating. Dr. Fall testified that the DIME

physician's 18 percent rating was incorrect because there was no medical reason for the claimant's range of motion to increase from the MMI date of June 22, 2016 to the date of the DIME and there were no objective changes. Dr. Fall further testified that the claimant did not sustain a new lumbar injury in December of 2017. Relying on Dr. Hemler's December 20, 2017 report, Dr. Fall determined that the claimant had a flare-up or a temporary increase in symptoms because the claimant's physical findings remained the same.

The ALJ determined that the respondents produced clear and convincing evidence to overcome the DIME physician's opinion that the claimant sustained an 18 percent whole person rating as a result of the February 8, 2016, injury. The ALJ further determined that the 10 percent whole person rating assigned by Dr. Hemler is appropriate.

The ALJ then concluded that the claimant failed to prove that he sustained a compensable lumbar spine injury in the course and scope of his employment on December 14, 2017. The ALJ found that the December 14, 2017 incident did not constitute a new injury. But, rather, was a "flare-up or exacerbation of his admitted February 8, 2016 lumbar spine injury." ALJ Order at 6, ¶ 19. The ALJ also credited Dr. Fall's testimony that the claimant suffered a flare-up or temporary increase in his symptoms which can occur with low back conditions. The ALJ denied the claim.

The claimant does not appeal the ALJ's determination that the respondents overcame the DIME physician's impairment rating and the award of the 10 percent whole person rating. The claimant only disputes the ALJ's determination to deny compensability for the alleged December 14, 2017, incident. The claimant contends that the ALJ's findings of fact do not support his conclusions and that the ALJ failed to apply the *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990) to the facts of this claim. Because the ALJ's findings concerning the cause of the claimant's exacerbation are contradictory and insufficient to permit appellate review, we set aside the ALJ's denial of the claim and remand for further findings.

As the claimant correctly argues on appeal, a claimant suffers a compensable injury if employment related activities aggravate, accelerate, or combine with a pre-existing condition to cause a need for medical treatment. Section 8-41-301(1)(c), C.R.S. 2000; *H & H Warehouse v. Vicory, supra; see also, Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). We reject the respondents' assertion in their brief that that these principles and the holding in *H & H Warehouse* are limited only to the aggravation, acceleration of a *non-industrial* pre-existing conditions. *See University*

Park Care Center v. Industrial Claim Appeals Office, 43 P.3d 637 (Colo. App. 2001); *Eastman Kodak Co. v. Industrial Commission*, 725 P.2d 85 (Colo. App. 1986), *overruled on other grounds, Allee v. Contractors, Inc.,* 783 P.2d 273 (Colo. 1989), claimant's pre-existing permanent disability from a prior industrial back injury did not preclude the claimant from recovering workers' compensation benefits for a second, separate compensable back injury with the same employer. *See Standard Metals Corp. v. Ball*, 172 Colo. 510, 474 P.2d 622 (1970)(issue of whether the claimant's condition is the natural and proximate progression of the original industrial injury or a new injury is one of fact for resolution by the ALJ).

Pain is a typical symptom from the aggravation of a pre-existing condition. The claimant is entitled to medical benefits for treatment of pain, so long as the pain is proximately caused by the employment-related activities and not the underlying pre-existing condition. *See Merriman v. Industrial Commission*, 120 Colo. 400, 210 P.2d 448 (1949). Moreover, an industrial aggravation is the "proximate" cause of medical treatment 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 contrast, the claimant suffers a "worsening" of a pre-existing condition if the need for treatment is the natural and proximate consequence of a prior industrial injury, without any contribution from a separate, intervening causative factor. *See Larson's Workers' Compensation Law*, § 131.03(1)(b); *Cox v. Allegis/Aerotech*, W.C. No. 4-642-468, W.C. No. 4-642-607 (April 5, 2006).

Whether the claimant's condition was a logical and recurrent consequence of the original injury, rather than an aggravation of that injury, is a question of fact for resolution by an ALJ. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). Here, the evidence was susceptible of conflicting inferences with respect to whether the claimant sustained a compensable aggravation of a pre-existing condition, or merely experienced a flare-up of symptoms attributable to a prior injury.

The question of whether the claimant has proven a causal relationship between an industrial injury and the need for medical treatment is one of fact for determination by the ALJ. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999). Thus, we must uphold the ALJ's pertinent findings if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. However, the ALJ must make sufficient findings of fact and conclusions of law to indicate the basis of the order and support meaningful appellate review. *See Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5

P.3d 385 (Colo. App. 2000); *George v. Industrial Commission*, 720 P.2d 624 (Colo. App. 1986).

Here, the findings are contradictory and insufficient to ascertain the basis of the ALJ's conclusion to deny the claim. Although the ALJ need not enter findings concerning every piece of evidence, the findings must be sufficient to indicate the factual and legal basis of the ALJ's determination, and purely conclusory findings are inadequate. Section 8-43-301(8); *Womack v. Industrial Commission*, 168 Colo. 364, 451 P.2d 761 (1969).

The ALJ found that the claimant reinjured his back on December 14, 2017. ALJ Order at 3 ¶ 4. The ALJ further found that the "claimant exacerbated his symptoms in December of 2017 when he suffered a pop" while pushing a weight and leaning to his left. ALJ Order at 6 ¶ 19. Based on these findings, the claimant's pain and need for medical treatment appears to be caused by a new injury on December 14, 2017, which is contrary to the ALJ's determination to deny the claim. *H & H Warehouse v. Vicory supra.*

The ALJ, however, also found Dr. Fall's testimony persuasive that the claimant only suffered a flare-up or temporary increase in symptoms which she would expect to occur with a low back condition. This appears to support the ALJ's conclusion that the claimant did not sustain a new injury and that the need for medical treatment was a natural progression of the claimant's prior injury.

Because the ALJ's order fails to resolve the conflict in these contradictory findings concerning the cause of the claimant's symptoms, it is impossible for us to ascertain the basis of the ALJ's conclusion. While the record might support either the inference that the exacerbation was caused by the December 14, 2017, event or the natural progression of the claimant's degenerative condition, we cannot determine whether the ALJ relied on substantial evidence to support his conclusion because he cited to evidence that is contrary to his result.

It is the ALJ's sole prerogative to determine the cause of the claimant's aggravation. *See Gelco Courier v. Industrial Commission*, 702 P.2d 295 (Colo. App. 1985). We, therefore, remand the matter to the ALJ to resolve the conflicts in the evidence and to determine whether the claimant's condition was caused by the December 14, 2017, event or the result of a natural progression of his pre-existing condition.

IT IS THEREFORE ORDERED the ALJ's denial of compensability in W.C. No. 5-066-360 in the order dated August 3, 2018, is set aside and remanded for further findings consistent with the views expressed herein.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

John A. Steninger

CERTIFICATE OF MAILING

Copies of this order were mailed to the parties at the addresses shown below on

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