BROWN BAG SEMINAR

Thursday, February 20, 2014

(third Thursday of each month)
Noon - 1 p.m.

633 17th Street

2nd Floor Conference Room
(use elevator near Starbucks)

1 CLE (including .4 ethics)

Presented by

Craig Eley

Manager of Director's Office
Prehearing Administrative Law Judge
Colorado Division of Workers' Compensation

Sponsored by the Division of Workers' Compensation
Free

This outline covers ICAP and appellate decisions issued from

January 11, 2014 through February 14, 2014

Contents

Industrial Claim Appeals Office decisions

Deshane v. GCA Services 2
Huskinson v. Metro Construction 7
Luke v. Hospital Shared Services 14
Padilla v. Wal-Mart Stores 24
Snell v. City & County of Denver 29
Teegardin v. J.C. Penney 35

Supreme Court decisions

City of Brighton v. Rodriguez 47
Harman-Bergstedt, Inc. v. Loofbourrow 77

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-894-543-02

IN THE MATTER OF THE CLAIM OF

FRANK DESHANE III,

Claimant,

v.

GCA SERVICES GROUP, INC.,

Employer,

and

TRAVELERS INDEMNITY COMPANY,

Insurer,
Respondents.

FINAL ORDER

The respondents seek review of an order of Administrative Law Judge Felter (ALJ) dated July 17, 2013, that ordered medical and temporary total benefits. We affirm.

The respondents appeal a portion of the ALJ's order pertinent to an award of temporary benefits commencing February 23, 2013, and continuing. On that date, the claimant was released from jail and committed to a community corrections facility. The respondents contend the claimant is precluded by § 8-42-113(1) C.R.S. from receiving temporary benefits while participating in the community corrections program.

The ALJ determined the claimant injured his left shoulder at work on April 26, 2012. He aggravated the left shoulder injury while at work on July 19, 2012. His physicians recommended restrictions featuring no use of the left shoulder. The claimant was diagnosed with a labral tear of the shoulder and a surgical consult was prescribed.

The claimant was working at the time of injury for the employer washing, driving and parking rental cars at the Denver International Airport (D.I.A.). The parties stipulated that in the event the ALJ determined the injury was work related, the claimant was not entitled to receive temporary disability benefits until August 20, 2012. The employer had been accommodating the claimant's restrictions. On August 20, the employer lost its contract at the D.I.A. and most of the employees, including the claimant, were laid off. The parties also stipulated that between November 27, 2012, and February 22, 2013, the claimant was not to receive temporary benefits. During that period the claimant was confined to the Weld County Jail due to a parole violation subsequent to an earlier felony conviction.

The parties agreed the claimant was released from jail on February 22, 2013, and committed to a community corrections program in a halfway house run by Intervention Community Corrections Services. The ICCS company has a contract with the 19th Judicial District to provide community corrections programs. The claimant resides at the ICCS halfway house in Greeley. He must remain in the house for a minimum of eight consecutive hours every day. He may leave by obtaining a pass from his case manager to conduct job search activities, to work at a job, to attend legal appointments and health appointments. Should the claimant leave the house without permission, he will be considered an escapee and may be rearrested and prosecuted for that violation. The claimant is charged with serving the balance of his sentence at the halfway house. The staff at ICCS may recommend his sentence be reduced by ten days for every month he is in the facility and displays qualities of good behavior. The claimant has been pursuing job searches but had not secured a job at the time of the June 27, 2013, hearing. He was still residing in the halfway house at the time of the hearing.

The ALJ concluded that § 8-42-113 did not apply to the claimant so as to prevent him from receiving temporary total benefits after February 22. That section bars benefits while a claimant is confined in a jail. The ALJ ruled the ICCS halfway house did not qualify as "a jail, prison or any department of corrections facility." In addition, the ALJ surmised the claimant was not incarcerated or confined as required for the implementation of § 8-42-113(1). Accordingly, the ALJ awarded the claimant temporary total benefits while he was in the halfway house. [1]

On appeal, the respondents dispute only the award of temporary benefits after February 22. They contend the case law as represented by *City and County of Denver v. Industrial Claim Appeals Office*, 98 P.3d 969 (Colo. App. 2004), does not apply to this situation, that a community corrections program does constitute jail 'confinement,' that the statute arbitrarily treats privately run community corrections programs differently from those run by the government, and that it is unfair for the respondents to be required to pay temporary benefits to convicted felons whom employers will likely not hire due to their convictions.

Section 8-42-113(1) specifies that a claimant is not entitled to receive any variety of worker's compensation benefits during a week "following conviction [in] which such individual is confined in a jail, prison, or any department of corrections facility." The Court of Appeals ruled in *City and County of Denver*, *supra*, a claimant serving his sentence in a privately run community corrections program was not in a jail, prison or

[1] Whereas the ALJ's conclusions of law provide for an award "from February 23, 2013, and continuing," the ALJ's Order only directs the respondents to pay temporary benefits through the date of the hearing. We conclude the failure of the Order to reference the payment of continuing benefits was oversight.

department of corrections (DOC) facility. Therefore, the exclusion required by § 8-42-113(1) did not apply and the claimant was entitled to receive permanent partial disability benefits. The respondents argue that in this case, the claimant was on probation until he violated one of its conditions. Only at that point was the claimant returned to jail and from there to community corrections. While that journey to community corrections varies somewhat from the path in *City and County of Denver*, the distinction does not bear any significance. In both cases, the claimants are serving their sentences in a community corrections program. The conclusion then, in *City and County of Denver*, that a community corrections program "is not a jail, prison or any Department of Corrections facility", would apply in the present situation.

The respondents contend the claimant's situation in the ICCS facility does constitute a species of "confinement." Therefore, regardless of whether the location of the confinement was in a privately run facility or in a government building, the claimant is argued to be 'confined' and § 8-42-113(1) applies. Setting aside for the moment the requirement that the claimant must be 'confined' in a jail, prison or DOC facility, which does not describe a community corrections program, *see*, *City and County of Denver*, *supra*, we held in *Vasquez v. City and County of Denver*, W.C. No. 4-462-671 (April 16, 2003), that § 8-42-113(1) refers to confinement which impairs the offender's earning capacity. In *Vasquez*, which was affirmed in *City and County of Denver*, the claimant resided in the local jail but was able to leave during the day to work at a job. Because the claimant's ability to earn wages was thereby unfettered, he was not 'confined' for the purposes of § 8-42-113(1). The terms of the claimant's commitment to the ICCS community corrections program are not different from those of the claimant in *Vasquez*. The claimant is able to leave the ICCS facility to search for work, and once secured, to maintain employment. We do not find cause to depart from the reasoning of *Vasquez* in this case. The claimant then, cannot be characterized as 'confined' through his participation in the community corrections program.

The respondents complain that when § 8-42-113(1) states by its terms that it applies to confinement in jails, prisons or any DOC facility, it is excluding confinement in a privately run facility. Because an individual in a private institution is in the same position as is an individual in a DOC or other governmental jail, prison or facility, the respondents explain the failure to apply § 8-42-113(1) to private institutions is a denial of the equal protection of the laws. The statute however, does not distinguish between government jails and private jails. It specifically references confinement in "a" jail or prison. The statute's statement of application to "any DOC facility" has been construed to exclude DOC community correction facilities. In *City and County of Denver*, the court examined § 17-27-102(3) C.R.S. 2003, pertinent to the community corrections regime. That section provides community corrections programs could be run by a "unit of local government, the DOC, or any private … corporation or association." The court then

resolved that a community corrections program so described "is not a jail, prison or DOC facility." Accordingly, neither a DOC community corrections facility nor a private community corrections facility allows for the application of § 8-42-113(1) to its participants. The similarly situated individuals dispersed between either of these types of institutions are therefore treated similarly.

The respondents' concluding argument recites that is unfair for them to be required to pay temporary benefits to a convicted felon. It is observed that employers are reluctant to hire convicted felons, especially those convicted of heinous felonies. In this case, the claimant was a convicted felon prior to his employment by the respondent. Despite his heinous crime, the respondent employer hired him. The claimant then, has a track record of overcoming this employment disability. The same argument could be made in the case of claimants that also possess generally perceived characteristics which make finding employment difficult, such as advanced age or insufficient education. The General Assembly however, has not used these unfortunate employment circumstances to disqualify individuals from the receipt of benefits. The respondents contend the claimant will have no incentive to seriously seek out a job when he receives a workers' compensation check every two weeks. Of course, that disincentive is present in any case where temporary benefits are paid. It is not a reason that § 8-42-113(1) should be applied in this matter.

The ALJ's determination that § 8-42-113(1) does not pertain to this case because the claimant is not 'confined,' or incarcerated, and the claimant is committed to a location which is not a jail, prison or any DOC facility, is supported by substantial evidence and the case law. Accordingly, the claimant is eligible to receive temporary disability benefits after February 22, 2013.

IT IS THEREFORE ORDERED that the ALJ's order issued July 18, 2013 is affirmed.

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

1/13/2014 by RP .

FRANK DESHANE III, 3060 BRIDGE STREET #216, BRIGHTON, CO, 80601 (Claimant)
GCA SERVICES GROUP, INC., 1350 EUCLID STE 1500, CLEVELAND, OH, 44115 (Employer)
TRAVELERS INDEMNITY COMPANY, Attn: KARLIN EBERHART, P O BOX 173762, DENVER, CO, 80217-3762 (Insurer)
LAW OFFICE OF O'TOOLE & SBARBARO, P.C., Attn: JOHN A. SBARBARO, ESQ., 226 WEST 12TH AVENUE, DENVER, CO, 80204-3625 (For Claimant)
RAY LEGO & ASSOCIATES, Attn: JONATHON S. ROBBINS, ESQ., 6060 S. WILLOW DRIVE, SUITE 100, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-918-495-01

IN THE MATTER OF THE CLAIM OF

LISA MARIE HUSKINSON,

Claimant,

v.

METRO CONSTRUCTION, INC.,

Employer,

and

NON INSURED,

Insurer,
Respondents.

FINAL ORDER

The respondent seeks review of an order of Administrative Law Judge Cannici (ALJ) dated August 21, 2013, that ordered the respondent to pay medical benefits, temporary disability benefits, and penalties. We affirm the order in part (regarding compensability and medical benefits) and reverse the remainder of the order.

A hearing was conducted in this matter on July 17, 2013, in regard to the issues of compensability, medical benefits and the average weekly wage. The claimant appeared in person and through counsel. The respondent employer did not appear. At the conclusion of the hearing the ALJ entered an order from the bench finding the claim compensable, directing the respondent to pay medical benefits, establishing the amount of the AWW, awarding temporary total disability benefits beginning January 1, 2012, and continuing, assessing a 50% increase in benefits due to the failure of the respondent to maintain insurance, and assessing a penalty of one day's compensation for up to 365 days due to a failure to timely admit or deny the claim pursuant to § 8-43-203(2)(a) C.R.S.

On appeal, the respondent contends the ALJ did not have personal jurisdiction over the employer because the respondent was not served "with documents naming it as a party until after the hearing." We find this assertion to be unsupported by the record.

The claimant testified at the hearing that she served as an employee of Metro Construction supervising a crew which conducted door to door sales of windows to residential customers. On September 1, 2011, she was in front of the employer's office location at 2641 Walnut Street in Denver. While entering the building to attend a sales meeting she stepped on a loose manhole cover causing her to fall and injure her right

ankle and low back. She stated she immediately reported the injury to the office manager and then to Jerod Raisch, who was identified as the owner of Metro Construction. Mr. Raisch and the employer made accommodations for the claimant's difficulty walking and she continued to work for Metro Construction until December, 2011. Metro Construction did not refer her to a physician. She therefore sought treatment with two chiropractors.

The file from the Office of Administrative Courts (OAC) submitted with the appeal by the respondent shows the claimant completed a Worker's Claim for Compensation form on May 1, 2013. This form identified the employer as Metro Construction, which maintained an address at 2641 Walnut Street in Denver. The form stated the injury was reported to Jerod Raisch at Metro Construction. The claimant had obtained counsel and filed an Application for Expedited Hearing on June 10, 2013. This application did not show that it was sent to the respondent. It identified the employer as Metro Construction and certified a copy was sent to the administrator for the insurance carrier, Bituminous Fire & Marine.

Bituminous filed a Response to the Application for Hearing on June 14, 2013. The Response specified Metro Construction, Inc. was the alleged employer. It listed the issues for hearing as including compensability, medical benefits and the contention by Bituminous that it did not have coverage for this employer. A copy of this Response was mailed to Jerod Raisch, at Metro Construction, Inc. at the 2641 Walnut address.

The OAC sent a Notice of Expedited Hearing on June 17, 2013. This notice was mailed to Jerod Raisch, Metro Construction, Inc., 2641 Walnut Street, Denver, CO 80205, and also to Mr. Raisch, Metro Construction, Inc., 1732 Wazee Street, Suite 205, Denver, CO 80202. The Notice specified a hearing in the matter was scheduled for July 17, 2013, and stated the time and location for the hearing. The caption of the Notice listed the employer's name as "Metro Construction and Restoration, LLC" and the carrier as Bituminous Fire & Marine.

On June 27, 2013, Bituminous Fire & Marine filed an Uncontested Motion To Dismiss Bituminous Fire & Marine as a party to the proceedings for the reason that it did not have a policy with Metro Construction. The attorney filing the motion on behalf of Bituminous verified the alleged employer was Metro Construction, Inc. and that company had addresses at both 2641 Walnut Street and 1732 Wazee Street**,** Suite 205, in Denver. The attorney also recited that she had spoken personally with Mr. Raisch about the claim and confirmed his company did not have insurance with Bituminous. The Motion included reference to the date and time of the hearing scheduled in the claim for July 17. A copy of the Motion was sent to Mr. Raisch at Metro Construction, Inc. at both addresses. Attached to the Motion was a copy of the claimant's Worker's Claim for

Compensation, and the Notice of Contest filed on behalf of Bituminous. The Motion was granted and Bituminous was withdrawn from the claim.

In its brief in support of its petition to review, the respondent acknowledges the claimant served on it a Case Information Sheet (CIS) on July 10, 2013. The CIS identified the issues for the hearing scheduled for July 17, to include compensability, medical benefit and the average weekly wage. The caption identified the employer as "Metro Construction and Restoration, LLC".

The ALJ submitted a written Findings of Fact, Conclusions of Law and Order on August 21, 2013. The Order stated the employer was Metro Construction, Inc. The order was mailed to Jerod Raisch at Metro Construction, Inc. at both its 2641 Walnut and its 1732 Wazee, Suite 205 addresses.

In its Petition to Review and in its Brief In Support, the respondent claims that because the employer was specified in the CIS to be "Metro Construction and Restoration, LLC" it declined to attend the July 17 hearing. The respondent points out that this second company is registered with the Colorado Secretary of State and is distinct from Metro Construction, Inc. Metro Construction and Restoration LLC has an address listed as 8616 Dudley Court, in Westminster, Colorado and at 455 King Street in Denver. In contrast, the listing of Metro Construction, Inc. with the Secretary of State is 1732 Wazee Street, Suite 205, in Denver, and its agent is Jerod Raisch. It is argued that because Metro Construction, Inc. was not served with documents naming it as a party prior to the hearing, the ALJ did not have personal jurisdiction in regard to Metro Construction, Inc. and therefore had no authority to enter orders pertinent to its liability for workers' compensation benefits.

Personal jurisdiction is the legal authority to enter orders concerning the parties. *People in the Interest of Clinton*, 762 P.2d at 1386; *In re the Custody of Nugent*, 955 P.2d 584 (Colo. App. 1997). Due process protections provide that the ALJ does not have personal jurisdiction over a party unless the party has been provided fair and adequate notice of proceedings which may result in an order for the payment of benefits. *See Stone's Farm Supply, Inc. v. Deacon*, 805 P.2d 1109, 1113 (Colo. 1991); *Colorado State Board of Medical Examiners v. Palmer*, 157 Colo. 40, 400 P.2d 914 (1965); *Hall v. Home Furniture Co.*, (Colo. App. 1996)."The fundamental requisites of due process are notice and the opportunity to be heard." *Hendricks v. Indus. Claim Appeals Office*, 809 P.2d 1076, 1077 (Colo. App. 1990). In an administrative hearing turning on questions of fact, "due process requires that the parties be apprised of all the evidence to be submitted and considered, and that they be afforded a reasonable opportunity to confront adverse witnesses and to present evidence and argument in support of their position." *Id.* In *Ford v. Katzson Brothers, Inc.*, W.C. 4-790-320 (November 12, 2009), it was observed that the

Act and the rules set forth procedures to provide the notice aspect of procedural due process.

> The Workers' Compensation Act provides that at least thirty days prior to any hearing, "the office of administrative courts in the department of personnel shall send written notice to *all* parties by regular mail."§ 8-43-211(1), C.R.S. 2009 (emphasis supplied). Moreover, the Office of Administrative Courts has promulgated a procedural rule regarding notice of hearings. See Office of Administrative Courts' Rule of Procedure (OACRP) 11, 1 Code Colo. Reg. 104-3 (2009)

As noted above, the record shows Metro Construction, Inc. did receive numerous pleadings and documents identifying it as the alleged employer in this matter. A copy of the claim for compensation benefits, the response to the application for a hearing and the motion by Bituminous Fire & Marine were very specific as to the identity of Metro Construction as the employer, the date and circumstances of the alleged injury and the date and time of the pending hearing. While the Notice of Expedited Hearing included the incorrect "Restoration LLC" as part of the respondent's name, the certificate of mailing was explicit as to the employer, its agent, its name as Metro Construction and its address. The same can be said of the CIS. A reasonable party given the information provided the respondent would not have been misled. If the respondent was unsure of its status, a reasonable party in those circumstances would have made inquiry of the OAC or the claimant's counsel as to its responsibilities pertinent to the July 17 hearing. In these circumstances it was not reasonable for the respondent to simply ignore the notice it was provided and fail to attend the hearing on July 17.

The ALJ's record establishes compliance with the various statutes and rules relevant to the notice of claims and hearings. Section 8-43-102 provides any person may "submit a written notice … to the employer" of an injury claim. The record shows the attorney for Bituminous Fire & Marine submitted this notice when it was attached to the June 27 motion to dismiss Bituminous. Section 8-43-211 directs the OAC to send written notice to all parties at least 30 days prior to a scheduled hearing. The OAC complied by sending that notice on June 17. The certificate of mailing for that notice reveals it was not sent to the address for "Metro Construction Restoration LLC" but, instead, was sent to Metro Construction, Inc., to its agent Jerod Raisch, and to both its addresses. OAC Rule 6 requires service of pleadings to be made by mail to the address of the parties "given in the pleadings." OAC Rule 11 states the notice of hearing is to be sent to the

address on the entry of appearance or on the response to the application. All of the relevant pleadings were sent to the respondent at the address contained in the entry of appearance and the response filed by Bituminous. That address corresponds to the address the respondent specifies in its Petition to Review. OAC Rule 23 directs the ALJ to make findings in a hearing in which a party does not appear. The ALJ is to find the notice of hearing was sent to the address provided by the non-appearing party or, if none was provided, that the notice was sent to an address at which it is likely to be received. The ALJ made that finding at the outset of the July 17 hearing. The record does not reveal any irregularities in compliance with these relevant notice procedures. Accordingly, the respondent's contention the ALJ failed to obtain personal jurisdiction over the employer is rejected.

A properly executed certificate of mailing creates a presumption that a notice was received, but the presumption may be overcome by competent evidence. *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993). Here, the respondent does not contend it failed to receive any of the documents asserted to have been sent by the various certificates of mailing listing either its 2641 Walnut or its 1732 Wazee, Suite 205, addresses. In fact, the respondent specifically acknowledges in its petition to review that it did receive the claimant's CIS mailed to those addresses.

However, insofar as the respondent was provided notice of the topics for hearing, it was only advised of those issues through the response to the application for hearing filed by Bituminous and the CIS submitted by the claimant. Those documents referenced only the issues of compensability, medical benefits and the average weekly wage. The respondent was not provided notice that temporary benefits, failure to obtain insurance or penalties for a failure to admit or deny were issues to be addressed by the ALJ. Accordingly, we must set aside that portion of the ALJ's order dealing with those three issues.

IT IS THEREFORE ORDERED that the ALJ's order issued August 21, 2013, is affirmed insofar as it found the claim compensable, awarded medical benefits and established the average weekly wage. To the extent the ALJ ordered any additional benefits or penalties the order is set aside.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

2/7/2014 by RP .

LISA MARIE HUSKINSON, 10816 MILWAUKEE STREET, NORTHGLENN, CO, 80233 (Claimant)
METRO CONSTRUCTION, INC., Attn: JEROD WEBB RAISCH, 2641 WALNUT STREET, DENVER, CO, 80205 (Employer)
ANDERSON, HEMMAT & MCQUINN, LLC, Attn: ETHAN A. MCQUINN, ESQ., 5613 DTC PARKWAY, SUITE 150, GREENWOOD VILLAGE, CO, 80111 (For Claimant)
WILLIAM HADDEN ZIMMERLING, Attn: WILLIAM HADDEN ZIMMERLING, ESQ., 3200 CHERRY CREEK SOUTH DRIVE, SUITE 660, DENVER, CO, 80209 (For Respondents)
METRO CONSTRUCTION, INC., Attn: JEROD WEBB RAISCH, 1732 WAZEE STREET, SUTIE 205, DENVER, CO, 80202 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-788-773-01

IN THE MATTER OF THE CLAIM OF SALLY A. LUKE, Claimant, v. HOSPITAL SHARED SERVICES, Employer, and ACE AMERICAN INSURANCE COMPANY, Insurer, Respondents.	FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Friend (ALJ) dated July 29, 2013, that denied and dismissed her petition to reopen, her request for a change of physician, and her request for penalties. We affirm.

The claimant sustained a compensable injury on March 12, 2009. The claimant reported that while working, she tripped over a lid to a trash can, lost her balance, fell onto her left side, and struck her head on the trash can. The claimant described pain in her low back and over the left SI joint with resolving pain in her hip, shoulder, and knee. Dr. Chythlook diagnosed lumbar strain without neurologic finding, left hip contusion, left shoulder pain and contusion, and scalp contusion.

Thereafter, the claimant was followed and treated by Drs. Aschberger and Burris. The claimant was diagnosed with a left shoulder impingement and left knee meniscal tear as a result of the compensable injuries.

The claimant was examined by Dr. Burris on January 4, 2010. He stated that the claimant's examination was relatively benign. He diagnosed left knee strain, left shoulder strain, and low back pain. On January 25, 2010, Dr. Burris opined that the claimant had full range of motion in the lumbar spine with no focal findings.

On February 15, 2010, Dr. Aschberger opined that the claimant was at maximum medical improvement (MMI). He opined that the claimant's lumbar range of motion "looks full" consistent with Dr. Brurris' opinion that the claimant had full range of motion in the lumbar spine. Dr. Aschberger rated the claimant's impairment at 14% for the lower extremity for the hip and knee, and 7% impairment at the left upper extremity for the shoulder. He did not rate any impairment to the lumbar spine, consistent with his

and Dr. Burris' opinion that the claimant had full range of motion and no focal findings in the lumbar spine. Dr. Burris examined the claimant again on February 22, 2010. His diagnosis remained left knee strain, left shoulder strain, and low back pain. Dr. Burris placed the claimant at MMI on this date and released her from further care.

On March 5, 2010, the respondents filed a final admission of liability (FAL), admitting liability for medical benefits to that date, temporary total disability benefits, scheduled impairment benefits, and medical care after MMI. The claimant did not object to the FAL, and did not request a Division sponsored independent medical examination (DIME).

On June 1, 2010, the claimant again sought treatment from Dr. Aschberger. The claimant had numerous pain complaints, including increased pain radiating to the left leg, and back and hip pain. The claimant followed up with Dr. Aschberger on August 4, 2010. His assessment was chronic ischial bursitis, and knee pain with bursitis with injection and marginal symptomatic relief. After several more visits with Dr. Ashcberger and several injections for the hip and ischium without significant gains, Dr. Burris did not recommend further injections. Dr. Burris stated that no additional treatment was warranted at that time for her chronic ischial bursitis. He saw no overall change to her MMI status.

For the next two-and-a-half years following MMI, the claimant underwent comprehensive maintenance medical care from Drs. Burris, Aschberger, Zimmerman, Hewitt, and Aspergren. The claimant received left ischial tuberosity corticosteroid injections, physical therapy, topical anti-inflammatories, an intra-articular cortisone injection, viscosupplementation injections, and Lidoderm patches. The claimant also underwent electrical acupuncture in the lower back, left hip, and lower extremity.

As pertinent here, the respondents subsequently sought a records review from Dr. Roth. Dr. Roth did not examine the claimant. The respondent insurer received Dr. Roth's report on July 5, 2012. The respondent insurer, however, did not provide a report to the claimant until August 10, 2012. The respondents circulated Dr. Roth's report to some of the claimant's treating physicians and requested their opinions.

The claimant followed up with Dr. Burris on July 18, 2012. Dr. Burris opined that the claimant underwent comprehensive conservative care, and based on the original mechanism of injury, her workup, and her response to treatment, it was difficult for him to relate her continued complaints to the industrial accident. Dr. Burris further opined that the claimant reached MMI on February 22, 2010, and her continued treatment was not reasonable or necessary for her original work injury.

The claimant followed up with Dr. Aschberger on September 6, 2012. Dr. Aschberger noted that the claimant had no lasting gains from injections other than the injections to the knee. He opined that he saw no change in the date of MMI.

Thereafter, on September 12, 2012, the respondents wrote a letter to Dr. Aschberger advising him that the respondent insurer declined to authorize any additional medical treatment. In the letter, the respondents noted that Dr. Aschberger previously had indicated he would not be recommending any additional maintenance treatment.

Subsequently, on October 15, 2012, the claimant sought care from Dr. Yamamoto. Dr. Yamamoto opined that the claimant needs treatment for low back pain that had not been adequately addressed, likely needs surgery for a strain of the rotator cuff capsule, may need a left knee replacement for osteoarthrosis, may have a labral tear of the left hip, and needs further treatment and possible surgery for coccydynia. In his report, Dr. Yamamoto related the claimant's need for treatment to the compensable injury and opined that the claimant was not at MMI. Dr. Yamamoto later opined that the claimant's low back was worse than it was before the case was closed, that the claimant had mild major depression, that she needed to continue on Cymbalta, and she needed an MRI arthrogram for her left hip pain.

Thereafter, the claimant filed a petition to reopen her workers' compensation claim based upon a change of condition and/or mistake and attached Dr. Yamamoto's report. The basis for the claimant's petition to reopen was that her authorized providers were mistaken about placing her at MMI on February 22, 2010, and mistaken about her injuries at the time she was placed at MMI. The claimant also filed her application for hearing, listing the following as issues to be heard: medical benefits, authorized provider, petition to reopen, penalties, and a motion to strike Dr. Roth as a witness and motion to strike all evidence based on his reports or opinions. The claimant also sought penalties, alleging, in part, that the respondents failed to exchange Dr. Roth's report in violation of W.C.R.P. 5-4, that Dr. Roth failed to provide his report in violation of §8-43-404(2), C.R.S., and that the respondents failed to provide medical benefits in violation of §8-42-101, C.R.S.

On May 21, 2013, a hearing was held on the claimant's petition to reopen, her request for a change of physician to Dr. Yamamoto, and her request for penalties. As pertinent here, during the hearing, the respondents did not submit the report from Dr. Roth into evidence, and they did not call Dr. Roth to testify at the hearing. The claimant testified at the hearing that she suffered low back pain as a result of her fall, and that her low back pain never has resolved. The claimant further testified that she relied on her treating physicians to determine her condition.

The ALJ subsequently entered his order, denying the claimant's petition to reopen, her request for a change of physician to Dr. Yamamoto, and her request for penalties. The ALJ found that the claimant did not prove her treating providers made a mistake in placing her at MMI in February 2010. Finding Dr. Burris' opinion to be credible and persuasive, the ALJ found that the treatment proposed by Dr. Yamamoto was not related to the compensable injury. The ALJ also concluded that the claimant's

alleged mistake in not objecting to the FAL or requesting a DIME was not the type of mistake that justifies a reopening. The ALJ further concluded that the claimant has received extensive and appropriate maintenance care for her subjective increase in pain, no objective changes have been found, she has not shown surgery is reasonably needed, and she has not shown her claim should be reopened for a worsening of condition. The ALJ did rule, however, that the treatment provided by Drs. Hewitt and Aschberger has been reasonable maintenance care. The ALJ concluded that if the claimant needs additional maintenance treatment for her industrial injury, she should seek treatment from Drs. Hewitt or Aschberger.

To the extent the claimant requested a penalty for the insurer's failure to authorize any further medical care in violation of §8-42-101, C.R.S., the ALJ found the claimant had not shown she was denied any medical care related to the compensable injury. To the extent the claimant requested a penalty under §8-43-404(2)(a), C.R.S. for Dr. Roth's failure to provide her with a copy of his report at the time it was furnished to the insurer, the ALJ found Dr. Roth was not subject to the requirements of the statute. The ALJ found Dr. Roth performed a medical record review and, therefore, was not an "examining physician," he was not a party to the claim, and he was not noticed into the hearing. Further, the ALJ ruled that while the insurer violated "W.C.R.P. 5-4(B)" (mistakenly referred to as "W.C.R.P. 5-4(B)" by the ALJ, which does not apply because this was a lost time claim) by failing to timely provide a copy of Dr. Roth's report to the claimant, the insurer cured the violation by ultimately providing the report to the claimant, and not introducing Dr. Roth's report or testimony from Dr. Roth during the hearing. The ALJ further concluded that there was no evidence demonstrating the respondent insurer's conduct was objectively unreasonable.

I.

On review, the claimant argues that the ALJ erred in denying her petition to reopen. The claimant contends that when she was placed at MMI, she relied upon her treating doctors in terms of what she understood her medical condition to be. The claimant explains that the medical records document extensive treatment for her low back and hip, her persistent symptoms in those areas, and her limited range of motion in those areas. The claimant contends, therefore, that she did not object to the respondents' FAL based upon a mistaken diagnosis and on a mistaken reliance on her treating doctors. Thus, the claimant contends that based on the holding in *Berg v. Industrial Claim Appeals Office*, 128 P.3d 270 (Colo. App. 2005), the ALJ erred in ruling that the claimant's mistake in not requesting a DIME is not the type of mistake that justifies a reopening. We are not persuaded the ALJ erred.

Section 8-43-303(1) C.R.S. authorizes an ALJ to reopen any award within six years after the date of injury on a number of grounds, including error, mistake, or a change in condition. *Heinicke v. Industrial Claim Appeals Office*, 197 P.3d 220 (Colo.

App. 2008); *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). Reopening may be granted based on any mistake of fact which calls into question the propriety of a prior award. Section 8-43-303(1), C.R.S.; *Standard Metals Corp. v. Gallegos*, 781 P.2d 142 (Colo. App. 1989). When a party seeks to reopen based on mistake, the ALJ must determine "whether a mistake was made, and if so, whether it was the type of mistake which justifies reopening." *Travelers Insurance Co. v. Industrial Commission*, 646 P.2d 399, 400 (Colo. App. 1981).

Generally, the authority to reopen a claim under §8-43-303(1), C.R.S., is discretionary with the ALJ. Thus, we may not interfere with the order unless there is fraud or a clear abuse of discretion. *Renz v. Larimer County School District Poudre R-1*, 924 P.2d 1177 (Colo. App. 1996). An abuse is not shown unless the order is beyond the bounds of reason, as where it is unsupported by the law or contrary to the evidence. *See Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). Moreover, the extent to which various causative factors contributed to the claimant's disability or need for medical treatment, is also a question of fact for the ALJ. *See Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999); *Ramirez v. Garfield's Off Broadway*, W.C. No. 4-689-414 (March 13, 2007). We are bound by the ALJ's resolution of factual issues if they are supported by substantial evidence and may not interfere with his assessment of the probative value of the evidence. *See Eisnach v. Industrial Commission*, 633 P.2d 502 (Colo. App. 1981).

The claimant's argument notwithstanding, we perceive no error in the ALJ's determination that there was no mistake in placing her at MMI on February 22, 2010, or no mistake in her diagnosis. Findings of Fact at 6 ¶29; Conclusions of Law at 6-7. In his physician reports and during his deposition, Dr. Aschberger consistently opined that there was no change in the claimant's MMI status, and that he did not see any significant change in her treatment approach that was likely. In his report dated September 6, 2012, Dr. Aschberger opined that the treatment the claimant had received was maintenance treatment for her original injury. Exs. L, M, N, 45; Depo. of Dr. Aschberger at 10-13, 15, 50; Findings of Fact at 5 ¶25. Further, Dr. Aschberger testified that he was able to rule out low back pathology. He also opined that he found no basis for an impairment rating of the spine. Dr. Aschberger also testified that he found no evidence of any pathology within the claimant's hip joint, and no permanent injury to the left hip. Depo. of Dr. Aschberger at 8, 17, 20, 47-49, 76-77, 79. Dr. Burris also testified that the claimant was at MMI as of February 22, 2010. Depo. of Dr. Burris at 14, 18-19, 50. Dr. Burris explained that the claimant has undergone a very comprehensive course of treatment, and that there were no obvious signs of trauma after her trip and fall. He testified that as a result, he would expect a pretty quick recovery. Since the claimant has continued complaints, Dr. Burris testified that he did not believe that these complaints were related to her trip and fall. Depo. of Dr. Burris at 21-22, 28-34. Moreover, the ALJ credited the opinions of Drs. Aschberger and Burris over those of Dr. Yamamoto, which is a matter

within the sole discretion of the finder of fact. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). As such, we may not disturb the ALJ's order on this ground. Section 8-43-301(8), C.R.S.

Further, the claimant's reliance on *Berg* is misplaced. In *Berg*, the Colorado Court of Appeals held the ALJ properly reopened a claim where there was a mistake in the claimant's diagnosis, even though the claimant failed to contest a FAL following a DIME. Contrary to the facts in *Berg*, however, here the ALJ did not find that there was a mistake in the claimant's diagnosis. Rather, the ALJ found, with record support, that the claimant's continuing pain complaints were not related to her industrial injury. Findings of Fact at 6 ¶29; Conclusions of Law at 6-7. Dr. Burris testified that he did not believe that the claimant's mechanism of her industrial injury is the cause of her continued complaints. He opined that the claimant's original mechanism of injury, the lack of obvious signs of trauma after the trip and fall, and the comprehensive course of treatment the claimant underwent, demonstrate that her present complaints are not related to her industrial accident. Depo. of Dr. Burris at 21-22; Ex. I. Section 8-43-301(8), C.R.S.

II.

The claimant next argues that the ALJ erred in denying her request for a change of physician to Dr. Yamamoto. Relying on the holding in *Ruybal v. University Health Sciences Center*, 768 P.2d 1259 (Colo. App. 1988), the claimant contends that the right to select an ATP for further treatment passed to her because the respondents failed to provide reasonable and related medical treatment as of September 2012. Alternatively, the claimant contends that she is entitled to an order authorizing Dr. Yamamoto as her ATP pursuant to the ALJ's discretionary authority under §8-43-404(5)(a)(VI), C.R.S. The claimant explains that she provided evidence that her ATPs no longer were working to make her whole. Again, we are not persuaded that the ALJ erred.

In *Ruybal*, the claimant sustained an industrial injury and notified her employer that she had been injured, but the employer did not offer to provide her with medical treatment. The claimant then sought treatment on her own from her regular physician at a Kaiser facility. The Kaiser physician found the claimant's problem to be stress related and referred her to a mental health therapist within the Kaiser facility. After treatment, however, the Kaiser therapist determined that the claimant's illness was work-related and, therefore, not covered by the Kaiser medical plan. The claimant then obtained a psychological evaluation from Dr. Medelman. The employer ultimately denied liability for the claimant's injury, arguing it did not arise out of and in the course of her employment. An ALJ subsequently found the claimant's injury to be compensable and also found Dr. Medelman an authorized treating physician. On appeal, the Colorado Court of Appeals upheld the ALJ's order. The Court held that the Kaiser therapist never became the claimant's treating physician. Instead, the Kaiser therapist declined to treat the claimant because her treatments were not covered under her Kaiser plan. Thus, the Court

held that the claimant did not fully exercise her right to select her own treating physician until she chose Dr. Medelman. The Court therefore determined the claimant's selection of the psychologist was her initial selection and not a change of physicians.

The claimant's reliance on *Ruybal* is misplaced. Here, unlike in *Ruybal*, the ALJ found that the claimant has undergone a comprehensive course of treatment for her injuries. He further found that Drs. Hewitt and Aschberger had been providing appropriate maintenance treatment for the claimant's injuries. Findings of Fact at 6-7 ¶¶28, 29. The ALJ also found, with record support, that the claimant failed to make a proper showing for a change of physician to Dr. Yamamoto. Conclusions of Law at 7-8. Relying upon Dr. Burris' opinion, the ALJ found and concluded that the treatment proposed by Dr. Yamamoto is not related to the compensable injury. Again, during his deposition, Dr. Burris testified that given the claimant's mechanism of injury he would have expected a pretty quick recovery. Since she has continued pain complaints, however, he did not believe they were related to her trip and fall. Further, Dr. Burris testified that he disagreed with all of the treatments proposed by Dr. Yamamoto. Depo. of Dr. Burris at 21-22, 28-34. Section 8-43-301(8), C.R.S. Thus, we will not disturb the ALJ's order on this ground.

We similarly are not persuaded by the claimant's argument that under §8-43-404(5)(a)(VI), C.R.S., she is entitled to a change of physician to Dr. Yamamoto. Section 8-43-404(5)(a)(VI), C.R.S. allows a claimant to obtain a change of physician by making a written request to the insurer. If the insurer fails to respond to the written request within twenty days, the insurer is deemed to have waived the right to object to the change and the physician selected by the claimant is authorized to treat the injury. *Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996). Here, the claimant has not demonstrated that the respondent insurer failed to respond to a written request within twenty days for a change of physician to Dr. Yamamoto. Nevertheless, we again note that the ALJ also found that Drs. Hewitt and Aschberger had been providing appropriate maintenance treatment for the claimant's injuries, and that the treatment proposed by Dr. Yamamoto was not related to the compensable injury. Findings of Fact at 6-7 ¶¶28, 29. Consequently, we will not disturb the ALJ's order on this ground.

III.

Last, the claimant argues the ALJ erred in denying her request for penalties under W.C.R.P. 5-4, §8-43-404(2), C.R.S., and §8-42-101, C.R.S. Once more, the claimant argues that the respondents failed to timely provide Dr. Roth's report to her in violation of W.C.R.P. 5-4. Additionally, the claimant contends that penalties should be assessed for Dr. Roth's failure to timely provide his report to the claimant in violation of §8-43-404(2), C.R.S. The claimant also contends that the respondents obtained a tactical advantage by circulating Dr. Roth's report to Drs. Burris and Aschberger and then obtaining opinions from them based on Dr. Roth's report before she ever saw it. The

claimant further argues that the respondents violated §8-42-101, C.R.S. by sending a letter to Dr. Aschberger on September 12, 2012, denying further treatment. We are not persuaded that the ALJ erred.

Section 8-43-304(1), C.R.S. allows an ALJ to impose penalties of up to $1000 per day against any party "who violates any provision of articles 40 to 47 of [Title 8], or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director or panel or any judgment or decree made by any court ...." The imposition of penalties under §8-43-304(1), C.R.S., is a two step process. The ALJ must first determine whether the disputed conduct constituted a violation of the Act, of a duty lawfully enjoined, or of an order. If the ALJ finds such a violation, he may impose penalties if he also finds that the actions were objectively unreasonable. *See City Market, Inc. v. Industrial Claim Appeals Office*, 68 P.3d 601 (Colo. App. 2003).

Here, we agree with the ALJ that since the respondents cured their violation, penalties are not warranted for the violation of W.C.R.P. 5-4(A)(5). WC.R.P. 5-4(A)(5), 7 Code Colo. Reg. 1101-3, provides that "[a] copy of every medical report not filed with the Division shall be exchanged with all parties within fifteen (15) working days of receipt." While it is true, as the claimant argues, that the respondent insurer failed to timely provide a copy of Dr. Roth's report to the claimant, this error was cured. The respondents ultimately provided Dr. Roth's report to the claimant on August 10, 2012, and then the respondents did not introduce Dr. Roth's report into evidence during the hearing, and did not call Dr. Roth to testify during the hearing. Tr. at 4-5; Findings of Fact at 6 ¶30. We further note that during Dr. Burris' deposition, he testified that he did not rely upon any conclusions drawn by Dr. Roth about any treatment provided to the claimant after February 2010. He further testified that there was nothing about Dr. Roth's report which influenced his judgment about the treatment provided to the claimant after February 2010. Dr. Burris' deposition at 36-41. In fact, at one point during his deposition, Dr. Aschberger testified that he disagreed with Dr. Roth's opinion regarding relatedness to the industrial injury. Depo. of Dr. Aschberger at 43-44. As such, we are not persuaded to disturb the ALJ's order on these grounds.

Additionally, the claimant's argument notwithstanding, we agree with the ALJ that §8-43-404(2)(a), C.R.S. is inapplicable here. That section provides that an "employee shall be entitled to receive from the examining physician . . . a copy of any report that the physician . . . makes to the employer, insurer, or division upon the examination, and the copy shall be furnished to the employee at the same time it is furnished to the employer, insurer, or division. The employee shall also be entitled to receive reports from any physician selected by the employer to treat the employee upon the same terms and conditions and at the same time the reports are furnished by the physician to the employer." As found by the ALJ, Dr. Roth did not examine or treat the claimant but,

instead, performed a records review. The claimant has failed to point to any evidence demonstrating that the contrary is true. As such, we will not disturb the ALJ's denial of penalties as a result.

To the extent the claimant argues the ALJ erred in denying her claim for penalties under §8-43-304, C.R.S. for the respondents' alleged failure to provide medical benefits in violation of §8-42-101(1)(a), C.R.S., we are not persuaded there was any error. In support of her contention, the claimant relies on the letter sent by the respondents to Dr. Aschberger, which declined to authorize any further maintenance treatment. While §8-42-101(1)(a), C.R.S. does require every employer to furnish medical treatment reasonably necessary at the time of the injury and thereafter during the disability to cure and relieve the claimant from the effects of the injury, the ALJ found that the claimant had not shown she was denied any medical care related to the compensable injury. In either her brief in support or in her proposed findings of fact, the claimant has not stated what specific medical care the respondents failed to provide. *Cf. Larsen v. Archdiocese of Denver*, 631 P.2d 1163 (Colo. App. 1981)(where no formal offer of proof, reviewing court cannot determine without such offer whether or not claimed error is prejudicial). As such, we are not persuaded that there is any error in the ALJ's order on this ground.

IT IS THEREFORE ORDERED that the ALJ's order dated July 29, 2013, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

David G. Kroll

Kris Sanko

Kris Sanko

CERTIFICATE OF MAILING

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

1/30/2014 by RP .

SALLY A. LUKE, 19365 EAST 41ST AVENUE, DENVER, CO, 80249 (Claimant)
HOSPITAL SHARED SERVICES, Attn: SALY MARTINEZ, 900 SOUTH BROADWAY, SUITE 100, DENVER, CO, 80209 (Employer)
ACE AMERICAN INSURANCE COMPANY, Attn: EVELYN RADEMACHER, P O BOX 31082, TAMPA, FL, 33631 (Insurer)
TAUSSIG SCIPIONE, P.C., Attn: JOHN TAUSSIG, ESQ., 5377 MANHATTAN CIRCLE, SUITE 203, BOULDER, CO, 80303 (For Claimant)
NATHAN, BREMER, DUMM & MYERS, P.C., Attn: ANNE SMITH MYERS, ESQ./TIMOTHY R. FIENE, ESQ., 7900 EAST UNION AVENUE, SUITE 600, DENVER, CO, 80237 (For Respondents)
ACE AMERICAN INSURANCE COMPANY, Attn: STEPHEN YOUNG, P O BOX 6569, SCRANTON, PA, 18505-6569 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-905-664-01

IN THE MATTER OF THE CLAIM OF

GILBERT PADILLA,

Claimant,

v.

ORDER

WAL-MART STORES, INC.,

Employer,

and

NEW HAMPSHIRE INSURANCE COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Stuber (ALJ) dated October 3, 2013, that denied and dismissed his claim for compensation and benefits. The claimant contends that the ALJ abused his discretion in denying him the opportunity to present rebuttal evidence during the hearing. We set aside the ALJ's order and remand for further findings and a new order.

The claimant filed a claim for compensation and benefits alleging that he sustained an industrial injury on November 9, 2012, when pulling pallets of product to stock on the store shelves. The claimant did not report any work injury and finished his shift. On November 11, 2012, the claimant sought care at Parkview Hospital emergency room, reporting a history of chronic low back pain with acute gradual worsening over the last several weeks.

On November 12, 2012, the claimant called Dr. Kemling and reported low back pain and confusion. Dr. Kemling admitted the claimant to Parkview Hospital. A brain magnetic resonance image (MRI) showed while matter lesions. A lumbar MRI showed severe degenerative disc disease at L2-3 and moderate degenerative disease at T2-L1 and L3 through L5, as well as spinal stenosis. Dr. Danylchuk also examined the claimant, who reported that he had suffered low back pain for some time and had also suffered a work injury about six years earlier. On November 30, 2012, Dr. Kemling reexamined the claimant who reported a history of back pain that he felt was due to heavy lifting at work.

On December 14, 2012, the claimant filed a claim for compensation and benefits, alleging a November 9, 2012, injury pulling a hand jack. The respondents contested the claimant's claim.

A hearing was held on the issues of compensability and temporary benefits. As pertinent here, during the hearing, the respondents alleged that the claimant did not sustain an acute injury but, rather, suffered from a chronic preexisting degenerative condition. The respondents introduced testimony from their independent medical examiner, Dr. Steinmetz, in support of their position. Dr. Steinmetz testified that based on his review of the claimant's medical records, as well as his physical examination and personal interview of the claimant, it was his opinion that the claimant was suffering from preexisting chronic progressive degenerative changes. Dr. Steinmetz testified that the claimant's claim of a work injury was inconsistent with what the claimant told the physicians at Parkview Medical Center and inconsistent with what the ER records reported.

After Dr. Steinmetz testified, the claimant attempted to introduce the testimony of his wife, Mrs. Padilla, for the purpose of rebutting Dr. Steinmetz's testimony. The claimant made an offer of proof stating that Mrs. Padilla would testify that she was in the Parkview Hospital emergency room with the claimant, and that she heard the claimant tell the emergency room physician that he sustained a work injury on November 9, 2012. The respondents objected to the claimant's wife testifying on the ground that the claimant had not disclosed her as a witness. The respondents specifically asserted that Mrs. Padilla was not listed on any pleadings, she was not listed on the claimant's application for hearing, she was not listed on the response to the application for hearing, and when discovery was conducted and the claimant was asked who would be presented as a witness, Mrs. Padilla was not listed and her testimony was not disclosed. As such, the respondents asserted that allowing Mrs. Padilla to testify would constitute unfair surprise. Tr. at 174. In response, the claimant asserted that Mrs. Padilla was a rebuttal witness, and the claimant's counsel did not "know what they were going to say." The ALJ sustained the objection on the ground that the testimony was not "rebuttal." Tr. at 176.

The ALJ subsequently issued his order, concluding that the claimant failed to prove by a preponderance of the evidence that he suffered an injury on November 9, 2012, arising out of and in the course of his employment. The ALJ concluded that the claimant's back pain was the result of his significant preexisting degenerative changes in his lumbar spine rather than from an accidental work injury. The ALJ specifically noted that Dr. Steinmetz based his opinion, in part, on the claimant's prior medical records which made no reference to a work injury or a back injury while pulling a pallet while at work. Additionally, the ALJ found that while the claimant appeared to be an honest person, as testified to by the store manager, his memory problems did not "instill any confidence in the trier-of-fact that claimant's allegations are accurate about a November

9, 2012, accident." Findings of Fact at 5-6 ¶29. Consequently, the ALJ denied and dismissed the claimant's claim for compensation and benefits.

On review, the claimant argues that the ALJ abused his discretion in preventing him from presenting the rebuttal testimony of his wife. The claimant contends that the substance of his wife's testimony directly contradicted the respondents' theory of the case, which is that he did not sustain a work injury on November 9, 2012.

An ALJ has wide discretion to control the course of a hearing and make evidentiary rulings. Section 8-43-207(1)(c), C.R.S.; *IPMC Transportation Co. v. Industrial Claim Appeals Office*, 753 P.2d 803 (Colo. App. 1988). We may not interfere with the ALJ's evidentiary rulings in the absence of an abuse of discretion. *In re Marriage of Antuna*, 8 P.3d 589 (Colo. App. 2000); *Denver Symphony Ass'n v. Industrial Commission*, 34 Colo. App. 343, 526 P.2d 685 (1974). The appellate standard on review of an alleged abuse of discretion is whether the ALJ's order exceeds the bounds of reason, as where it is contrary to the applicable law or unsupported by the evidence. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993); *Rosenberg v. Board of Education of School District # 1*, 710 P.2d 1095 (Colo. 1985). Further, the party challenging the exclusion of evidence as an abuse of discretion must show sufficient prejudice before it is reversible error. *Williamson v. School District No. 2*, 695 P.2d 1173 (Colo. App. 1984).

Rebuttal evidence "may take a variety of forms, including any competent evidence which explains, refutes, counteracts, or disproves the evidence put on by the other party, even if the rebuttal evidence also tends to support the party's case-in-chief." *Warden v. Exempla, Inc*., 291 P.3d 30, 35 (Colo. 2012)(quoting *People v. Welsh*, 80 P.3d 296, 304 (Colo.2003)). Thus, such testimony may be admitted in rebuttal even if it might have supported the proponent's case in chief. *People v. Lewis*, 180 Colo. 423, 506 P.2d 125 (1973). The party offering rebuttal evidence "must demonstrate that the evidence is relevant to rebut a specific claim, theory, witness or other evidence of the adverse party." *v. Welsh*, 80 P.3d 296, 304 (Colo.2003). Consequently, Colorado evidentiary rules afford a party presenting rebuttal evidence significant leeway so long as the evidence rebuts some portion of an opposing party's claim. *Id.*

Section 8-43-301(8), C.R.S. provides that we have authority to set aside an ALJ's order only where the findings of fact are not sufficient to permit appellate review, conflicts in the evidence are not resolved, the findings of fact are not supported by the evidence, the findings of fact do not support the order, or the award or denial of benefits is not supported by applicable law.

Here, while it is clear that the ALJ has wide discretion to control the course of a hearing and make evidentiary rulings, we have authority to set aside an ALJ's order where the findings of fact are not sufficient to permit appellate review. Section 8-43-301(8), C.R.S. We conclude that the ALJ's oral ruling regarding Mrs. Padilla's proffered

testimony is insufficient to permit appellate review. The ALJ summarily ruled that the proffered testimony from Mrs. Padilla was not rebuttal evidence, but the factual basis for the ALJ's ruling in this regard was not stated. While there may be evidence in the record from which the ALJ could infer that the proffered testimony was case-in-chief evidence, there also is evidence that the ALJ could rule that the proffered evidence was rebuttal evidence. The ALJ's oral ruling does not indicate what, if any, evidence or basis that was relied upon in reaching this conclusion. Under these circumstances, therefore, we conclude that it is necessary to set aside the ALJ's order and remand for further findings and a new order regarding the proffered testimony from Mrs. Padilla. Section 8-43-301(8), C.R.S.

Our order should not be read as requiring the ALJ to allow the testimony should he ultimately determine the claimant's wife is a true rebuttal witness. The ALJ, of course, could exercise his discretion and determine whether or not to permit the testimony. *In re Marriage of Antuna, supra* (Colo. App. 2000)(admission of rebuttal testimony is within discretion of the trial judge); *IMPC Transportation Co. v. Industrial Claim Appeals Office, supra.*

IT IS THEREFORE ORDERED that the ALJ's order dated October 3, 2013, is set aside and remanded for further findings and a new order.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Brandee DeFalco-Galvin

Kris Sanko

Kris Sanko

CERTIFICATE OF MAILING

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

_____ 2/12/2014 _____ by _____ KG _____ .

GILBERT PADILLA, 3205 TUCCI LANE, PUEBLO, CO, 81005 (Claimant)
WAL-MART STORES, INC., Attn: GLORIA OJADA, 78 N MCCULLOCH BLVD., PUEBLO WEST, CO, 81007 (Employer)
NEW HAMPSHIRE INSURANCE COMPANY, Attn: SARAH WICKHAM/KIMBERLY HARRINGTON, C/O: % CLAIMS MANAGEMENT INCORPORATED, P O BOX 1288, BENTONVILLE, AR, 72712 (Insurer)
STEVEN U. MULLENS, P.C., Attn: ROBERT W. TURNER, ESQ., 105 EAST MORENO AVENUE, COLORADO SPRINGS, CO, 80901-2940 (For Claimant)
CLIFTON & BOVARNICK, P.C., Attn: JOHN M. ABRAHAM, ESQ., 789 SHERMAN STREET, SUITE 500, DENVER, CO, 80203 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-318-938-03

IN THE MATTER OF THE CLAIM OF RAYMOND SNELL, Claimant, v. CITY AND COUNTY OF DENVER, Employer, and SELF-INSURED, Insurer, Respondents.	ORDER

The claimant seeks review of an order of Administrative Law Judge Friend (ALJ) granting the respondent's motion for summary judgment dated October 2, 2013, that dismissed the claimant's claim for benefits. We set aside the order and remand the matter for further proceedings.

The claimant in this matter filed a Worker's Claim for Compensation on December 10, 1996. The projected date of injury is stated to be May 18, 1981. The date of injury is not entirely clear because the description of the injury asserts: "I was a police officer from 10-16-1973 for the city of Denver. I have no idea when I developed a mental disorder after my employment." The last day the claimant states he worked for the City of Denver is May 18, 1981. The respondent filed a Notice of Contest on December 30, 1996. The claimant submitted an application for a hearing on April 30, 2013. The application endorsed for hearing the issues of compensability, medical benefits, temporary benefits from May, 1981, the average weekly wage, permanent total disability benefits, a penalty claim, reopening and additional issues.

A hearing was scheduled for October 7, 2013. However, the respondent requested the ALJ to order a summary judgment. The respondent's motion contended the claimant had filed a handful of claims all asserting the same or similar issues. Listed were claims featuring a date of injury on January 1, 1979, alleging mental stress, January 1, 1981, for hypertension and anxiety, February 9, 1981, related to hypertension and April 1, 1981, referencing an injury to kidneys, blood pressure and hypertension and a claim alleging a penalty for the improper disclosure of a medical report on January 1, 1981. The respondent specified in its motion the 1979 claim was settled and the January, 1981,

penalty claim was denied by the ALJ and that order was affirmed by the Industrial Claim Appeals Office (ICAO). The respondent also attaches to its motion documents revealing the adjudication and dismissal of the January 1, 1981, and February 9, 1981, claims based on hypertension. Both orders of the ALJ dismissing the claims were appealed to the ICAO and the dismissals were affirmed.

The respondent then argued in its motion for summary judgment that the claim in the present matter had been decided adversely to the claimant because it presented the same issue as those in the January 1, 1981 and February 9, 1981 claims. The respondent reasoned the present claim is barred by the doctrine of issue preclusion and the statute of limitations has run preventing the claim's reopening. The ALJ agreed. The ALJ referred to case law which set forth the four elements necessary to establish issue preclusion due to the previous adjudication of an issue. There must be (1) finality of the prior adjudication, (2) an identity of subject matter, (3) an identity of claims for relief, and (4) identity or privity among the parties. *Holnam v. Industrial Claim Appeals Office*, 159 P.3d 795 (Colo. App. 2006). The ALJ observed that on the basis of the respondent's motion and its attachments, all four elements had been shown. Accordingly, the ALJ deemed the claim was barred by the doctrine of claim preclusion.

On appeal, the respondent reiterates the argument presented in its motion for summary judgment. The claimant appears and is unrepresented as he has been throughout the proceedings in this claim. Unfortunately, his arguments are unfocused and it is difficult to discern a pertinent response to the respondent's summary judgment motion. However, we conclude the motion does not establish sufficiently that the subject matter and the claims for relief in the present claim share an identity with the previously decided matters.

Office of Administrative Courts Rule of Procedure Rule (OACRP) 17, allows an ALJ to enter summary judgment where there are no disputed issues of material fact. *See* Office of Administrative Courts Rule of Procedure (OACRP) 17, 1 Code Colo. Reg. 104-3 at 7. Moreover, to the extent that it does not conflict with OACRP 17, C.R.C.P. 56 also applies in workers' compensation proceedings. *Fera v. Industrial Claim Appeals Office*, 169 P.3d 231 (Colo. App. 2007); *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988)(the Colorado rules of civil procedure apply insofar as they are not inconsistent with the procedural or statutory provisions of the Act).

Summary judgment is a drastic remedy and is not warranted unless the moving party demonstrates that it is entitled to judgment as a matter of law. *Van Alstyne v. Housing Authority of Pueblo*, 985 P.2d 97 (Colo. App. 1999). All doubts as to the existence of disputed facts must be resolved against the moving party, and the party against whom judgment is to be entered is entitled to all favorable inferences that may be

drawn from the facts. *Kaiser Foundation Health Plan v. Sharp*, 741 P.2d 714 (Colo. App. 1987). However, once the moving party establishes that no material fact is in dispute, the burden of proving the existence of a factual dispute shifts to the opposing party. The failure of the opposing party to satisfy its burden entitles the moving party to summary judgment. *Gifford v. City of Colorado Springs*, 815 P.2d 1008 (Colo. App. 1991).

In the context of summary judgment, we review the ALJ's legal conclusions de novo. *See A.C. Excavating v. Yacht Club II Homeowners Association*, 114 P.3d 862 (Colo. 2005). Pursuant to §8-43-301(8), C.R.S., we only have authority to set aside an ALJ's order where the findings of fact are not sufficient to permit appellate review, conflicts in the evidence are not resolved, the findings of fact are not supported by the evidence, the findings of fact do not support the order, or the award or denial of benefits is not supported by applicable law.

In paragraph 15 of the ALJ's findings of fact, the ALJ concludes:

> 15. The claim for relief in both the January 1, 1981 and February 9, 1981 claims dealt with compensability of claimant's hypertension, which he alleged was caused by his employment with Respondent. The subject matter of the present claim is compensability of claimant's hypertension, which he alleges was caused by his employment with Respondent. This shows identity of claims for relief, satisfying the third element of claim preclusion.

However, as noted above, the Worker's Claim for Benefits in this matter alleges "I have no idea when I developed a mental disorder after my employment." Whereas there may possibly be some overlap of hypertension with a mental disorder, it is impossible to discern if that overlap exists in this matter given that we are limited to the motion for summary judgment and the arguments submitted on appeal. The claimant's arguments are diffuse and mostly distinct from the topic at hand. Nonetheless, he does not admit that his claim does not include a mental disorder or that it pertains to hypertension.

In *Holnam*, *supra*, the claimant sustained a shoulder injury. He asserted his injury also affected his cervical spine. When an ALJ ruled the cervical area was not involved in the original work injury, the claimant brought a second claim alleging the cervical spine was injured while performing modified duty after the shoulder injury and due to over compensation for the limited use of his shoulder. The Court of Appeals determined both

claims were dealing with the same injury. The Court reasoned "the same claim or cause of action requirement is bounded by the injury for which relief is demanded, and not by the legal theory on which the person asserting the claim relies." *Holnam* at 798. In *Holnam* the claimant sought in both claims compensability for a cervical injury in conjunction with the same shoulder injury. In this matter the earlier claim includes a hypertension condition while the latter is a personality disorder. The record contains no evidence linking one to the other. Given the limited description of the two injuries, they do not appear to be the same injury 'for which relief is requested.'

One of the documents attached to the motion for summary judgment is the November 13, 1996, decision of the ICAO affirming the ALJ's dismissal of the February 9, 1981, claim pertaining to the claimant's hypertension. In that decision the panel discussed the argument between the parties as to how to analyze a May 20, 1981, medical report from Dr. Harris. In the report, the doctor related how the claimant suffered from "uncontrolled hypertension." Dr. Harris then also stated there was a "possibility" the claimant was afflicted by a "personality disorder … in view of his anxiety resulting from job related activities." In the ALJ's order being reviewed, the ALJ had found that "Dr. Harris did not comment on any possible source to the uncontrolled hypertension." The panel agreed "the ALJ was not compelled to infer that Dr. Harris was drawing any correlation between the claimant's hypertension and the 'possibility' of a personality disorder." As a result, the ALJ was inferred to be noting that hypertension and the suspected personality disorder were not related to each other. This inference by the ALJ at that point belies the assumption that the earlier dismissal of the claimant's claims served as a dismissal of the current claim involving the mental disorder. The record pertinent to the motion for summary judgment does not establish an identity of claims or subject matter.

The claimant's arguments contain references to his wish to reopen his previously settled claim, to a penalty request alleging the tardy filing of a claim with the Division by the respondent, to fraud and alleged discrimination and to several additional grievances. Many of those assertions may indeed be found to have previously been decided or to be untimely raised. We strongly urge the claimant to consult with an attorney to assist him in organizing his claim. However, to the extent the ALJ's order for summary judgment dismissed the claimant's entire claim at this juncture, it is not supported by substantial evidence in the record. We therefore set aside the order for summary judgment dismissing the claim and remand the matter to the Office of Administrative Courts for further proceedings.

IT IS THEREFORE ORDERED that the ALJ's order issued October 2, 2013, is set aside and remanded for further proceedings.

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

2/6/2014 by KG .

RAYMOND SNELL, 636 KITTREDGE STREET, AURORA, CO, 80011 (Claimant)
CITY AND COUNTY OF DENVER, Attn: ASSISTANT CITY ATTORNEY, C/O: MICHELLE S. SISK, ESQ., 201 WEST COLFAX AVENUE DEPT 1108, DENVER, CO, 80202 (Employer)
CITY AND COUNTY OF DENVER, Attn: CLAIMS ADJUSTER, 201 WEST COLFAX AVENUE DEPT 1105, DENVER, CO, 80202 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-748-106-02

IN THE MATTER OF THE CLAIM OF

CHUN CHA TEEGARDIN,

Claimant,

v.

FINAL ORDER

J.C. PENNEY COMPANY,

Employer,

and

AMERICAN HOME ASSURANCE COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Walsh (ALJ) dated August 22, 2013, that denied and dismissed her request for penalties and attorney fees and costs. The respondents seek review of ALJ Walsh's order that denied and dismissed their request for attorney fees and costs. We affirm.

ALJ Walsh found that the claimant was working for the respondent employer as a hairdresser when she suffered an admitted injury to her right shoulder on December 24, 2007. Dr. Pak was the claimant's authorized treating physician and eventually placed the claimant at maximum medical improvement (MMI) on April 1, 2009.

Dr. McBride subsequently performed a Division Independent Medical Examination (DIME) on September 21, 2009. In his report, Dr. McBride listed the claimant's chief complaints as left shoulder pain and right shoulder pain, as well as other pain. Dr. McBride opined that the claimant's left shoulder pain was not related to her workers' compensation injury. Dr. McBride agreed with Dr. Pak that maintenance physical therapy should be performed for the next year for the claimant's right shoulder.

The respondents filed a revised final admission of liability (FAL) on October 14, 2009, admitting for ongoing future medical care to the right shoulder only. The respondent insurer's adjuster, Ron Camerino, denied treatment for the left shoulder based on the DIME opinion that it was unrelated to the work injury. Dr. Pak provided maintenance medical treatment to the claimant following MMI.

During and after January 2011, the claimant concurrently was being seen at Peak Vista Community Health Center (Peak Vista) for unrelated treatment. As of January 2011, there was no referral from Dr. Pak to Peak Vista and no recommendation that the claimant needed Cyclobenzaprine to treat her work related right shoulder injury.

On January 14, 2011, Dr. Pak evaluated the claimant's ongoing symptoms in her right shoulder. Dr. Pak recommended Celebrex and six physical therapy session. He noted that the claimant showed improvement while on Lidoderm. On January 21, 2011, the respondent insurer received a prescription from Dr. Pak for 20 tablets of Lidoderm. The respondents authorized the prescription.

In November 2011, the respondent insurer received a prescription for Lidoderm patches from Peak Vista and Nurse Practitioner Eileen Johnson. The prescription was authorized by the respondent insurer. Subsequently, the respondent insurer received a request for water therapy from NP Johnson. The respondent insurer denied the water therapy because NP Johnson and Peak Vista were not within the chain of referral and not authorized to treat, and there was no medical documentation supporting that the request was reasonable, necessary, or work related. At the time it denied the request, the respondent insurer was unaware of any referrals from Dr. Pak to Peak Vista.

On January 6, 2012, the respondent insurer denied a prescription from NP Johnson for Cyclobenzaprine. The prescription was denied because NP Johnson was not an authorized provider. There was no documentation showing the request for authorization or why the Cyclobenzaprine was reasonable, necessary, and related to the work injury.

Thereafter, on February 1, 2012, the claimant's husband sent an email to the respondents' counsel stating his wife had injured both her left and her right shoulder in the industrial accident. He stated that Dr. Pak had referred his wife to her "family [p]ractitioner," and that the respondent insurer denied treatment with Dr. Pak. The claimant's husband requested an evaluation with Dr. Pak to evaluate the claimant's right shoulder. The respondents' counsel responded stating that the claimant's family physician was outside the chain of referral and not authorized to treat. The respondents' counsel requested any written past referrals from Dr. Pak to her family physician. The response also noted that no request for authorization of care or prescriptions had been received from Dr. Pak's office and that treatment for the unrelated left shoulder would be denied. The respondents, however, immediately scheduled a demand appointment with Dr. Pak for the earliest date available, March 20, 2012. Neither the claimant nor her husband provided any past referrals to Peak Vista or NP Johnson, and there are no records supporting a past referral.

Subsequently, on February 9, 2012, Dr. Pak drafted a "[t]o whom it may concern" letter and generically referred the claimant to her "[p]rimary care physician" for prescription refills. The letter never provided a specific referral to Peak Vista or to NP Johnson, and also did not state what body part was to be treated and/or the medical necessity of the treatment. At the time Dr. Pak drafted his generic referral letter, he had not examined the claimant since January 14, 2011.

Thereafter, on February 21, 2012, the respondents filed an application for hearing, listing medical benefits, authorized provider, and reasonably necessary as issues to be heard. At this time, the respondents did not know who the claimant's family physician was or the body part that was to be treated.

On March 8, 2012, the respondents sent correspondence to Dr. Pak, and copied the claimant, stating that it was their understanding that no further care to the right shoulder was needed based on his last report and based on the report from the DIME physician, Dr. McBride. The correspondence also stated that Dr. Pak's letter did not provide any basis as to why the referral and prescriptions were related to the work injury. The correspondence notified Dr. Pak that the referral would be denied because the issue was going to hearing.

On March 20, 2012, Dr. Pak evaluated the claimant. Dr. Pak never stated that the claimant would need to be treated with Peak Vista or NP Johnson. On May 3, 2012, Dr. Pak then referred the claimant to Dr. Jenks, which was authorized by the respondent insurer. In June 2012, Dr. Jenks wrote a prescription for Lidoderm patches that was authorized by the respondents and filled by the claimant.

On August 8, 2012, a hearing was held before ALJ Henk on reasonable and necessary medical benefits, and whether Peak Vista was an authorized provider. During the hearing, the claimant raised the issue of whether all issues listed in the respondents' February 21, 2012, application for hearing were ripe. ALJ Henk concluded that the hearing could go forward on all issues. After hearing, ALJ Henk issued her summary order finding that on February 9, 2012, Dr. Pak referred the claimant to her primary care physician for prescription refills for her admitted right shoulder work related injury. ALJ Henk held that Dr. Pak's referral to the claimant's primary care physician for medication maintenance was within the normal chain of referral. ALJ Henk held that since the claimant's primary care physician at this time was Peak Vista, then Peak Vista was an authorized treating provider. ALJ Henk also found that the treatment at Peak Vista for prescription refills was reasonable and necessary, and related to the industrial injury.

Subsequently, on February 4, 2013, the claimant filed an application for hearing listing as issues to be heard penalties for the failure to provide reasonable and necessary

medical benefits, penalties for the dictation of care, and attorney fees and costs for the claimant's preparing for the hearing in front of ALJ Henk on August 8, 2012. The claimant specifically asserted that the respondents violated §8-42-101(1)(a), C.R.S. by refusing to provide medical care from February 9, 2012, through June 18, 2012. The claimant stated that the respondents were aware when she received her prescription for Lidoderm patches in November 2011, that the prescription was written for two additional refills. The claimant stated that one of the refills would have covered the date of February 9, 2012, but this refill was refused by the respondents. Consequently, the claimant asserted that between the dates of February 9, 2012, and June 18, 2012, she was without medical care for her work injury. Additionally, the claimant argued that the respondents violated §8-43-503(3), C.R.S. by dictating medical care to Dr. Pak as of the date of their letter of March 8, 2012, through June 17, 2012. The claimant asserted that in this letter the respondents announced that the treatment recommended by the claimant's primary physician would not be authorized even though Dr. Pak already made a written referral for that treatment.

On February 9, 2013, the respondents filed their response to the claimant's application for hearing, seeking attorney fees and costs for the claimant's endorsement of an unripe issue. For purposes of their request for attorney fees and costs, the respondents contended that ALJ Henk allowed the hearing before her to go forward on all issues, and that this was so after claimant's counsel raised the issue of ripeness in front of her. The respondents argued that the claimant did not appeal ALJ Henk's decision after receiving her order. The respondents further argued that the claimant did not seek attorney fees or costs at the time of the hearing in front of ALJ Henk, and the claimant should not be allowed to seek them after the fact in front of ALJ Walsh.

After hearing, ALJ Walsh denied and dismissed the claimant's request for penalties, attorney fees, and costs and also denied the respondents' request for attorney fees and costs. ALJ Walsh found that the claimant failed to establish it was more likely than not that the respondent insurer violated §8-42-101(1)(a), C.R.S. by failing to furnish medical benefits or dictating medical care in violation of §8-43-503(3), C.R.S. ALJ Walsh also found that based on the totality of the circumstances, the respondent insurer acted in an objectively reasonable manner. ALJ Walsh further found that the claimant and the respondents failed to establish it was more likely than not that their applications for hearing contained issues that were not ripe for hearing at the time of the filing. The claimant and the respondents have appealed ALJ Walsh's order.

I.

On review, the claimant reiterates her argument that the respondents failed to furnish medical benefits in violation of §8-42-101(1)(a), C.R.S. when they did not refill her prescriptions from Peak Vista. The claimant further argues that the respondents

dictated medical care in violation of §8-43-503(3), C.R.S. when they denied Dr. Pak's referral of the claimant to her primary care physician. The claimant contends that ALJ Walsh erred in crediting the respondents' assertions that they did not know who Dr. Pak was referring the claimant to for maintenance care, and they did not know what body parts the referral was intended to cover. The claimant also asserts that ALJ Walsh erred in denying her request for attorney fees and costs under §8-43-211(2)(d), C.R.S. The claimant alleges that at the time the respondents filed their application for hearing, they endorsed the issues of reasonable and necessary medical benefits and authorized provider, and those issues were not ripe. The claimant again argues that Dr. Pak referred her to her primary care provider, Peak Vista, and once a referral is made that physician is authorized as a matter of law. Consequently, the claimant argues that ALJ Walsh's order must be set aside, and the case remanded for a determination of the amount of penalties under §8-43-304(1), C.R.S. and attorney fees and costs under §8-43-211(2)(d), C.R.S.

A.

We are not persuaded by the claimant's argument that penalties are warranted under §8-43-304(1), C.R.S. for the alleged failure to furnish medical benefits in violation of §8-42-101(1)(a), C.R.S. when the respondents did not refill her Peak Vista prescriptions.

Section 8-42-101(1)(a), C.R.S. provides as follows:

> Every employer, regardless of said employer's method of insurance, shall furnish such medical, surgical, dental, nursing, and hospital treatment, medical, hospital, and surgical supplies, crutches, and apparatus as may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee from the effects of the injury.

Additionally, as pertinent here, §8-43-304(1), C.R.S., allows an ALJ to impose penalties of up to $1000 per day against any party "who violates any provision of articles 40 to 47 of [Title 8], or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director or panel or any judgment or decree made by any court ...." The imposition of penalties under §8-43-304(1), C.R.S., is a two step process. The ALJ must first determine whether the disputed conduct constituted a violation of the Act, of a duty lawfully enjoined, or of an order. If the ALJ finds such a violation, he may impose penalties if he also finds that the actions were objectively unreasonable. *See City Market, Inc. v. Industrial Claim Appeals Office*, 68 P.3d 601 (Colo. App. 2003).

Here, the claimant correctly argues that when an authorized treating physician refers a claimant to another health care provider, the treatment rendered by the referred provider is compensable as part of the legal chain of authorization. *See Mason Jar Restaurant v. Industrial Claim Appeals Office*, 862 P.2d 1026, 1029 (Colo. App. 1993); *Greager v. Industrial Comm'n*, 701 P.2d 168 (Colo. App.1985). But, this is not what ALJ Walsh found here. Instead, ALJ Walsh found, with record support, that the respondents' decision to deny Peak Vista's prescription refills was based upon a reasonable belief that there was no referral to Peak Vista and that Peak Vista, therefore, was not an authorized provider. The claimant's argument notwithstanding, we agree with ALJ Walsh that Dr. Pak's referral was generic, and it did not list or mention either Peak Vista or NP Johnson. Findings of Fact at 5 ¶12; Ex. Q at 251. Section 8-43-301(8), C.R.S.

Further, while the respondent insurer's adjuster, Mr. Camerino, most certainly gave conflicting testimony during his deposition and during the hearing regarding Dr. Pak's referral, ALJ Walsh ultimately credited Mr. Camerino's testimony that he did not know who the claimant's primary care physician was, and that there was no referral from Dr. Pak to Peak Vista or NP Johnson. ALJ Walsh also credited Mr. Camerino's testimony that he did not know which body part Dr. Pak's referral was intending to cover. Mr. Camerino testified that he questioned why Dr. Pak's referral occurred because he believed that the claimant may have been attempting to treat for her unrelated left shoulder. Findings of Fact at 4-5 ¶¶10, 15; Tr. at 51-52, 54-55, 57-59, 61-64, 74, 76, 78-80. Section 8-43-301(8), C.R.S. To the extent the claimant cites to conflicting testimony from Mr. Camerino and argues for a different result, it was well within ALJ Walsh's authority to resolve the conflict by crediting part of the testimony, as he clearly did here. *See Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968).

It also is important to note that ALJ Walsh also credited Dr. Pak's prior hearing testimony that while he did not recall the circumstances of his February 9, 2012, generic referral, he did not normally refer claimants to Peak Vista for pain management treatment. Dr. Pak testified that he instead usually refers claimants to other physicians, including Dr. Jenks. Findings of Fact at 6-7 ¶23; Aug. 8, 2012, Hearing Tr. at 24-27. We agree with ALJ Walsh's conclusion that given the totality of the circumstances, including the lack of communication from Dr. Pak concerning his referral, the respondents acted in an objectively reasonable manner. We further add that an admission of liability for the payment of ongoing medical benefits after MMI does not amount to an admission that all subsequent medical treatment is causally related to the industrial injury, or that all subsequent treatment is reasonable and necessary. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). Even if the respondents are obligated by admission to pay ongoing medical benefits after MMI, they always remain free to challenge the cause of the need for continuing treatment and the reasonableness and

necessity of specific treatments. *Hanna v. Print Expediters Inc.* 77 P.3d 863 (Colo. App. 2003); *Davis v. ABC Moulding*, W.C. No. 3-970-332 (September 19, 1999). Thus, under these circumstances, we will not disturb ALJ Walsh's denial of penalties under §8-43-304(1), C.R.S. based on the respondents' alleged failure to furnish medical benefits under §8-42-101(1)(a), C.R.S. *See City Market, Inc. v. Industrial Claim Appeals Office, supra*.

Finally, we note that in a preamble section to his order, ALJ Walsh concluded that the claimant was precluded by the statute of limitation in §8-43-304(5), C.R.S, from pursuing a penalty more than one year after the respondents denied the Lidoderm prescription refill request by NP Johnson on January 9, 2012. The claimant's request for a penalty premised on that denial was first included in her application for a hearing dated February 4, 2013. Because the one year limitations period runs from the date a party first knows or reasonably should know the facts giving rise to a possible penalty, this penalty claim, as the ALJ observed, would be barred by the statute of limitations. *Spracklin v. Industrial Claim Appeals Office*, 66 P.3d 176, 178 (Colo. App. 2002).

B.

We similarly are not persuaded by the claimant's argument that she is entitled to penalties under §8-43-304(1), C.R.S. for the alleged dictation of medical care in violation of §8-43-503(3), C.R.S. when the respondents denied Dr. Pak's referral of the claimant to her primary care physician.

Section 8-43-503(3), C.R.S. provides in pertinent part as follows:

> Employers, insurers, claimants, or their representatives shall not dictate to any physician the type or duration of treatment or degree of physical impairment. Nothing in this subsection (3) shall be construed to abrogate any managed care or cost containment measures authorized in articles 40 to 47 of this title.

The burden of showing that penalties are warranted was upon the claimant, and whether she met that burden is generally a factual question for resolution by the ALJ. We must uphold the ALJ's determination if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; *Coven v. Industrial Commission*, 694 P.2d 366 (Colo. App. 1984). Substantial evidence is probative evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding, without regard to the existence of contradictory testimony or contrary inferences. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). The substantial evidence standard requires that we view evidence in the light most favorable to the prevailing party, and defer to the ALJ's assessment of the sufficiency and probative weight of the evidence.

Thus, the scope of our review under the substantial evidence standard is "exceedingly narrow." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 2003).

Here, the claimant's argument notwithstanding, we agree with ALJ Walsh that the respondents' March 8, 2012, letter to Dr. Pak did not have the intent or effect of dictating medical care. Neither the respondents' letter nor the record contains probative evidence demonstrating that the respondents ordered or directed Dr. Pak to engage in a specific course of conduct. Instead, the respondents' letter to Dr. Pak questioned the referral based on the DIME report, and also questioned whether the referral was related to the work injury or instead was related to treatment of the left shoulder. The letter stated that the respondents were unsure of why the referral was made to the claimant's primary care physician and whether it is related to the industrial injury. Ex. K at 82-83. Similarly, the record lacks evidence demonstrating that Dr. Pak was influenced or compelled to engage in a specific course of conduct or treatment because of the respondents' letter or actions. There is no evidence in the record to support that treatment was denied because of the respondents' actions or letter. In fact, after the respondents sent their March 8, 2012, letter to Dr. Pak, Dr. Pak continued to recommend ongoing maintenance treatment of the claimant's right shoulder, and he referred the claimant to Dr. Jenks for pain management of her right shoulder. Ex. L at 93-94.

Additionally, our review of the record supports ALJ's Walsh's conclusion that given the totality of the circumstances, including the lack of communication from Dr. Pak concerning his referral, the respondents acted in an objectively reasonable manner. Again, ALJ Walsh found, with record support, that Dr. Pak's letter was generic, it never provided a specific referral to Peak Vista or to NP Johnson, and it also did not state what body part was to be treated and/or the medical necessity of the treatment. Ex. Q at 251. Section 8-43-301(8), C.R.S. As noted above, the respondents always remain free to challenge the cause of the need for continuing treatment and the reasonableness and necessity of specific treatments. *Hanna v. Print Expediters Inc., supra*; *Davis v. ABC Moulding*, *supra.* We further note that at the time Dr. Pak drafted his generic referral letter dated February 9, 2012, he had not examined the claimant for over one year, or since January 14, 2011. Hearing on 8/8/12 at 23. Consequently, ALJ Walsh's analysis of the March 8, 2012, letter and plausible inferences drawn from the record support a determination that the respondents did not dictate to Dr. Pak the type or duration of treatment to be provided in violation of §8-43-503(3), C.R.S. Thus, we are not persuaded to interfere with ALJ Walsh's denial of penalties under §8-43-304(1), C.R.S. for the respondents' alleged dictation of medical care.

C.

The claimant also appeals ALJ Walsh's denial of her request for attorney fees and costs under §8-43-211(2)(d), C.R.S. The claimant alleges that at the time the respondents

filed their application for hearing, they endorsed the unripe issues of reasonable and necessary medical benefits and authorized provider. The claimant again argues that Dr. Pak referred her to her primary care provider, and once a referral is made, that physician is authorized as a matter of law. We are not persuaded that ALJ Walsh erred.

Section 8-43-211(2)(d), C.R.S., provides "if any person requests a hearing or files a notice to set a hearing on issues which are not ripe for adjudication at the time such request or filing is made, such person shall be assessed the reasonable attorney fees and costs of the opposing party in preparing for such hearing or setting." An issue is not "ripe for adjudication" if, under the statutory scheme, there is a legal impediment to its resolution. *See BCW Enterprises, LTD v. Industrial Claim Appeals Office*, 964 P.2d 533 (Colo. App. 1997). Whether an issue is ripe for review is a legal question that an appellate court reviews *de novo*. *See Youngs v. Industrial Claim Appeals Office*, 297 P.3d 964 (Colo. App. 2012).

Here, as stated previously, ALJ Walsh found, with record support, that when the respondents filed their application for hearing on February 21, 2012, and endorsed the issues of reasonable and necessary medical benefits and authorized provider, they did not know who the claimant's family physician was or the body part that the referral intended to cover. Findings of Fact at 4 ¶12; Ex. I at 79. Further, as determined above, ALJ Walsh credited Mr. Camerino's testimony that he did not know who the claimant's primary care physician was or which body part Dr. Pak's referral was intending to cover. Findings of Fact at 4-5 ¶¶10, 15; Tr. at 51-52, 54-55, 57-59, 61-64, 74, 76, 78-80. Section 8-43-301(8), C.R.S. Again, it was well within ALJ Walsh's authority to resolve the conflicting testimony by crediting part, as he did here. *See Colorado Springs Motors, Ltd. v. Industrial Commission*, *supra.* Consequently, the claimant's argument notwithstanding, we agree with ALJ Walsh that at the time the respondents filed their application for hearing, the issues they endorsed were ripe. As such, we will not disturb ALJ Walsh's order denying the claimant's request for attorney fees and costs under §8-43-211(2)(d), C.R.S. based on the allegation that the respondents raised unripe issues when they filed their application for hearing.

II.

The respondents contend that ALJ Walsh erred in denying their request for attorney fees and costs under §8-43-211(2)(d), C.R.S. The respondents argue that at the time the claimant filed her application for hearing, she raised the unripe issue of attorney fees and costs for preparing for the hearing held in front of ALJ Henk on August 8, 2012. The respondents argue that ALJ Walsh found that the claimant raised the issue of ripeness at the August 8, 2012, hearing in front of ALJ Henk, and that ALJ Henk denied this issue and ruled that the hearing could go forward on all issues. The respondents therefore contend that the claimant's subsequent endorsement of the issue of attorney fees

and costs in her application was unripe based on the doctrines of law of the case and issue preclusion. We are not persuaded by the respondents' arguments.

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

The law of the case doctrine is a "discretionary rule of practice ... based primarily on considerations of judicial economy and finality." *Brodeur v. American Home Assurance Co.*, 169 P.3d 139, 149 (Colo. 2007). Under this doctrine, although a court is "'not inexorably bound by its own precedents, prior relevant rulings made in the same case are generally to be followed."' *In re Bass*, 142 P.3d 1259, 1263 (Colo.2006) (quoting *People ex rel. Gallagher v. District Court*, 666 P.2d 550, 553 (Colo. 1983)). "When a court issues final rulings in a case, the 'law of the case' doctrine generally requires the court to follow its prior relevant rulings." *Giampapa v. American Family Mut. Ins. Co.*, 64 P.3d 230, 243 (Colo. 2003).

It is true, as the respondents argue, that at the hearing before ALJ Henk, the claimant raised the issue of ripeness. The claimant specifically contended that once a referral is made, the treating physician to whom the referral is made, results in that physician being authorized as a matter of law. The claimant argued that as a result, the respondents did not have a ripe issue on which to proceed. The claimant then stated, however, that this was "an issue that, independently, will be addressed in another hearing." Tr. at 143-147. Also at the hearing before ALJ Henk, the respondents argued that the only issues to be decided were the referral to the primary care physician, whether it was reasonable and necessary, and authorized provider. Tr. at 137, 140-143, 147-149. It also is true, as the respondents assert, that ALJ Walsh found that ALJ Henk previously determined the hearing could go forward on all issues. Findings of Fact at 7 ¶26. Nevertheless, ALJ Henk did not make any findings or conclusions regarding the claimant's request for attorney fees and costs based on the allegation that the respondents raised an unripe issue for hearing. Since both issue preclusion and law of the case require

a final judgment or rulings in a prior proceeding, however, we conclude that neither doctrine applies here. *See Sunny Acres Villa, Inc. v. Cooper*, *supra; Giampapa v. American Family Mut. Ins. Co.*, *supra*. Consequently, we agree with ALJ Walsh's determination that at the time the claimant filed her application for hearing, she did not raise an issue that was unripe. As such, we will not disturb ALJ Walsh's order denying the respondents' request for attorney fees and costs under §8-43-211(2)(d), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order issued August 22, 2013, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

David G. Kroll

Kris Sanko

Kris Sanko

CERTIFICATE OF MAILING

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

1/17/2014 by RP .

CHUN CHA TEEGARDIN, 1115 MARTIN DRIVE, COLORADO SPRINGS, CO, 80915 (Claimant)
AMERICAN HOME ASSURANCE COMPANY, Attn: RONALD L. CAMERINO, C/O: CHARTIS INSURANCE, INC. - (SAN DIEGO, CA OFFICE), P O BOX 25977, SHAWNEE MISSION, KS, 66225 (Insurer)
STEVEN U. MULLENS, P.C., Attn: STEVEN U. MULLENS, ESQ., P O BOX 2940, COLORADO SPRINGS, CO, 80901 (For Claimant)
SENTER GOLDFARB & RICE, L.L.C., Attn: WILLIAM M. STERCK, ESQ./SEAN ELLIOTT, ESQ., 1700 BROADWAY, SUITE 1700, DENVER, CO, 80290 (For Respondents)

Supreme Court of the State of Colorado
2 East 14th Avenue • Denver, Colorado 80203

2014 CO 7

Supreme Court Case No. 12SC737
Certiorari to the Court of Appeals
Court of Appeals Case No. 11CA1868

Petitioners:

City of Brighton and CIRSA,

v.

Respondent:

Helen M. Rodriguez.

Judgment Affirmed
en banc
February 3, 2014

Attorneys for Petitioners:
Ritsema & Lyon, P.C.
Kelly F. Kruegel
Denver, Colorado

Attorneys for Respondent:
The Frickey Law Firm
Janet Frickey
Lakewood, Colorado

Dean Neuwirth P.C.
Dean Neuwirth
Denver, Colorado

Attorneys for Amicus Curiae WCEA:
William J. Macdonald P.C.
William J. Macdonald
Denver, Colorado

CHIEF JUSTICE RICE delivered the Opinion of the Court.
JUSTICE EID dissents, and **JUSTICE COATS** joins in the dissent.

¶1 We granted certiorari to consider whether an "unexplained" fall -- i.e., a fall with a truly unknown cause or mechanism -- satisfies the "arising out of" employment requirement of Colorado's Workers' Compensation Act, section 8-41-301(1)(c), C.R.S. (2013), and is thus compensable as a work-related injury. We also granted certiorari to decide whether an employer fails to meet its burden to modify an admission of liability under section 8-43-201(1), C.R.S. (2013), when it fails to prove that an employee's injuries did not "arise out of" employment.[1]

¶2 Respondent Helen Rodriguez injured herself after falling down a flight of stairs at work. While we agree with the court of appeals' holding that Rodriguez's unexplained fall was compensable, we disagree with its reasoning. The court of appeals erred when it endorsed Rodriguez's view that her injuries arose out of employment because "uncertainty about the cause of an injury cannot properly bar a workers' compensation claim if every one of the potential causes satisfie[d] the conditions of recovery." See Rodriguez v. ICAO, 2012 COA 139, ¶¶ 6–7. We hold that an unexplained fall necessarily stems from a "neutral" risk, i.e., a risk that is attributable

---

[1] Specifically, we granted certiorari to resolve the following issues, which we reframed slightly for clarity:

1. Whether the court of appeals erred in finding that a fall that occurred during the course of an employee's employment, but whose exact cause/mechanism was unknown, satisfies the "arising out of" employment requirement of section 8-41-301(1)(c), and is compensable under the Workers' Compensation Act.
2. Whether the court of appeals erred in finding that an employer, who initially admitted liability for the injuries of its employee, did not meet its burden under section 8-43-201(1), because it failed to prove that the employee's injuries did not "arise out of" the employee's employment.

neither to the employment itself nor to the employee him- or herself. Under our longstanding "but-for" test, such an unexplained fall "arises out of" employment if the fall would not have occurred but for the fact that the conditions and obligations of employment placed the employee in the position where he or she was injured. Rodriguez's unexplained fall arose out of employment under this test.

¶3 In addition, we hold that under section 8-43-201(1), a party seeking to modify an issue determined by a general or final admission, a summary order, or a full order has the burden to prove by a preponderance of the evidence that such a modification should be made. Here, Petitioners City of Brighton and the Colorado Intergovernmental Risk Sharing Agency (collectively "the City") initially admitted liability for Rodriguez's injuries but later sought to modify that admission. We affirm the court of appeals' holding that the City failed to meet the burden of proof to make this modification. See Rodriguez, ¶ 10.

I. Facts and Procedural History

¶4 Rodriguez worked as a special events coordinator for the City of Brighton. On January 8, 2009, Rodriguez was walking to her office, which was located in the basement of the Brighton City Hall building ("City Hall"). She paused at the top of a flight of concrete stairs running along the outside of City Hall to greet two of her co-workers, Scott Miller and Dennis Williams, who were standing toward the bottom of the stairs. After a brief chat with Miller and Williams, she began to walk down the stairs, which were dry and unobstructed. All of a sudden, she tumbled forward. Rodriguez hit her head, lost consciousness, and did not remember precisely how she

fell -- for example, she did not know whether she tripped, slipped, lost her balance, or something else entirely. Prior to falling, Rodriguez was not experiencing a headache, neck pain, dizziness, or vision problems.

¶5 After her fall, Rodriguez was taken by ambulance to a nearby emergency room. She underwent Computed Tomography ("CT") and Magnetic Resonance Angiogram ("MRA") scans, which revealed four unruptured aneurysms on the right side of her brain. A few weeks later, she underwent surgery for these aneurysms.

¶6 As a result of her fall, Rodriguez experienced head, neck, and back injuries. Twenty days after Rodriguez's fall, the City filed a general admission of liability ("GAL") for these injuries. In late 2010, however, the City sought to modify that GAL (and effectively withdraw it entirely), arguing that the injuries resulting from Rodriguez's fall were not compensable because they did not "arise out of" her employment. Specifically, the City argued that either (1) her fall was caused by her brain aneurysms, or (2) her fall was "unexplained." A hearing on this matter was held before Administrative Law Judge Ted A. Krumreich ("the ALJ") in December of 2010.

¶7 Miller and Williams, the only witnesses to Rodriguez's fall, testified at this hearing. Both were located toward the bottom of the stairs when they paused to chat with Rodriguez. Neither knew why Rodriguez fell as she did. For example, neither saw her trip, slip, or lose her balance. Both testified that the stairs appeared to be dry and unobstructed. Specifically, Miller stated that Rodriguez took two-to-four steps, and then "all of a sudden just went forward." Williams testified that he observed Rodriguez descend a few steps prior to pitching forward, and that it appeared as if someone "just

literally yanked a rug out from underneath her." Miller and Williams also testified that Rodriguez had been speaking and acting normally immediately prior to her fall.

¶8 At the hearing, the ALJ also heard testimony from Dr. Jeffrey Wunder, who had performed an independent medical examination of Rodriguez at the City's request. Dr. Wunder opined that the "most likely" cause of Rodriguez's fall was a fainting or dizziness episode caused by Rodriguez's brain aneurysms, although he could not state this conclusion with a "reasonable degree of medical probability." The ALJ also reviewed two opposing reports from Dr. Lynn Parry and Dr. Alexander Feldman. Both Dr. Parry and Dr. Feldman opined that Rodriguez's brain aneurysms were not the cause of her fall, as the aneurysms were asymptomatic prior to the fall.

¶9 In his Order, the ALJ specifically discredited Dr. Wunder's testimony and credited the testimony of the two other doctors. The ALJ found that Rodriguez's fall was not precipitated by her brain aneurysms, nor was it caused by her tripping or missing a step or by any dangerous condition on the stairs. The ALJ noted that the witnesses to the fall were unable to state precisely why it occurred and that Rodriguez herself could not remember. Thus, he concluded that Rodriguez's fall was "unexplained." As a result, he concluded that her injuries were noncompensable, because in failing to describe her fall's precise causal mechanism, Rodriguez also failed to show that her injury "arose out of" her employment as required by section 8-41-301(1)(c). Accordingly, the ALJ allowed the City to modify its GAL, concluding that it had sustained its burden under section 8-43-201(1). The Industrial Claims Appeals Office ("ICAO") affirmed the ALJ's decision, and Rodriguez appealed.

¶10 The court of appeals set aside the ICAO's order. Because the City initially admitted liability for Rodriguez's injuries and then later contested liability based on the "arising out of" requirement of the Act, the court of appeals held that the City was required to prove that Rodriguez's injuries did not "arise out of" her employment. Rodriguez, ¶ 10 (citing § 8-43-201(1)) ("[A] party seeking to modify an issue determined by a general or final admission . . . shall bear the burden of proof for any such modification."). Consequently, the court of appeals held that the City did not carry its burden because "the ALJ's finding -- that the fall was unexplained -- signal[ed] a failure of proof on [the City's] part." Id. Rodriguez's injuries were therefore held to be compensable under the Act. Although not central to its holding regarding compensability, the court of appeals also endorsed Rodriguez's argument that "uncertainty about the cause of an injury cannot properly bar a workers' compensation claim if every one of the potential causes satisfies the conditions of recovery." Id. at ¶ 6. We granted certiorari.

II. Standard of Review

¶11 The determination of whether an employee's injuries arose out of employment is a question of fact for resolution by the ALJ. See In re Question Submitted by U.S. Court of Appeals for the Tenth Circuit, 759 P.2d 17, 20 (Colo. 1988) ("The determination of whether an employee's injuries arose out of an employment relationship depends largely on the facts presented in a particular case."). "The totality of the circumstances must be examined in each case to see whether there is a sufficient nexus between the employment and the injury." Id. The ALJ's factual findings must be upheld if they are

supported by substantial evidence. § 8-43-301(8), C.R.S. (2013); see also Panera Bread, LLC v. ICAO, 141 P.3d 970, 972 (Colo. App. 2006) (describing the substantial evidence standard).

¶12 Unlike factual findings, this Court reviews an administrative agency's conclusions of law de novo. Colo. Dep't of Labor & Emp't v. Esser, 30 P.3d 189, 193 (Colo. 2001). Thus, while we give considerable weight to the ICAO's reasonable interpretations of its own enabling statute, we are not bound by its legal interpretations. See Anderson v. Longmont Toyota, Inc., 102 P.3d 323, 326 (Colo. 2004); see also § 8-43-308, C.R.S. (2013) (providing that an appellate court may reverse an order of the ICAO if "the award or denial of benefits is not supported by applicable law").

¶13 Specifically, this case requires us to determine the meaning of two sections of Colorado's Workers' Compensation Act ("the Act"). "To discern the legislative intent, we look first to the plain and ordinary meaning of the statutory language." People v. Madden, 111 P.3d 452, 457 (Colo. 2005). A commonly accepted meaning is preferred over a strained or forced interpretation. M.S. v. People, 812 P.2d 632, 636 (Colo. 1991). Additionally, courts look to the overall statutory context when construing meaning. Bd. of Cnty. Comm'rs v. Hygiene Fire Prot. Dist., 221 P.3d 1063, 1066 (Colo. 2009). Importantly, "To effectuate its remedial and beneficent purposes, we must liberally construe the Act in favor of the injured employee." Specialty Rests. Corp. v. Nelson, 231 P.3d 393, 398 (Colo. 2010).

III. Analysis

¶14 First, we review the well-established analytical categories that we have used to evaluate the three types of risks that cause injuries to employees in the workplace. We hold that an "unexplained" fall -- i.e., a fall with a truly unknown cause or mechanism -- falls into the "neutral risk" category. Consistent with our longstanding precedent regarding neutral risks, we also hold that the "but-for" test applies to determine whether unexplained falls "arise out of" employment. Next, we apply this test to the facts of Rodriguez's case and hold that her injury "arose out of" employment under section 8-41-301(1)(c) and is accordingly compensable under the Act.

¶15 Second, we hold that under section 8-43-201(1), a party seeking to modify a general or final admission, a summary order, or a full order has the burden to prove by a preponderance of the evidence that such a modification should be made. We then apply this burden to the facts of Rodriguez's case and conclude that the City did not meet this burden to modify its GAL.

A. Rodriguez's Unexplained Fall Arose Out of Employment and Was Compensable Under the "But-For" Test

¶16 To recover benefits under the Act, an employee's injury must both occur "in the course of" employment and "aris[e] out of" employment. § 8-41-301(1)(c). The employee must meet this standard by a preponderance of the evidence. § 8-43-201(1). The parties in this case agree that Rodriguez's injury occurred "in the course of" her employment; thus, our analysis focuses on determining whether her unexplained fall "arose out of" her employment.

¶17 The term "arising out of" refers to the origin or cause of an employee's injury. Horodyskyj v. Karanian, 32 P.3d 470, 475 (Colo. 2001). Specifically, the term calls for examination of the causal connection or nexus between the conditions and obligations of employment and the employee's injury. Id. An injury "arises out of" employment when it has its "origin in" an employee's work-related functions and is "sufficiently related to" those functions so as to be considered part of employment. Id. It is not essential, however, that an employee be engaged in an obligatory job function or in an activity resulting in a specific benefit to the employer at the time of the injury. City of Boulder v. Streeb, 706 P.2d 786, 791 (Colo. 1985); see also In re Question, 759 P.2d at 22 ("The employee need not necessarily be engaged in the actual performance of work at the moment of injury in order to receive compensation.").

¶18 Here, the City concedes that the activity causing Rodriguez's injury -- walking down the stairs to her basement office -- was sufficiently work-related to be considered part of Rodriguez's employment. It argues, however, that Rodriguez necessarily could not provide a sufficient causal connection between her work activities and her injuries because she could not provide evidence regarding the precise mechanism for her fall down the stairs (e.g., tripping, slipping, or losing her balance). We disagree.

¶19 All risks that cause injury to employees can be placed within three well-established, overarching categories: (1) employment risks, which are directly tied to the work itself; (2) personal risks, which are inherently personal or private to the employee him- or herself; and (3) neutral risks, which are neither employment related nor personal. 1 Arthur Larson & Lex K. Larson, Larson's Workers' Compensation Law §§

4.01–4.03, at 4-1 to -3 (2013) (hereinafter Larson); see also Horodyskyj, 32 P.3d at 475–77 (dividing assaults by co-employees into these three categories for the purpose of determining whether an assault "arose out of" employment).

¶20 The first category, employment risks, encompasses risks inherent to the work environment itself. Employment risks include, for example, a gas explosion at work that burns an employee's body, Rio Grande Motor Way v. De Merschman, 100 Colo. 421, 422, 68 P.2d 446, 447 (1937), or the breakdown of an industrial machine that partially amputated an employee's finger, Leffler v. ICAO, 252 P.3d 50, 50 (Colo. App. 2010). The causal connection between such prototypical industrial risks and employment is intuitive and obvious, and the resulting injuries are universally considered to "arise out of" employment under the Act. See id.; see also Larson, § 4.01, at 4-2. Rodriguez's injury does not fit into this first risk category because the stairs were dry and free of obstructions, and the ALJ specifically found that nothing about the condition of the stairs contributed to Rodriguez's fall. See In re Margeson, 27 A.3d 663, 667 (N.H. 2011) ("Typically, a slip and fall is only attributable to an employment-related risk if it results from tripping on a defect or falling on an uneven or slippery surface on an employer's premises.").

¶21 In contrast, the second category contains risks that are entirely personal or private to the employee him- or herself. See Horodyskyj, 32 P.3d at 475–77; Larson, § 4.02, at 4-2. These risks include, for example, an employee's preexisting idiopathic[2]

[2] We have never explicitly defined "idiopathic." We have, however, used the term consistently with the leading treatise in the field:

illness or medical condition that is completely unrelated to his or her employment, such as fainting spells, heart disease, or epilepsy. See, e.g., Irwin v. Indus. Comm'n, 695 P.2d 763, 765–66 (Colo. App. 1985) (holding that an employee who had a medical history of blacking out and who did so at work did not suffer an injury "arising out of" employment); Gates Rubber Co. v. Indus. Comm'n, 705 P.2d 6, 7 (Colo. App. 1985) (holding same, regarding an employee who had an epileptic seizure and struck his head on a level, nonslippery concrete floor). Such "personal risks" also include an assault at work arising solely from an employee's private, and not professional, life. See, e.g., Velasquez v. Indus. Comm'n, 41 Colo. App. 201, 202–03, 581 P.2d 748, 749 (1978) (holding that employees who were shot by a co-worker at work did not suffer injuries "arising out of" employment because the assailant had purely personal, and not employment-related, motivations for the attack); Horodyskyj, 32 P.3d at 478 (holding that most claims of sexual harassment fall into "the category of inherently private assaults that do not arise out of the employment" (internal quotation marks omitted)).

> Generally understood within the workers' compensation framework to mean "self-originated," [idiopathic] injuries usually spring from a personal risk of the claimant, e.g., heart disease, epilepsy, and the like. Such injuries are to be contrasted with those that are truly "unexplained." The latter generally are considered [to have arisen] from a neutral risk . . . . Idiopathic injuries are said to have arisen from a personal risk. Idiopathic injuries, therefore, often are not compensable.

Idiopathic injuries, Larson's Workers' Compensation Glossary, http://www.lexisnexis.com/legalnewsroom/workers-compensation/b/worker-comp-glossary/archive/2012/11/11/larson-s-workers-compensation-glossary.aspx (last visited Jan. 30, 2014) (emphasis added).

¶22 These types of purely idiopathic or personal injuries are generally not compensable under the Act, unless an exception applies.[3] See Velasquez, 41 Colo. App. at 202–03, 581 P.2d at 749; see also Irwin, 695 P.2d at 765. Here, however, the ALJ specifically found that Rodriguez's fall was not attributable to her preexisting brain aneurysms and that there was no other evidence to indicate that her fall was caused by an idiopathic condition. We are bound by that factual finding. See Metro Moving & Storage Co. v. Gussert, 914 P.2d 411, 415 (Colo. App. 1995) (stating that a reviewing court should defer to the ALJ's resolution of conflicts in the evidence, including the medical evidence). Thus, Rodriguez's fall was not caused by a personal risk.

¶23 The third category includes injuries caused by so-called "neutral risks." Horodyskyj, 32 P.3d at 477. Such risks are considered neutral because they are not associated with either the employment itself nor with the employee him- or herself. Id. For example, a neutral risk was implicated when: (1) an employee was killed by car thieves on the way back from an employment errand, Indus. Comm'n of Colo. v. Hunter, 73 Colo. 226, 227–30, 214 P. 393, 394 (1923);[4] (2) a farm hand was killed by a

---

[3] For example, when it comes to idiopathic injuries, the "special hazard" doctrine represents an important exception to the general rule of non-compensability. Under this doctrine, an injury is compensable even if the most direct cause of that injury is a preexisting idiopathic disease or condition so long as a special employment hazard also contributed to the injury. See, e.g., Ramsdell v. Horn, 781 P.2d 150, 152 (Colo. App. 1989) (holding that a carpenter's injuries from a fall were compensable even though he had an epileptic seizure directly causing his fall because the fall occurred while he was working on a twenty-five-foot-high scaffold, a "special hazard" of employment).

[4] See also, e.g., Indus. Comm'n of Colo. v. Pueblo Auto Co., 71 Colo. 424, 428, 207 P. 479, 480 (1922) (holding that a car salesman's death arose out of employment when he was killed by a car thief); State Comp. Ins. Fund v. Indus. Comm'n, 80 Colo. 130, 134, 249 P. 653, 655 (1926) (holding that an employee's injuries arose out of employment when he

lightning strike while tending to his employer's horses, Aetna Life Ins. Co. v. Indus. Comm'n, 81 Colo. 233, 234, 254 P. 995, 995 (1927); (3) an employee was murdered by a random, insane man while on the job, London Guarantee & Accident Co. v. McCoy, 97 Colo. 13, 15–17, 45 P.2d 900, 901–02 (1935); and (4) an employee was injured after a co-employee accidentally discharged a hunting rifle in the employer's parking lot, Kitchens v. Dep't of Labor & Emp't, 29 Colo. App. 374, 376, 379–80, 486 P.2d 474, 475–77 (1971).

¶24 We hold that an unexplained fall necessarily constitutes a neutral risk. It is clear that Rodriguez's fall was not the result of an occupational hazard or a personal risk. Because the precise mechanism of her unexplained fall was neither occupational nor personal, by definition, such a fall is fundamentally similar to other neutral risks -- like car thieves, lightning, murderous lunatics, and stray bullets -- because none of these risks has a connection with the employee's work or with the employee him- or herself. See Larson, § 7.04[1][c], at 7-31 ("[W]here the neutral-risk concept has been accepted for other purposes, a lot of confusion, circumlocutions, and fictions could be avoided in the unexplained-fall cases by merely accepting the proposition that what is unexplained is neutral.").

¶25 Importantly, however, injuries stemming from neutral risks, whether such risks be an employer's dry and unobstructed stairs or stray bullets, "arise out of" employment because they would not have occurred but for employment. That is, the employment causally contributed to the injury because it obligated the employee to

---

was robbed and murdered while on an employment errand).

engage in employment-related functions, errands, or duties at the time of injury. See Horodyskyj, 32 P.3d at 477 ("[A]n injury is compensable under the Act as long as it is triggered by a neutral source that is not specifically targeted at a particular employee and would have occurred to any person who happened to be in the position of the injured employee at the time and place in question."); Circle K Store No. 1131 v. Indus. Comm'n, 796 P.2d 893, 898 (Ariz. 1990) ("In a pure unexplained-fall case, there is no way in which an award can be justified as a matter of causation theory except by a recognition that . . . but-for reasoning satisfie[s] the 'arising [out of]' requirement." (internal quotation marks omitted)).

¶26 For over eighty years, this Court has consistently applied the "but-for" test (otherwise known as the "positional-risk" test) to injuries caused by neutral risks.[5] See Aetna, 81 Colo. at 234, 254 P. at 995 (holding that a lightning accident "arose out of" employment because the "employment required [the employee] to be in a position where the lightning struck him"); In re Question, 759 P.2d at 20 ("This court has most frequently used the positional-risk or 'but for' standard to define the 'arising out of' language."); Horodyskyj, 32 P.3d at 477 ("[W]e have applied the positional-risk or 'but-for' test to determine whether such injuries [attributable to neutral risks] arise out of the

[5] As we noted in In re Question, at least four other tests can be used in examining injuries caused by neutral risks, including the peculiar-risk doctrine, the increased-risk doctrine, the actual-risk doctrine, and the proximate cause test. 759 P.2d at 20 n.4. Over eighty years ago, however, in Aetna, 81 Colo. at 234, 254 P. at 995, this Court implicitly chose and applied the "but-for" test to the prototypical neutral risk: a lightning strike. We have consistently applied this test since our holding in Aetna. See infra at ¶ 31.

employment."). We reaffirm Aetna's holding that injuries from neutral risks "arise out of" employment. We therefore hold that the "but-for" test applies to unexplained falls because an unexplained fall stems from a neutral risk. The "but-for" test provides that an injury from a neutral risk "arises out of" employment "if it would not have occurred but for the fact that the conditions and obligations of the employment placed [the] claimant in the position where he [or she] was injured." Horodyskyj, 32 P.3d at 477 (emphasis added) (quoting Larson, § 3.05, at 3-5 to -6).

¶27 By applying the "but-for" test to unexplained falls, we reverse the court of appeals to the extent it held that an unexplained fall is compensable when "every one of the potential causes [of the fall] satisfies the conditions of recovery." Rodriguez, ¶¶ 6–7. Such a holding misses the mark because it introduces a kind of speculative fiction about all of the possible causes of a fall; such speculation is unhelpful when the evidence indicates that the cause of a fall is unknown. See Larson, § 7.04[1][c], at 7-31. This fiction is also entirely avoidable if a fall is properly categorized as arising from either an employment-related risk or a personal/idiopathic risk or a neutral risk. If a fall is the result of an employment-related risk, it very likely "arose out of" employment; if it is the result of a preexisting, idiopathic condition, it did not (unless an exception applies). If the cause of a fall is truly unknown, however, and the fall thus stems from a neutral risk, the "but-for" test is applied to determine whether the fall "arose out of" employment. Specifically, the resulting injury "arises out of" employment if it would not have occurred but for the fact that the conditions and

obligations of the employment placed the employee in the position where he or she was injured.

¶28 Moreover, some form of the "but-for" test appears to be the approach taken by the majority of states that have addressed unexplained falls.[6] See Larson, 7.04[1][a], at 7-24 ("In appraising the extent to which courts are willing to accept this general but-for theory . . . it is significant to note that most courts confronted with the unexplained-fall problem have seen fit to award compensation."). We are simply more persuaded by this approach than other possible alternatives.[7]

---

[6] See, e.g., Circle K Store No. 1131 v. Indus. Comm'n, 796 P.2d 893, 897–98 (Ariz. 1990); Delaplaine Farm Ctr. v. Crafton, 382 S.W.3d 689, 694 (Ark. Ct. App. 2011); McCready v. Payless Shoesource, 200 P.3d 479, 487 (Kan. Ct. App. 2009); Mulready v. Univ. Research Corp., 756 A.2d 575, 576, 583 (Md. 2000); Logsdon v. ISCO Co., 618 N.W.2d 667, 674 (Neb. 2000); Taylor v. Twin City Club, 132 S.E.2d 865, 868 (N.C. 1963); Grimaldi v. Shop Rite Big V, 90 A.D.2d 608, 608 (N.Y. App. Div. 1982); Turner v. B Sew Inn, 18 P.3d 1070, 1076 (Okla. 2000); Steinberg v. S.D. Dep't of Military & Veterans Affairs, 607 N.W.2d 596, 604–05 (S.D. 2000).

[7] A few states, such as Oregon and Ohio, require an employee to affirmatively rule out any idiopathic causes for a fall, which permits an inference that a fall arose out of employment. See, e.g., Phil A. Livesley Co. v. Russ, 672 P.2d 337, 341 (Or. 1983); Waller v. Mayfield, 524 N.E.2d 458, 463 (Ohio 1988). We conclude that this approach is misguided because it places an employee in the extremely difficult position of attempting to prove a negative. See Elkins v. United States, 364 U.S. 206, 218 (1960) ("[A]s a practical matter it is never easy to prove a negative . . . ."); Clementi v. Nationwide Mut. Fire Ins. Co., 16 P.3d 223, 231 (Colo. 2001) (placing a particular burden of proof on a party because that party was "in a much better position to prove that it has been prejudiced" and because the other party would "be forced to prove a negative"). This approach also conflates what should be distinct analytical categories. If an idiopathic cause contributes to a fall, then, by definition, the fall is not actually "unexplained." See Larson, § 7.04[1][b], at 7-27 ("Whenever personal disease or weakness contributes to the fall, an entirely new set of rules comes into play, since the risk is no longer neutral but either personal, or, perhaps 'mixed' . . . ."); Logsdon, 618 N.W.2d at 675 ("When there is at least some evidence of a possibility of a personal or idiopathic factor contributing to the fall, the fall is not properly categorized as a purely unexplained fall.").

¶29 Significantly, the "but-for" test does not relieve the employee of the burden of proving causation, nor does it suggest that all injuries that occur at work are compensated under workers' compensation law.[8] Rather, it acknowledges that an employee meets his or her burden to prove that an injury "arose out of" employment when the employee proves that an injury (1) had its "origin in" his or her work-related functions and is "sufficiently related to" those functions so as to be considered part of employment, and (2) arose from a neutral risk, whether that neutral risk is an unexplained fall down an employer's staircase or "an arrow out of nowhere." See Larson, § 7.04[1][b], at 7-28.

¶30 Demanding more precision about the exact mechanism of a fall is inconsistent with the spirit of a statute that is designed to compensate workers for workplace accidents regardless of fault. Sigala v. Atencio's Mkt., 184 P.3d 40, 43 (Colo. 2008); see also Frohlick Crane Serv., Inc. v. Mack, 182 Colo. 34, 38, 510 P.2d 891, 893 (1973) ("The statutory scheme grants the employee compensation . . . even though the employee may be negligent and even if the employer is not negligent."). Such an approach would also be antithetical to the clear remedial purposes of the Act. See Williams v. Kunau, 147 P.3d 33, 38 (Colo. 2006) ("The Act is remedial and beneficent in purpose and should be liberally construed to accomplish its humanitarian purpose of assisting injured workers and their families."); United Airlines, Inc. v. ICAO, 993 P.2d 1152, 1161 (Colo. 2000)

---

[8] As previously established, injuries caused by preexisting idiopathic conditions are generally not compensable (unless an exception applies), nor are injuries caused by purely "personal" risks arising solely from an employee's private, and not professional, life.

(supporting an interpretation of the Act that advanced "the goals of providing a dignified means of support to disabled workers and passing on the costs of industrial disabilities to consumers").

¶31 Additionally, a more demanding causation approach with regard to unexplained falls is inconsistent with our longstanding precedent regarding the compensability of injuries caused by neutral risks. For over eighty years, we have awarded benefits in cases involving neutral risks, which -- by definition -- are not connected to the employment itself. See, e.g., Hunter, 73 Colo. at 230, 214 P. at 394 (murder by car thieves); Aetna, 81 Colo. at 234, 254 P. at 995 (lightning strike); McCoy, 97 Colo. at 15–17, 45 P.2d at 901–02 (murder by random insane man); Kitchens, 29 Colo. App. at 376, 379–80, 486 P.2d at 475–77 (co-employee accidentally shooting another co-employee with hunting rifle). Indeed, employees must only demonstrate that there were specific connections to employment in cases not involving neutral risks. For example, if an employee has epilepsy and is injured after having a seizure at work, the employee must show that he or she was exposed to an additional "special hazard" of employment. See, e.g., Ramsdell v. Horn, 781 P.2d 150, 152 (Colo. App. 1989) (holding that a carpenter's injuries from a fall were compensable because even though he fell as a result of an epileptic seizure, he did so while located on a twenty-five-foot-high scaffold, a "special hazard" of employment).

¶32 The City relies on Finn v. Industrial Commission, 165 Colo. 106, 437 P.2d 542 (1968), for the proposition that an unexplained fall can never "arise out of" employment. Specifically, the City points to the following language:

> We do not agree that a presumption exists that an employee found injured on his employer's premises is presumably injured from something arising out of his work, i.e., that the doctrine of [r]es ipsa loquitur or some variation of it applies here. On the contrary, the burden of proof in these cases is on the claimant who must show a direct causal relationship between his employment and his injury.

Id. at 109, 437 P.2d at 544. A close examination of Finn's facts reveals, however, that this Court upheld the denial of benefits in that case because the employee's injury was idiopathic.

¶33 In Finn, an employee was found lying unconscious on the floor of a brewery, "with blood running from his ears." Id. at 107, 437 P.2d at 543. While the employee speculated that he might have been hit by a forklift, he could not remember precisely how he had been injured and there were no witnesses to his accident. Id. at 108, 437 P.2d at 543. Notably, however, the fact-finder specifically credited testimony implying that the employee's injury was caused by some sort of idiopathic condition: "A supervisor who had seen the claimant a few minutes before the accident found him twisted behind some boxes, his feet thrashing as he repeatedly lifted his head which fell striking his face on the floor. . . . [T]he onset of the injury was triggered by some 'mysterious innerbody malfunction.'" Id., 437 P.2d at 543 (emphasis added).

¶34 Thus, while Finn's rationale is not a model of clarity, its central holding -- that an injury due to a "mysterious innerbody malfunction" does not "arise out of" employment merely because that injury occurs at work -- is entirely consistent with this Court's precedent regarding the non-compensability of idiopathic injuries. See Irwin, 695 P.2d at 765–66 (acknowledging Finn's holding and stating that "we leave open for

determination at a further time the question whether a truly unexplained fall . . . arises out of employment and is compensable" (emphasis added)); Brown v. Indus. Comm'n, 167 Colo. 391, 393–94, 447 P.2d 694, 695 (1968) (citing Finn's "direct causal relationship" language in holding that an employee's back injury did not "arise out of" employment because it was caused by his preexisting idiopathic condition).

¶35 We clarify here, however, that our statement in Finn that an employee must show a "direct causal relationship between his employment and his injury," 165 Colo. at 109, 437 P.2d at 544, applies only to cases involving idiopathic -- and thus not unexplained -- falls.[9] Indeed, this statement from Finn is merely a restatement of the "special hazard" doctrine.[10]

¶36 In sum, it is clear that Rodriguez's fall "arose out of" her employment. The ALJ specifically found that her fall was not caused by an employment-related risk (e.g.,

---

[9] We note that this analysis conflicts with the following unpublished court of appeals' decisions, which held that unexplained falls were noncompensable injuries: Colo. Springs Sch. Dist. v. ICAO, No. 11CA2283 (Colo. App. Aug. 16, 2012); Morgan Corp. v. ICAO, No. 11CA0102 (Colo. App. Dec. 22, 2011); LaFarge Constr., Inc. v. ICAO, No. 09CA2114 (Colo. App. Sept. 30, 2010); Lientz v. ICAO, No. 03CA0380 (Colo. App. Mar. 4, 2004).

[10] The City also points to the older, but similarly inapposite, case of Industrial Commission v. London & Lancashire Indemnity Co., 135 Colo. 372, 374, 311 P.2d 705, 706 (1957), in support of its position that unexplained injuries cannot "arise out of" employment. That case involved an employee who died after falling from a fourth-floor window of the employer's warehouse. Id., 311 P.2d at 706. Notably, however, the employer presented substantial -- and unrebutted -- evidence that the employee's death was not due to a work-related accident (e.g., being pushed out of or falling out of the window). Id. at 377–78, 311 P.2d at 707–08. Instead, there was evidence that the employee's death was the result of suicide, meaning that it was "intentionally self-inflicted" and thus by definition could not "arise out of" employment. Id., 311 P.2d at 707–08. In contrast, there was no evidence here that Rodriguez's fall was "self-inflicted."

slippery, obstructed, or otherwise dangerous stairs), nor by a personal, idiopathic risk (e.g., her aneurysms). Rather, the cause was unknown, and thus her fall was unexplained. We hold that such an unexplained fall is necessarily caused by a neutral risk. Because Rodriguez's fall would not have occurred but for the fact that the conditions and obligations of her employment -- namely, walking to her office during her work day -- placed her on the stairs where she fell, her injury "arose out of" employment and is compensable.

B. A Preponderance Standard Applies When Parties Seek to Modify a General Admission of Liability

¶37 An employer must provide notice to an employee regarding whether it will contest or admit liability for a workplace injury within twenty days of being made aware of that injury. § 8-43-203(1)(a), C.R.S. (2013). When an employer decides not to contest liability and instead files an admission, the employer "has, in effect, admitted that the claimant has sustained the burden of proving entitlement" to benefits. Rocky Mtn. Cardiology v. ICAO, 94 P.3d 1182, 1184 (Colo. App. 2004). Indeed, once an admission has been filed, the employer may not unilaterally modify that admission if the employer comes to believe an injury is not compensable. See § 8-43-203(2)(d); § 8-43-303, C.R.S. (2013). Rather, the employer must request a hearing before an ALJ and continue to make benefits payments until the ALJ enters an order allowing modification of the admission, in full or in part. § 8-43-203(2)(d); § 8-43-303; see also Rocky Mtn. Cardiology, 94 P.3d at 1185 ("An employer is required to continue paying pursuant to an admission of liability and may not unilaterally withhold payment until a

hearing is held to determine whether there is sufficient evidence to permit withdrawal of the admission.").

¶38 Section 8-43-201(1) does not specify what burden of proof governs the modification of an admission. It only provides a specific burden for the employee in making his or her initial claim: "A claimant in a workers' compensation claim shall have the burden of proving entitlement to benefits by a preponderance of the evidence . . . ." § 8-43-201(1) (emphasis added) ("the initial claim provision"). Later, in the same sentence of the same provision, the Act states that "a party seeking to modify an issue determined by a general or final admission, a summary order, or a full order shall bear the burden of proof for any such modification." Id. (emphasis added) ("the modification provision"). The Act's other provisions do not define this burden of proof more precisely, and there is no case law discussing the specific quantum of evidence necessary to sustain the burden for modifying an admission. Accordingly, in order to determine whether the City met its burden, we must clarify the burden imposed by the statute.

¶39 We hold that a party seeking to modify an issue determined by a general or final admission must prove that it is entitled to this modification by a preponderance of the evidence.[11] Because the initial claim provision and the modification provision appear in the very same sentence of the very same statutory provision, it is logical that the

[11] This preponderance standard necessarily also applies to a party seeking to modify an issue determined by a summary order or a full order. See § 8-43-201(1).

General Assembly would anticipate that the same burden would apply to both.[12] Moreover, the legislature is aware that the default burden imposed in civil actions is a preponderance standard. See § 13-25-127, C.R.S. (2013); Leonard v. McMorris, 63 P.3d 323, 331 (Colo. 2003) ("We presume that the General Assembly knows the pre-existing law when it adopts new legislation or makes amendments to prior acts.").

¶40 If the legislature wanted a higher burden of proof to apply to modifications of admissions, it would have specifically provided for such a burden. The legislature was clearly capable of instituting a higher burden if it felt so inclined, as evidenced by the use of a "clear and convincing" burden of proof elsewhere in the Act. See § 8-42-107(8)(b)(III), C.R.S. (2013) (providing that a finding regarding maximum and permanent medical improvement made by an independent medical examiner "may be overcome only by clear and convincing evidence"); cf. Well Augmentation Subdistrict of Cent. Colo. Water Conservancy Dist. v. City of Aurora, 221 P.3d 399, 419 (Colo. 2009) ("When the General Assembly includes a provision in one section of a statute, but

---

[12] The modification provision was added to the Act only four years ago; thus, the legislature was aware of the preponderance burden on the claimant. See Workers' Compensation Act of Colorado, ch. 184, sec. 3, § 8-43-201, 2009 Colo. Sess. Laws 806, 807; see also Leonard v. McMorris, 63 P.3d 323, 331 (Colo. 2003) ("We presume that the General Assembly knows the pre-existing law when it adopts new legislation or makes amendments to prior acts."). The ICAO recently noted that the principal aim of this 2009 amendment was to reverse the effect of Pacesetter Corp. v. Collett, 33 P.3d 1230, 1233 (Colo. App. 2001), which essentially imposed the preponderance burden on the employee despite the fact that the employer had sought modification of its admission. In the Matter of the Claim of Scotty Dunn, W.C. No. 4-754-838-01, 2013 WL 5572762, at *2 (Colo. ICAO Oct. 1, 2013). The amendment, then, specifically placed that burden on the party seeking modification and made such a modification the procedural equivalent of "reopening" a case. Id.

excludes the same provision from another section, we presume that the General Assembly did so purposefully.”).

¶41 In this case, the City sought to modify its GAL by withdrawing its admission of liability entirely. Consequently, the City had the burden to prove by a preponderance of the evidence that Rodriguez’s injuries were not compensable because her claim failed to meet one or more of the requirements in section 8-41-301(1). The City’s contention that it met its burden to modify its GAL turns on its erroneous legal conclusion that an unexplained fall cannot “arise out of” employment. We hold, however, that unexplained falls can be compensable under the “but-for” test; we also hold that Rodriguez’s unexplained fall was compensable under that test. Because the ALJ specifically discredited the idiopathic explanation for Rodriguez’s injury -- and we are bound by that finding, see Metro Moving & Storage Co., 914 P.2d at 415 -- there is no other evidence on the record contesting the compensability of Rodriguez’s injury, given that the City conceded that Rodriguez’s injury occurred “in the course of” her employment, and did not otherwise contest liability. The City accordingly failed to meet its burden to modify the GAL under a preponderance standard, and we affirm the court of appeals’ holding on the burden of proof issue.

IV. Conclusion

¶42 We hold that when the cause of an employee’s fall is truly unknown, it necessarily arises from a neutral risk. Such an unexplained fall can be compensable as “arising out of” employment per section 8-41-301(1)(c) under the “but-for” test. This test provides that an injury “arises out of” employment if it would not have occurred

but for the fact that the conditions and obligations of the employment placed the employee in the position where he or she was injured. Rodriguez's unexplained fall "arose out of" employment under this test; accordingly, we affirm the court of appeals' holding regarding the compensability of her injuries.

¶43 We also hold that under section 8-43-201(1) a party seeking to modify an issue determined by a general or final admission, a summary order, or a full order has the burden to prove by a preponderance of the evidence that such a modification should be made. We affirm the court of appeals' holding that the City did not sustain its burden of proof to modify its general admission of liability under this preponderance standard.

JUSTICE EID dissents, and **JUSTICE COATS** joins in the dissent.

JUSTICE EID, dissenting.

¶44 To the majority, an unexplained injury that occurs at work is equivalent to being attacked by car thieves, struck by lightning, or hit by a stray bullet. Maj. op. ¶ 23–24. I disagree. The cause of such "neutral risks" in those cases is perfectly clear—that is, the car thieves, the lightning bolt, or the stray bullets. Such injuries are covered by workers compensation because work put the claimant in the position to be injured by the causal force—that is, the thief, bolt, or bullet. Here, by contrast, the ALJ determined that the cause of Rodriguez's injury was unexplained, and therefore found the injury (correctly in my view) non-compensable. To put it differently, Rodriguez failed to prove that her injury "arose out of" her employment. By deeming such unexplained injuries compensable, the majority significantly expands the scope of workers' compensation coverage in Colorado. Because such decisions are, in my view, better left to the legislature, I respectfully dissent.

¶45 As the majority notes, before Rodriguez may recover for her injury under Colorado's Workers' Compensation Act, she must establish by a "preponderance of the evidence" that the injury occurred "in the course of" and "arising out of" her employment. Maj. op. ¶ 16, citing §§ 8-41-301(1)(c), 8-43-201(1), C.R.S. (2013). The "arising out of" test requires a claimant to prove "a causal connection between the work conditions and the injury." In re Question Submitted by the U.S. Court of Appeals for the Tenth Circuit, 759 P.2d 18, 22 (Colo. 1988); see also Heinicke v. Indus. Claim Appeals

Office, 197 P.3d 220, 223 (Colo. App. 2008) (noting that a right to workers' compensation benefits does not arise "[w]here causation cannot be established").

¶46 In this case, as the majority observes, the ALJ did eliminate some potential causes of Rodriguez's injuries, finding that neither the condition of the stairs nor her preexisting brain aneurysms caused the fall. Maj. op. ¶¶ 9, 20, 22. But eliminating these two potential causes only shows two factors which did not cause the fall, and none that did. Without sufficient evidence to determine why Rodriguez fell, the ALJ ultimately concluded that the cause of the fall was "unexplained." Maj. op. ¶ 9. Because the cause of the fall was unexplained, Rodriguez could not, and did not, establish causation, and thus she did not carry her burden to show by a preponderance of the evidence that her injuries arose out of employment. In my view, we should simply affirm the ALJ's determination in all respects.

¶47 The majority nevertheless breathes new life into Rodriguez's claim by placing her unexplained fall on equal footing with "neutral risks" like car thieves, lightning bolts, or stray bullets. Maj. op. ¶¶ 23–24. These risks are not merely neutral, however; they are also known. If an injury were to arise from any of these causes, the claimant could demonstrate to the ALJ not only how she was injured, but more importantly, that the injury "would not have occurred but for the fact that the conditions and obligations of employment placed the employee in the position" where she was exposed to the risk of being injured. Maj. op. ¶ 2; see also In re Question, 759 P.2d at 22–25 (finding that an

assault victim's injuries arose out of employment because work obligations caused her to be present at the time and place where she was exposed to the "neutral" threat of the random assault); Aetna Life Ins. Co. v. Indus. Comm'n, 81 Colo. 233, 235–36, 254 P. 995, 996 (1927) (affirming an award of compensation for an employee whose employment obligations required him to be at the particular place where he was struck by lightning).

¶48 The majority's error, however, is to expand the concept of "neutral risks" to include injuries that occur at work where the cause is not known. Such an unexplained injury is not categorically "neutral," as the majority would have it. Rather, an unexplained injury defies categorization. It could have been caused by a neutral risk, but it could also be the result of an entirely personal risk of harm, or of an occupational hazard. In other words, "but for" the claimant's presence at work, the injury could have occurred anyway. Unlike an injury resulting from a known, neutral threat, an unexplained fall by definition does not establish causation, and therefore cannot satisfy the claimant's obligation to demonstrate that an injury arose out of employment.

¶49 Significantly, the majority does not question the ALJ's conclusion that the cause of Rodriguez's injury could not be determined, or offer a cause of its own. Yet somehow, the majority finds it "clear" that "Rodriguez's fall was not the result of an occupational hazard, nor a personal risk." Maj. op. ¶ 24. In doing so, the majority extends the ALJ's ruling well beyond its purview. Far from ruling out all occupational hazards or personal risks as potential causes of the injury, the ALJ held only that the fall

was not precipitated by Rodriguez's brain aneurysms, or by her tripping or missing a step or by any dangerous condition on the stairs. Id., ¶ 9. After eliminating these potential causes—and only these potential causes—the ALJ then concluded that the fall was "unexplained." Id. Rather than extrapolating from this modest holding the broad conclusion that no occupational hazard or personal risk could have caused the injury, the majority should take the ALJ's determination for what it is: a testament to Rodriguez's failure to establish that her injuries arose out of her employment.

¶50 Compounding this error, the majority next implies that the ALJ required Rodriguez to prove the "precise mechanism" of her fall, and thus applied too strict of a causal test. Maj. op. ¶¶ 18, 24. That simply is not the case. The ALJ applied the well-established "preponderance of the evidence" standard. By finding that the cause of the fall was unexplained, however, the ALJ correctly determined that Rodriguez could not meet the burden of proof required to establishing the cause of her injury. Thus, the ALJ's determination was not the result of Rodriguez being required to bear an excessive burden. The burden which the ALJ placed upon Rodriguez was correct; she simply failed to carry that burden.[1]

---

[1] The majority also holds that the City, seeking to modify an issue previously determined by an admission, failed to meet its burden of proving by a preponderance of the evidence that such a modification should be made. Maj. op. ¶¶ 39–41. As the majority observes, however, this holding rests on the conclusion that unexplained falls can be compensable under the "but-for" test." Id., ¶ 41. As shown above, this premise is incorrect. I would hold instead that where the ALJ concluded that the cause of the fall was unexplained, the City met its burden.

¶51 More significantly, the majority's position extends the ability to receive workers' compensation well beyond the scope prescribed by statute. The majority denies that its holding suggests "that all injuries that occur at work are compensated under workers' compensation law." Maj. op. ¶ 29. But by placing unexplained injuries on equal ground with injuries with neutral (and known) causes, the majority makes it possible to receive compensation after merely demonstrating that an injury was sustained on the job. This has never been enough, at least until today, to establish entitlement to workers' compensation—a causal connection must be shown. See § 8-41-301(1)(c); see also In re Question, 759 P.2d at 22. Otherwise, it would have been unnecessary for the legislature to have included the "arising out of" requirement. See Fetzer v. N.D. Workforce Safety and Ins., 815 N.W.2d 539, 543–44 (N.D. 2012) (holding, in a case involving an unexplained fall, that the "but-for reasoning of the positional risk doctrine is inconsistent with our statute that requires claimants to prove a causal connection between their employment and injury"). Thus, by holding that unexplained injuries are compensable, the majority significantly expands the scope of workers' compensation coverage in Colorado. Because I believe this expansion is an issue best left to the legislature, I respectfully dissent from the majority's opinion.

I am authorized to state that JUSTICE COATS joins in this dissent.

The Supreme Court of the State of Colorado
2 East 14th Avenue • Denver, Colorado 80203

2014 CO 5

Supreme Court Case No. 11SC926
Certiorari to the Colorado Court of Appeals
Court of Appeals Case No. 10CA2176

Petitioners:

Harman-Bergstedt, Inc., d/b/a Kentucky Fried Chicken and Zurich American Insurance Company,

v.

Respondents:

Elaine Loofbourrow and Industrial Claim Appeals Office.

Judgment Affirmed
en banc
January 27, 2014

Attorneys for Petitioners:
Thomas Pollart & Miller LLC
Margaret Keck
Greenwood Village, Colorado

Attorneys for Respondent Elaine Loofbourrow:
Law Office of O'Toole & Sbarbaro, P.C.
John A. Sbarbaro
Denver, Colorado

JUSTICE COATS delivered the Opinion of the Court.

¶1 Harman-Bergstedt and its insurer sought review of the judgment of the court of appeals reversing an Industrial Claim Appeals Office decision, which had disallowed Loofbourrow's award of temporary disability benefits. The ICAO panel had reasoned that once Loofbourrow's treating physician placed her at maximum medical improvement, notwithstanding the failure of her injury to result in any work loss at all, temporary total disability benefits could not be awarded for the injury for which she had been initially treated in the absence of a division-sponsored independent medical examination challenging that placement. By contrast, the court of appeals concluded that under the unique circumstances of this case, including especially the fact that Loofbourrow had never yet been awarded temporary disability benefits and the fact that her employer had never filed a final admission of liability from which the statutory window for seeking a division-sponsored independent medical examination could be measured, such an independent medical exam was not a prerequisite to an award of temporary total disability benefits.

¶2 Because a determination of maximum medical improvement has no statutory significance with regard to injuries resulting in the loss of no more than three days or shifts of work time, Loofbourrow's award of temporary total disability benefits was not barred by her failure to first seek a division-sponsored independent medical examination. The judgment of the court of appeals is therefore affirmed.

I.

¶3 On October 2, 2009, Elaine Loofbourrow filed an application for a hearing, seeking, among other things, temporary total disability benefits for work time lost as

the result of a worsening back injury she initially sustained in November of the previous year. Although she couched her application in terms of reopening a previous award, by the time of the hearing she made clear that she considered reopening unnecessary, and the presiding Administrative Law Judge simply considered the matter as a "full contest" in an open claim. Following the hearing, the ALJ made findings and conclusions.

¶4 From those findings and the undisputed portions of the record, it appears that in November 2008, Loofbourrow sustained an injury to her lower back while lifting and cooking chicken at the Kentucky Fried Chicken restaurant where she worked. She reported the injury to her employer, Harman-Bergstedt and, by extension, its insurer, Zurich American Insurance Company, and she sought medical treatment. Her employer referred her to an authorized treating physician, and between November 12 and December 9, 2008, she received medical treatment. Although she labored under some work restrictions during that time, her employer was able to accommodate those restrictions without wage loss and therefore did not report the injury to the division of workers' compensation or admit or deny liability. At the conclusion of this period, the treating physician reported Loofbourrow as having reached "maximum medical improvement" in documentation required by division regulation in conjunction with his bill.

¶5 Around the same time her treatment ended, Loofbourrow was demoted from manager to relief manager, apparently due to her store's poor performance and, as a result, experienced a decrease in pay.

¶6 Several months later, Loofbourrow again experienced back pain and on August 24, 2009, sought treatment from her private physician. When her private physician recommended various work restrictions that her employer was unable to accommodate, she sought temporary disability and other workers' compensation benefits. As relevant here, the presiding ALJ found Loofbourrow's injury to be compensable and awarded her temporary total disability benefits from August 24, 2009, the date on which she was first restricted from work. The ALJ concluded that she suffered a worsening of her low back condition as a natural progression of her November 8, 2008 injury and ordered temporary benefits based on an average weekly wage reflecting her salary at the time of the initial accident. Although her employer asserted as a bar to temporary disability benefits the authorized treating physician's placement of Loofbourrow at maximum medical improvement in his December 9 billing documents, the ALJ did not address that assertion in his findings and conclusions.

¶7 Loofbourrow's employer petitioned for review of the ALJ's decision to the Industrial Claim Appeals Office. Although the ICAO panel affirmed the ALJ's order in most respects, it set aside that portion of the order awarding temporary total disability benefits. The panel concluded that because temporary disability benefits must, by statute, cease when a claimant reaches maximum medical improvement and "may not be paid so long as the claimant continues at MMI," temporary benefits could not be awarded in this case for any period after December 9, 2008, in the absence of a division-sponsored independent medical examination demonstrating otherwise. Loofbourrow v. Harman-Bergstedt, Inc., W.C. No 4-804-458 (ICAO Oct. 7, 2010). In addition, the

panel noted that the claimant's case did not appear to be one involving reopening as contemplated by the statutory scheme, referring expressly to the facts that the case was not even found to be compensable until the entry of the ALJ's order; that no admission of liability had ever been filed; and that the presiding ALJ failed to address reopening in his statement of issues.

¶8 On appeal pursuant to C.A.R. 3.1, the court of appeals set aside the panel's order and remanded the case with directions to reinstate the ALJ's award of temporary total benefits. Partially in reliance upon the unique circumstances of the case, the court of appeals concluded that the ICAO panel erred in finding that Loofbourrow was not entitled to temporary benefits because she failed to challenge, by means of a division-sponsored independent medical examination, the finding of maximum medical improvement made by her original treating physician. In support of its conclusion, the intermediate appellate court conceded that an authorized treating physician's determination would typically be binding in the absence of a challenge according to the statutory procedures for an independent medical examination and that temporary benefits must terminate once maximum medical improvement is reached. It concluded, however, that in this case, where Loofbourrow was alleging a worsening condition as distinguished from contesting the finding of maximum medical improvement; where she had not been given a chance to request an independent medical examination; and where substantial evidence supported the ALJ's determination that she had proven a worsening of her original condition, the statute requiring temporary benefits to cease upon reaching maximum medical improvement was inapplicable, and the statutory

scheme did not preclude the assertion of a post-MMI worsening of condition in an open claim.

¶9 Loofbourrow's employer, Harman-Bergstedt, and its insurer petitioned for a writ of certiorari.

II.

¶10 The Workers' Compensation Act provides for both immediate medical treatment, see § 8-42-101, C.R.S. (2013), and disability indemnity compensation, see § 8-42-103, C.R.S. (2013), for workers who experience injuries arising out of their employment. Not all work-related injuries for which treatment must be provided, however, entitle the injured worker to disability benefits. In particular, if an injury for which treatment must be provided results in no more than three days or shifts of lost work time, only treatment, and not disability indemnity compensation, is statutorily provided for. § 8-42-103(1)(a), C.R.S. (2013).

¶11 When it comes to receiving these benefits, although the applicable statute of limitations does not bar an injured employee from initiating a claim for at least two years after his injury, § 8-43-103(2), C.R.S. (2013), the Workers' Compensation Act is actually designed to provide for disability benefits in many cases without forcing the employee to initiate a claim for compensation. The statutory scheme mandates that a worker notify his employer of an injury from accident within four days of the occurrence of the injury. § 8-43-102(1)(a), C.R.S. (2013). Giving notice, however, is not the same thing as filing a claim for disability benefits. Compare id., with § 8-43-103(2); see also Postlewait v. Midwest Barricade, 905 P.2d 21, 24 (Colo. App. 1995). In contrast

to injuries resulting in no more than three days' loss of work time, with respect to which an employer is merely obliged to notify its insurer, which is in turn merely obliged to report the accident to the division in monthly summary form, § 8-43-101(2), C.R.S. (2013),[1] with respect to injuries causing more than three days' loss of work time—injuries for which disability compensation benefits are payable, see § 8-43-103(1)—the employer must submit a report to the division within ten days of the injury, § 8-43-101(1), C.R.S. (2013).

¶12 In addition to this statutorily required report, the employer is also required to notify the division within 20 days after the report is or should have been filed with the division whether liability is admitted or contested. § 8-43-203(1)(a), C.R.S. (2013). If liability is admitted, the benefits are to be paid immediately. § 8-43-203(2)(b)(I), C.R.S. (2013). If a final admission of liability is not contested within 30 days, the case is automatically closed and may be reopened only according to the requirements of section 8-43-303, C.R.S. (2013).[2] See §§ 8-43-203(2)(b)(II)(A), (2)(d). If the admission of liability is contested by an injured worker who feels entitled to more compensation, the statutory scheme provides for the matter to be heard and for a division-sponsored

---

[1] The statute provides in pertinent part:

> [I]njuries to employees that result in no more than three days' or three shifts' loss of time from work . . . shall be reported by the employer only to the insurer of said employer's workers' compensation insurance liability, which injuries and exposure the insurer shall report only by monthly summary form to or as otherwise requested by the division.

[2] Section 8-43-303, C.R.S. (2013), allows an administrative law judge to review and reopen any award, with some exceptions, "on the ground of fraud, an overpayment, an error, a mistake, or a change in condition" within a certain number of years from the date of injury or the last payment of benefits.

independent medical examination if necessary,[3] § 8-43-203(2)(b)(II)(A), and if liability is denied altogether rather than being admitted by the employer, the scheme provides for, but does not require, an expedited hearing at the request of the claimant, § 8-43-203(1)(a).

¶13 For those injuries resulting in sufficient loss of work time for disability compensation and benefits to be payable, the Act makes provision for both temporary disability compensation for lost work time, see § 8-42-105, C.R.S. (2013) (Temporary Total Disability); § 8-42-106, C.R.S. (2013) (Temporary Partial Disability), and for permanent disability benefits once the extent of medical impairment can be determined, see § 8-42-107, C.R.S. (2013) (Permanent Partial Disability). "Maximum medical improvement" is a concept statutorily designed to identify a point in time beyond which further treatment is unlikely to improve the injured employee's condition. See § 8-40-201(11.5), C.R.S. (2013). A determination of maximum medical improvement is statutorily called for only in section 8-42-107(8), as the initial step in a procedure assessing whether permanent medical impairment has resulted from the injury; if so, the extent of that permanent medical impairment; and ultimately, the amount of permanent disability benefit to which the injured employee will be entitled.

[3] With specified exceptions, a division-sponsored independent medical examination is statutorily required before a hearing can be held on an employee's contest of a final admission of liability regarding certain findings of the treating physician relevant to the amount of compensation due, such as whether the claimant has reached maximum medical improvement and the degree of permanent impairment within the meaning of section 8-42-107, C.R.S. (2013). See §§ 8-42-107(8)(b)(II), (8)(c); § 8-42-107.2(1), C.R.S. (2013).

§ 8-42-107(8).[4] "Maximum medical improvement" therefore has statutory significance only in a determination of the amount, if any, of a permanent disability benefit and in marking the point in time at which temporary disability benefits terminate and permanent disability benefits begin. See § 8-42-105(3)(a), C.R.S. (2013) ("Temporary total disability benefits shall continue until . . . [t]he employee reaches maximum medical improvement."); § 8-42-106(2)(a), C.R.S. (2013) ("Temporary partial disability payments shall continue until . . . [t]he employee reaches maximum medical improvement."); § 8-42-107(3), C.R.S. (2013) ("Temporary disability terminates as to injuries coming under any provision of this section upon the occurrence of any of the events enumerated in section 8-42-105(3).").

¶14 "Maximum medical improvement," as a statutory term of art, therefore has no applicability or significance for injuries insufficiently serious to entail disability indemnity compensation in the first place. See § 8-42-107(8)(b)(I). While the concept is defined in terms of the ineffectiveness of further medical treatment and may therefore be useful in assessing the extent to which an employer is obligated to continue furnishing medical services to an injured employee, as a statutory term of art with consequences for contesting a final admission of liability, reopening a closed claim, or, as in this case, filing a new claim for an injury that has become compensable for the first time, it can logically have applicability only for injuries for which disability indemnity

[4] Section 8-42-107(8) is entitled "Medical impairment benefits—determination of MMI for scheduled and nonscheduled injuries" and provides in pertinent part: "An authorized treating physician shall make a determination as to when the injured employee reaches maximum medical improvement as defined in section 8-40-201(11.5)." § 8-42-107(8)(b)(I), C.R.S. (2013).

is payable. Whether or not an employer continues to furnish medical treatment for a worker whose injury can be accommodated without the loss of work time in excess of three days—and whether or not the division finds it useful for billing and recording purposes to "close" cases based on a determination that no further treatment is likely to improve the employee's condition, without regard to whether the injury was ever compensable, see, e.g., 7 Colo. Code Regs. 1101-3:16, Rule 16-7(E)—the statutory consequences of a finding of "maximum medical improvement" can apply only to injuries as to which disability indemnity is payable.

III.

¶15 The sole issue before this court is whether Loofbourrow could be entitled to an award of temporary disability benefits without having challenged, by means of a division-sponsored independent medical examination, the initial treating physician's assessment that she had reached maximum medical improvement. The intermediate appellate court found that, under the unique circumstances of this case, including particularly her claim of a worsening condition and the absence of a final admission of liability by her employer or earlier payment of temporary disability benefits, she could receive such an award. Excepting only that the circumstances of this case do not appear to us so unique, our analysis of the statutory scheme leads us to the same conclusion.

¶16 Loofbourrow's award of temporary total disability benefits was not barred by either the initial treating physician's placement of her at maximum medical improvement prior to her filing any claim for such benefits, or by her failure to challenge that placement by first obtaining a division-sponsored independent medical

examination, for the reason that her injury did not become compensable until her condition worsened and she was forced to lose in excess of three days of work time. See § 8-42-103(1)(a). No matter how it was characterized in his billing report to the division, the authorized treating physician's determination in December 2008 that further treatment was unlikely to improve Loofbourrow's condition could not amount to a finding of "maximum medical improvement," with its concomitant statutory consequences, because at that point, Loofbourrow had not yet suffered a compensable injury, and therefore no claim for disability indemnity benefits had been initiated by her or by her employer. As will ever be the case with a worsening injury that initially required treatment but did not result in excess of three days' lost work time, no award of temporary disability benefits or admission of final liability was possible and no claim that could be subject to reopening was ever opened or closed.

¶17 Whether the date of injury, and therefore the applicable wage for purposes of temporary disability benefits, should be measured from an original, treated but non-compensable injury or only from the point at which the injury becomes compensable through worsening, cf. City of Boulder v. Payne, 162 Colo. 345, 347, 426 P.2d 194, 195 (1967) (where injured fireman was treated but immediately returned to work and only much later became disabled from the initial injury, statute of limitations for claim for compensation implicitly ran only from the point the injury became a "compensable" injury through loss of work time), is not a matter before us on this petition. It is sufficient for resolution of the issue briefed and pending before us that Loofbourrow's award of temporary total disability benefits was not barred by her failure to challenge

the initial treating physician's assessment that she had reached maximum medical improvement.

IV.

¶18 Because a determination of maximum medical improvement has no statutory significance with regard to injuries resulting in the loss of no more than three days or shifts of work time, Loofbourrow's award of temporary total disability benefits was not barred by her failure to first seek a division-sponsored independent medical examination. The judgment of the court of appeals is therefore affirmed.