BROWN BAG SEMINAR

Thursday, January 15, 2015

(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

December 13, 2014 through January 9, 2015

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-877-223-04

IN THE MATTER OF THE CLAIM OF CHARLES HECKLER, Claimant, v. WERN AIR, INC., Employer, and PINNACOL ASSURANCE, Insurer, Respondents.	FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Turnbow (ALJ) dated June 4, 2014, that denied the claimant's request for temporary partial disability benefits. We affirm the decision of the ALJ.

The claimant sustained a work injury on January 25, 2012. The claimant was found to have achieved maximum medical improvement (MMI) on August 27, 2012, by his authorized treating physician, Dr. Sacha. A Division Independent Medical Exam (DIME) was requested and was performed by Dr. Jade Dillon. Dr. Dillon agreed with the MMI date of August 27, 2012, and assigned a permanent impairment rating of 20% of the whole person and a scheduled extremity rating of 3% of the arm at the shoulder. The respondents filed a Final Admission of Liability (FA) on March 14, 2013, awarding permanent disability benefits based upon the impairment rating provided by the DIME physician. The FA stated the claimant's indemnity benefits were limited by the combined benefits cap set forth in § 8-42-107.5 C.R.S.

The claimant filed an application for a hearing in regard to the issue of future medical benefits. Prior to hearing in regard to this issue, the parties entered into a full and final settlement of the claim. A settlement agreement was executed by the parties and approved by the Director of the Division of Workers' Compensation on July 9, 2013.

Before the negotiation of the settlement, the claimant sent to the respondents on May 28, 2013, a request for 59.5 hours of temporary partial disability (TPD) benefits. These hours were accumulated through the claimant's absences from work to attend 31 doctor's visits lasting from 1 to 2.5 hours in duration beginning on January 8, 2013, and concluding on May 24, 2013. The respondents paid the claimant mileage to attend the appointments but declined to pay for the TPD benefits.

The claimant submitted an application for a hearing in regard to these hours of TPD in January, 2014. At the hearing convened on May 6, 2014, the claimant testified he believed the respondents would pay for the TPD benefits regardless of the status of the settlement of the claim. The claimant also testified his treating physician had placed him at MMI, as did the DIME physician, as of August 27, 2012. At the outset of the hearing, the respondents' counsel stated the respondents disputed the claim for TPD benefits because the dates for the missed time were subsequent to the date of MMI, because the claimant's benefits exceeded the combined benefits cap and because the claim had been settled by the parties. At the conclusion of the hearing, the claimant's counsel objected to the issue of MMI being considered because the respondents had not listed it as a defense in their response to the application for a hearing. The ALJ ruled in a written order of June 4, 2014, that the claim for TPD benefits was denied because the claim was closed by the parties' settlement, because the claimant had reached the cap on combined benefits and because TPD could not be collected for lost wages after the date of MMI.[1]

On appeal, the claimant contends the settlement agreement was ambiguous as to whether the TPD claim was included among the issues being settled, that the combined benefits cap only applies after MMI has been established and the issue of MMI was not endorsed by the respondents as a defense to be used at the hearing. We are not convinced by the claimant's position.

I.

The parties' settlement was codified through use of the prescribed form drafted by the Director, W.C. Rule of Procedure 7-2 (A), 7 Code Colo. Reg. 1101-3. That form allows the parties to include one paragraph in the agreement which contains terms that

[1] The ALJ also determined the claimant had been provided a return to work release from his treating doctor and was working without medical restrictions. The ALJ deemed that circumstance precluded a claim for TPD benefits. It is not specified as to whether this is due to the absence of a 'disability' as that term is used in § 8-42-106, *see, Nogueda v. Varsity Contractors*, W.C. No. 4-209-382 (January 31, 1998); *Ramirez v. Wal-Mart Stores*, W.C. No. 4-689-381 (August 24, 2007). However, because the record does not contain any evidence in regard to the claimant's work restrictions, and the parties do not argue the point, we perceive the discussion to be dicta and not a subject for this appeal.

are specific to the particular claim and that are within the jurisdiction of the Director to review. The claimant points to such a paragraph in the settlement, ¶ 9A, as being ambiguous to the extent that a reasonable interpretation would hold that the respondents agreed to pay the TPD claim. Paragraph 9A provides: "The parties agree that the settlement amount includes the balance of the indemnity benefits admitted to by the respondents. Claimant has been paid indemnity benefits through June 21, 2013, and no additional indemnity payment other than as outlined in paragraph 2 will be made." That paragraph 2 specifies: "In full and final settlement of all benefits, compensation, penalties and interest to which claimant is or might be entitled … Respondents agree to pay and Claimant agrees to accept the following: $25,000, in addition to all benefits that have been previously paid to or on behalf of the claimant." The claimant asserts the settlement provides that indemnity benefits for the period prior to June 21 have been paid. The claimant testified that not all were paid and the settlement agreement requires the respondents to pay these TPD benefits.

The respondents argue these paragraphs do not constitute an agreement to pay contested TPD benefits and also rely on the terms of paragraph 3 of the agreement. That section states: "As consideration for the amount paid under the terms of this settlement, claimant … gives up the right to claim all compensation and benefits to which claimant might be entitled … including … (a) Temporary total and temporary partial disability benefits …"

Given the plain meaning of these paragraphs, they do not support the interpretation assigned to them by the claimant. It is not reasonable to construe the statement that the claimant had been paid indemnity benefits through June 21 to be a warranty that the respondents would pay any indemnity claim the claimant could assert that arose during that period. That paragraph refers to benefits "admitted" by the respondents. Reference to the FA filed by the respondents reveals the respondents did not admit to the TPD requested. The paragraph 9A also refers to the terms in paragraph 2. That paragraph states the claimant is being paid $25,000 to settle all claims for money to which the claimant "might" be entitled and for which the claimant has not already been paid. The claimant testified he knew he had not been paid for the 59.5 hours of TPD. The agreement then, unambiguously states he is accepting the $25,000 to settle this TPD claim for which he had not been paid. To construe the settlement terms otherwise is not reasonable. Consistent with the claimant's argument, he would be able to assert payment of additional permanent partial indemnity benefits he claims are owed between the date of MMI and June 21, since those benefits were also not admitted or paid by the respondents. The claimant's interpretation of the Director's settlement form would prevent it from ending a wide range of issues contested by the parties to a claim. The

salutary effect of a settlement would become illusory and would fail to allow the termination of many claims without first incurring the time and expense of additional litigation. We therefore find the claimant's contention implausible.

II.

The ALJ applied § 8-42-106(2)(a) to hold that TPD benefits for periods after the date of MMI are barred. The record contains the FA filed by the respondents asserting the date of MMI to be August 27, 2012. The claimant testified his authorized treating physician as well as the DIME doctor noted he was at MMI on that date. The ALJ therefore concluded the record established the claimant had been placed at MMI and could not receive TPD benefits after August 27. The claimant asserts the respondents waived this issue by not listing it as a defense in their response to the application for a hearing.

In our view, the parties tried the issue of TPD preclusion due to MMI. In this regard, we conclude that the issue was tried by consent of the parties. *See Woodruff World Travel, Inc. v. Industrial Commission*, 38 Colo.App. 92, 554 P.2d 705(Colo.App. 1976); *Robbolino v. Fischer-White Contractors*, 738 P.2d 70 (Colo. App. 1987). At the outset of the hearing, the claimant's attorney explicitly set forth that the respondents were pursuing three defenses to the TPD claim of the claimant. These included a bar due to the attainment of MMI, the application of the combined benefits cap and the settlement of the claim. Tr. at 3-5 and 6. The claimant did not object at that point to arguing the issue before the ALJ. The claimant testified briefly on direct exam as to the reason he was entitled to the payment of TPD benefits. The respondents' attorney raised on cross examination a completely new issue, that of MMI. He posed several questions to the claimant as to whether he was aware his treating doctor and the DIME physician had placed him at MMI. The claimant replied that they had. Tr. at 14-15. The claimant did not object to any of this examination. The respondents' attorney then moved on to questions pertinent to the status of work restrictions assigned to the claimant. Tr. at 15-16. Only at the point the respondent's attorney finished his cross examination and the hearing concluded did the claimant's attorney make an objection that MMI was not included in the response to the application for a hearing. Tr. at 16. Nor did the claimant then object again to the submission of the respondents' FA into the record. Tr. at 19. That FA stated temporary benefits were terminated as of the August 27 date of MMI. Under these circumstances, we conclude the record supports the ALJ's implicit determination that the defense was tried by consent, and the claimant waived objection to the ALJ's consideration of the § 8-42-106(2)(a) defense. *See Mullings v. Marriott Distribution Center*, W.C. No. 4-484-108 (November 28, 2003), *aff'd. Marriott Distribution Center v.*

Industrial Claim Appeals Office, (Colo. App. 03CA2433, July 15, 2004) (not selected for publication).

The claimant also argues the ALJ could not entertain MMI as an issue because the claimant asserts he had submitted an application for a hearing within 30 days of the respondents' FA endorsing a challenge to the DIME's finding of MMI. This application, it is argued, prevented the issue of MMI from being closed by the FA. However, the ALJ in this hearing was not deciding whether the claimant was correctly placed at MMI by either the treating doctor or by the DIME physician. The ALJ was only making a finding that these doctors had made their determination of MMI. In the absence of a completed DIME process, including the conclusion of a hearing regarding the credibility of the DIME's ruling on MMI, the ALJ does not have jurisdiction to award temporary benefits after an authorized treating doctor has assigned a date of MMI. *Ayala v. Conagra Beef Co.*, W.C. No. 4-579-880 (July 22, 2004). Pursuant to *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002), the ALJ at that point may only resolve that a treating physician has indeed stated an MMI determination has been made. Once an authorized treating physician makes a determination of MMI, the ALJ may not disagree and award temporary benefits after that date until the DIME process has been completed. *Haakinson v. Loomis Fargo & Co.*, W.C. No. 4-544-827 (April 13, 2005). That is the nature of the ALJ's ruling in this matter. The parties agreed the claimant had been put at MMI by the authorized treating physician and the ALJ duly noted temporary benefits could not therefore be awarded pending completion of the DIME review.

III.

The ALJ observed the FA of the respondents did not agree to payment of the full award of permanent partial disability (PPD) benefits because of the application of the combined benefits cap in § 8-42-107.5. That section provides the claimant may not receive more than $76,605 (an amount adjusted annually by the Director) in combined PPD and temporary benefits in the event the claimant's permanent impairment rating is 25% or less. The claimant does not dispute that he received payment up to that cap. Instead, he argues that because MMI has never been determined in this claim, the benefits are not 'combined' (PPD cannot be calculated until MMI is ascertained) and the respondents are obligated to continue paying temporary benefits regardless of the cap. However, as noted above, MMI and an impairment rating has been assigned by a treating doctor. The effect of this designation allows for the application of the benefits cap just as it allows temporary benefits to be halted pursuant to § 8-42-106(2)(a). Until the DIME process is complete, these determinations by the authorized treating physician implicate the application of the combined benefits cap. The respondents may apply the cap in their

FA and the ALJ must acknowledge the treating physician's findings pertinent to an impairment rating. Without a completed DIME review, the ALJ has no jurisdiction to disagree with these determinations of the authorized treating physician. § 8-42-107(8)(b)(III).

In *Rogan v. Industrial Claim Appeals Office*, 91 P.3d 414 (Colo. App. 2003), the court, reviewing an ALJ's hearing order conducted post MMI, concluded the combined benefits cap applied to bar additional temporary benefits for a period prior to the date of MMI, when the claimant's impairment rating was 25% or less. Even though the claimant may have been awarded the temporary benefits had he not been placed at MMI, the fact that he had, allowed for a determination of PPD and his benefits were therefore now 'combined.' The combined benefits cap therefore was applied to bar an award of the additional temporary benefits. The situation here is significantly the same as that in *Rogan*. The claimant has been placed at MMI, his PPD award has been determined, and the benefits cap precludes an award of any additional temporary benefits.

For the reasons discussed above, we do not find a compelling reason to assign error to the order of the ALJ.

IT IS THEREFORE ORDERED that the ALJ's order issued June 4, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

David G. Kroll

Brandee DeFalco-Galvin

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

12/16/2014 by RP .

PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ./GRANT BUTTERFIELD, ESQ., 7501 E. LOWRY BLVD., DENVER, CO, 80230 (Insurer)
LAW OFFICE OF SCOTT MEIKLEJOHN, Attn: SCOTT A. MEIKLEJOHN, ESQ./DAVID L. WORSTELL, ESQ, 1626 WASHINGTON STREET, DENVER, CO, 80203 (For Claimant)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-913-144-01

IN THE MATTER OF THE CLAIM OF

ANGEL MONTES,

Claimant,

v.

MDT PERSONNEL, LLC,

Employer,

and

GUARANTEE INSURANCE CO./
PATRIOT RISK SERVICES,

Insurer,
Respondents.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Cain (ALJ) dated June 12, 2014, that denied and dismissed his claim for benefits. We affirm.

A hearing was held on the issues of compensability, temporary and medical benefits, and whether the claimant was responsible for termination from employment. After the hearing, the ALJ found that the claimant worked for a temporary services agency as a valet parking attendant. The respondent employer provided valet parking services to its client, a company that operates parking lots. The claimant's job required that he park cars and retrieve them from two parking lots. The small lot was approximately one and a half blocks from the drop off point and the large lot was several blocks away. When the claimant was required to travel to or from the large lot, he rode a shuttle bus. The claimant would run to and from the small lot. When retrieving a car from the large lot he would run from the shuttle bus to the key shack and then run to retrieve the car.

The claimant testified that on February 12, 2013, he was running to the key shack at the large lot when he heard and felt a pop in the back of his right knee. The claimant immediately experienced severe pain which he estimated was greater than 10 on a scale of 1 to 10. The claimant informed his supervisor that he experienced a pop in his knee. He does not recall if the supervisor offered him medical treatment. The claimant experienced pain all that night but worked a full shift on February 13, 2013. The claimant

recalled that he was having noticeable trouble parking as many cars on February 13 because he could not run.

The claimant testified that on February 14, 2013, he carpooled to work with two other employees. They parked the car in a designated employee parking area at 10 minutes before his shift was to begin at 8:00 a.m. From this parking area to the sign-in point for work was a 16 to 17 minute walk. Since his knee was hurting, however, the claimant could not walk fast enough to arrive at the sign-in point before his shift began. Instead, he waited for the shuttle bus and ended up arriving late to work. The claimant's supervisor demanded his badge because he had "no-called no-showed."

The claimant testified that prior to becoming a valet in September 2012 he never had any problem with his right leg. He did admit, however, that during the period from September 2012 to February 12, 2013, he had some discomfort in his right leg. He also testified that in December 2012, he was experiencing problems with his calf and swelling in his knee. He stated that he told his immediate supervisor, Susan Bonham, about problems with his leg because she noticed the claimant was not performing his job as well as usual. The claimant also stated that he was limping and everyone noticed.

On December 4, 2012, Ms. Bonham noted that the claimant had a deep muscle strain and was struggling with mobility issues. Ms. Bonham testified that the claimant equated the problem to "like an old football injury, something that flares up every now [and then] and that it shouldn't significantly impact his work." The claimant told Ms. Bonham that it was "a chronic thing." Ms. Bonham also testified that on February 12, 2013, the claimant told her he had hurt his knee while running for a car in the garage. Ms. Bonham stated she offered the claimant medical treatment but he declined. Ms. Bonham testified that the claimant appeared to be having some mild discomfort and was putting weight more on one leg. Ms. Bonham also testified that the claimant worked on February 13, 2013, and she did not recall he was inhibited and it seemed like a regular day.

The claimant did not obtain any treatment for his knee or ankle until he went to Lutheran Medical Center emergency room on April 4, 2013. The claimant told a triage nurse that he had experienced right knee pain for the past few months, and that in February he felt a pop behind the knee while running. The claimant told the physician's assistant that he had intermittent right knee pain for six months and he initially injured his knee around October 2012 when he felt he sprained it. The claimant reportedly did not seek treatment and the pain went away without treatment. The physician's notes reflect that the claimant had somewhat chronic knee pain over the past six months, and that the claimant reported a second injury in February 2013 when he was walking and twisted and

sprained his knee. X-rays that were performed showed no evidence of fracture. The claimant was diagnosed with a knee sprain and referred to a workers' compensation clinic for follow-up. No restrictions were imposed. The claimant also reported a history of intermittent right ankle pain without history of trauma. The symptoms reportedly began six months ago, and the mechanism of injury was reported to be body motion. An x-ray was read as showing no significant abnormalities. The claimant was diagnosed with an ankle sprain.

The claimant was referred to Dr. Gellrick by his prior counsel. Dr. Gellrick examined the claimant on September 25, 2013. Dr. Gellrick wrote that by history the claimant was running on his job as a valet parker when he injured his knee, ankle, and foot. She assessed a right knee sprain and right ankle sprain. Dr. Gellrick referred the claimant for MRIs of the right knee and right ankle and limited him to sedentary duty with no running, jumping, and ladders. The MRI of the claimant's right knee was read as showing a complex tear of the posterior horn and body segment of the medial meniscus and mild-to-moderate tri-compartment cartilage degeneration most prominent in the weight-bearing medial compartment, overlaying the meniscal tears, and small volume joint effusion. The MRI of the claimant's right ankle showed abnormal edema and fluid surrounding the components of the deltoid ligament and ligaments of the sinus tarsi, which could be sequelae of injury or which could reflect stress reaction. The MRI further showed mild to moderate Achilles tendon degeneration with no frank tear.

Dr. Olsen performed an independent medical examination at the request of the respondents. Dr. Olsen opined that the right medial meniscal tear demonstrated by the MRI was degenerative in nature. He further opined that the claimant's ongoing right knee complaints were related to the October 2012 incident when the claimant first sprained his knee as opposed to an occupational injury on February 12, 2013. In support of his opinion, Dr. Olsen cited the history the claimant gave when he visited the Lutheran emergency room, and stated that he had experienced six months of intermittent knee pain and originally injured his knee in October 2012. Dr. Olsen noted there was no indication in the Lutheran history that the October 2012 incident was in any way related to the claimant's employment. Dr. Olsen explained that given the history of intermittent right knee pain and the presence of degenerative findings as noted on the MRI, it would support a diagnosis of degenerative meniscal tear as was revealed on the MRI imaging. Dr. Olsen further opined that the claimant's ankle problems are the result of a chronic degeneration of his Achilles tendon, as evidenced by the MRI and clinical examination.

Crediting the opinions of Dr. Olsen over those of Dr. Gellrick, the ALJ found and concluded that the claimant failed to satisfy his burden of proving he sustained a

compensable knee injury on February 12, 2013. The ALJ also found and concluded that the claimant failed to prove he sustained a right ankle injury during the course and scope of his employment. The ALJ further found that the claimant failed to prove he sustained an occupational ankle disease by the conditions of his employment.

On appeal, the claimant argues that the ALJ erred in failing to amend the pleadings to conform to the evidence, which he argues reflects an occupational disease of his right knee that manifested in either October or December 2012. The claimant contends that in his order, the ALJ only addressed whether the claimant sustained an accidental injury on February 12, 2013, but remained silent on whether the claimant suffered an occupational disease. We are not persuaded the ALJ erred.

Initially, to the extent the claimant argues that the ALJ erred in failing to explicitly address the issue of an occupational disease of the right knee in his order, we perceive no error. It is well settled that the ALJ is not held to crystalline standard in articulating his findings of fact. *George v. Industrial Commission*, 720 P. 2d 624 (Colo. App. 1986). Neither is the ALJ required to explicitly discuss theories he rejected as unpersuasive. *Uptime Corp. v. Colorado Research Corp*., 161 Colo. 87, 420 P.2d 232 (1966). Thus, the claimant's argument notwithstanding, the ALJ was not required to explicitly discuss the issue of occupational disease of the right knee.

Additionally, at the commencement of the hearing, when the parties stated the issues for the ALJ to consider, the claimant did not raise the issue of occupational disease of the right knee. Tr. at 4-10. Further, the claimant failed to raise the issue of an occupational disease of his right knee in his proposed findings or position statement filed before entry of the ALJ's order. In fact, in his proposed findings, the claimant explicitly argued to the contrary, or that he did not have a six month history of knee pain. The claimant therefore failed to raise this argument before the ALJ and it has not been preserved for our review. *Johnson v. Industrial Commission*, 761 P.2d 1140 (Colo. 1988); *Robbolino v. Fischer-White Contractors*, 738 P.2d 70 (Colo. App. 1987); *Colorado Compensation Ins. Authority v. Industrial Claim Appeals Office*, 884 P.2d 1131 (Colo. App. 1994). The claimant's failure to identify by the time of the ALJ's order the issue of an occupational disease of the right knee resulted in its waiver. *See, e.g., Hanna v. Print Expediters, Inc.*, 77 P.3d 863, 865-66 (Colo. App. 2003) (issue of future medical benefits after MMI waived when not requested prior to order not reserving issue for future determination); *see also Johnson v. Industrial Comm'n*, 761 P.2d at 1147 (waiver may be implied when party's conduct manifests intent to relinquish right or privilege or acts inconsistently with assertion).

Nevertheless, to the extent the claimant did preserve the issue, and argues that the ALJ should have amended the pleadings to conform to the alleged evidence, or that the issue of occupational disease of the right knee was tried by consent, we again are not persuaded to disturb the ALJ's order. On cross-examination, the respondents questioned the claimant regarding his previous testimony on direct examination that he was experiencing symptoms in his right knee around December 2012. Tr. at 61-65. Further, the respondents introduced an ER record that the claimant complained of a right knee injury in October 2012. Ex. B at 14, 18. The claimant's testimony and the ER report might be interpreted as indicating support for an occupational disease claim of the right knee commencing in October or December 2012. However, the claimant has not pointed to any evidence demonstrating, nor have we discovered any evidence supporting a finding, that the October or December 2012 events were caused, aggravated, or accelerated by the claimant's employment or working conditions. Section 8-40-201(14), C.R.S.; *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999). It is sufficient for the ALJ to enter findings concerning the evidence he considers dispositive of the issues, and evidence and inferences inconsistent with the order are presumed to have been rejected. *Magnetic Engineering Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Further, the ALJ is presumed to have considered and applied the relevant legal principles. *Shafer Commercial Seating, Inc. v. Industrial Claim Appeals Office*, 85 P.3d 619 (Colo. App. 2003). It was plausible for the ALJ to reasonably infer from the record evidence that the occupational disease analysis was inapplicable to the claimant's right knee. Regardless of the ability of the evidence to support conflicting inferences, we must uphold the ALJ's determination. *See F. R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

Additionally, while the ALJ expressly rejected an occupational disease claim for the right ankle but did not expressly address an occupational disease of the right knee, we conclude that he nevertheless implicitly rejected the issue of occupational disease of the claimant's right knee. The statutory definition of "injury" under §8-40-201(2), C.R.S. includes "occupational disease." *See generally City of Colo. Springs v. Industrial Claim Appeals Office*, 89 P.3d 504, 505 (Colo. App. 2004). Section 8-40-201(2), C.R.S. specifically provides that "'Accident', 'injury', or 'injuries' includes disability or death resulting from accident or occupational disease as defined in subsection (14) of this section." In his order, the ALJ expressly concluded that "the claimant failed to prove it is more probably true than not that on February 12, 2013, he sustained any injury arising out of and in the course of his employment" to his right knee. Order at 10. Further, the ALJ explicitly found that insofar as the claimant's testimony "could permit the inference that running to get the keys constituted a mechanism of injury sufficient to cause or aggravate the knee symptoms and condition, the ALJ declines to draw that inference."

Findings of Fact at 7 ¶27. Thus, since the ALJ clearly found that the running the claimant performed for his job did not cause or aggravate the symptoms in his right knee, his occupational disease claim of the right knee necessarily fails. Section 8-40-201(14), C.R.S. Moreover, Dr. Olsen's report provides ample support for the ALJ's implicit ruling in this regard. Ex. A. Section 8-43-301(8), C.R.S.

Additionally, in support of his occupational disease claim of the right knee, the claimant points to evidence that the ALJ did not find persuasive. While this evidence certainly could have been interpreted by the ALJ to find compensability of the right knee, he was not so persuaded. We may not reweigh the evidence and substitute our judgment for that of the ALJ. As stated in *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App. 1995), it is solely for the trier of fact to determine the persuasive effect of the evidence and whether the burden of proof has been satisfied. The ALJ found, with record support, that the claimant failed to satisfy his burden of proving the alleged occupational disease was caused, aggravated or accelerated by the claimant's employment or working conditions. Section 8-40-201(14), C.R.S.; *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999). Thus, we will not disturb the ALJ's order.

IT IS THEREFORE ORDERED that the ALJ's order dated June 12, 2014, is affirmed.

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

12/16/2014 by RP .

CAIRNS & ASSOCIATES, PC, Attn: GREGORY B. CAIRNS, ESQ., 3900 EAST MEXICO AVENUE, #700, DENVER, CO, 80210 (For Claimant)
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INDUSTRIAL CLAIM APPEALS OFFICE

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

IN THE MATTER OF THE CLAIM OF

GILBERT PADILLA,

Claimant,

v.

FINAL ORDER

WAL-MART STORES, INC.,

Employer,

and

NEW HAMPSHIRE INSURANCE COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Walsh (ALJ) dated August 21, 2014, that denied and dismissed his claim for compensation and benefits. We affirm.

This case previously was before us. The claimant had requested compensation and benefits alleging that he sustained an industrial injury to his lower back on November 9, 2012, when he was pulling pallets of product to stock on the store shelves. The respondents defended the claim on several grounds, including that no incident took place on November 9, 2012, that the claimant did not suffer any injury, and that the claimant suffered from a natural progression of his preexisting degenerative condition. In support, the respondents relied on the report of their independent expert witness, Dr. Steinmetz. Dr. Steinmetz noted that the claimant provided inconsistent histories to the Parkview Medical Center Emergency Room (ER) for the afternoon of November 11, 2012, when he sought treatment for his lower back. He opined that the claimant suffered only preexisting chronic degenerative and arthritic changes that were not due to a work injury.

During a hearing before ALJ Stuber on August 28, 2013, both parties submitted exhibits, which were admitted into evidence without objection. Respondents' Exhibit A included medical records from Parkview Medical Center ER on November 11, 2012. Dr. Macdonald and Nurse Wright attended to the claimant and recorded a history of chronic low back pain with acute gradual worsening over the last several weeks. The claimant denied any trauma, but reported that his work involved lots of lifting. Dr. Macdonald

diagnosed an acute exacerbation of chronic low back pain and discharged the claimant to follow up with his personal physician, Dr. Kemling.

Also admitted into evidence at the original hearing before ALJ Stuber, were medical records from Dr. Kemling. On November 12, 2012, the claimant, who previously had reported cognitive difficulties, called his personal physician, Dr. Kemling, and reported low back pain and confusion. Dr. Kemling admitted the claimant to Parkview Hospital. A brain magnetic resonance image (MRI) showed white 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. On November 12, 2012, Dr. Danylchuk examined the claimant, who reported that he had suffered low back pain for some time and also had suffered a work injury about six years earlier.

During the hearing before ALJ Stuber, the claimant was the only witness called in his case-in-chief. The claimant testified about his Parkview Medical Center ER visit on November 11, 2012, and that his wife accompanied him there. The claimant testified that he reported the history of the alleged November 9, 2012, work injury to Parkview Medical Center ER. He testified that his wife was present and heard his conversation with the Parkview Medical Center ER physician. The claimant denied telling the Parkview Medical Center ER physician or Dr. Danylchuk that he had suffered chronic back problems. He admitted that he told them that the pain had worsened over the last several weeks.

The respondents called three witnesses in their case-in–chief. As pertinent here, the respondents called Ms. Velasquez, who testified about receiving a workers' compensation claim form in January 2013. She testified that she requested the claimant to come into the store to complete an incident report and get the list of medical providers. Ms. Velasquez denied telling the claimant his date of alleged injury. The respondents then called Dr. Steinmetz, who testified consistent with his report. He noted the inconsistent histories obtained by the Parkview Medical Center ER, by Dr. Kemling, and by Dr. Danylchuk. Dr. Steinmetz testified about his own experience as an emergency physician and the importance of accurately recording the patient history. He noted that the MRI showed only multi-level degenerative changes, but nothing acute. He noted that the claimant only suffered a genetic preexisting progressive degenerative condition. Dr. Steinmetz doubted the claimant suffered any November 9, 2012, accident, but, if so, he did not suffer an injury requiring medical treatment. On cross-examination, the claimant asked Dr. Steinmetz if he would disagree with the claimant's wife if she testified that she was in the Parkview Medical ER and the claimant told the doctor about the November 9, 2012, injury. Dr. Steinmetz indicated that he would because he trusted the physicians to record the accurate history.

The claimant then called his wife to the stand. The respondents objected because the claimant's wife was not endorsed as a witness, and his answers to discovery also did

not disclose that she would be a witness. In response, the claimant argued that his wife was a rebuttal witness who would testify that she was in the Parkview Medical Center ER on November 11, 2012, and heard the claimant tell the physician about the injury on November 9, 2012. The claimant argued that his wife would be rebutting Dr. Steinmetz's reliance on inconsistent histories. ALJ Stuber sustained the objection, ruling that the proffered testimony was not rebuttal evidence.

ALJ Stuber subsequently entered his order denying and dismissing the claimant's claim for compensation and benefits. On appeal, the claimant argued that ALJ Stuber abused his discretion in preventing him from presenting the proffered rebuttal testimony of his wife. The claimant contended 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.

On February 12, 2014, we issued an order setting aside ALJ Stuber's order and remanded for ALJ Stuber to issue further findings and a new order regarding his oral ruling to exclude the proffered testimony of the claimant's wife. We concluded that ALJ Stuber's oral ruling was insufficient to permit appellate review. We explained that the basis for ALJ Stuber's oral ruling that the proffered testimony was not rebuttal evidence was not stated during the hearing or in his written order.

On April 28, 2014, ALJ Stuber entered an Order Pursuant to Remand. ALJ Stuber concluded that OACRP 13 provides that only endorsed witnesses may testify in a party's case-in-chief. He ruled that the claimant did not endorse his wife as a witness, but offered her testimony only as rebuttal to the testimony of Dr. Steinmetz. ALJ Stuber noted that he did not explain at the prior hearing that he considered the proffered testimony from the claimant's wife to actually be in rebuttal to the Parkview Medical Center ER physician and nurse and not truly rebutting the expert opinions of Dr. Steinmetz, who was not present in the Parkview Medical Center ER on November 11, 2012. He then ruled that the proffered testimony by the claimant's wife would rebut the Parkview Medical Center ER physician's recordkeeping, part of the basis for the opinion testimony by Dr. Steinmetz, and, therefore, the entire theory of the defense that the claimant provided inconsistent histories to providers. ALJ Stuber ruled that the proffered testimony would explain, refute, counteract, or disprove the evidence introduced by the respondents in either documentary or testimonial form. ALJ Stuber therefore ordered the claimant to set a hearing in order to present the proffered rebuttal testimony of his wife.

ALJ Stuber subsequently retired and ALJ Walsh held another hearing on July 22, 2014. The sole purpose of the hearing was to allow the claimant's wife to offer rebuttal testimony consistent with the offer of proof the claimant made at the hearing before ALJ Stuber.

During the hearing before ALJ Walsh, the claimant stated that he would introduce testimony from his wife regarding her presence in the Parkview Medical Center ER, and

that the claimant told the Parkview Medical Center ER physician about his November 9 injury. As pertinent here, the claimant then stated that his wife also would offer rebuttal testimony to Ms. Velasquez's testimony. He said his wife would testify that she received a telephone call from Ms. Velasquez on November 9, that Ms. Velasquez was concerned about the claimant, and she was wondering how he was. The respondents objected to the admission of this rebuttal testimony. The respondents asserted that they did not know that the claimant's wife would offer this testimony, and that it was unfair surprise. The respondents argued that they did not have Ms. Velasquez at the hearing, and if ALJ Walsh were to allow the claimant's wife to offer such testimony, then they should be allowed to offer surrebuttal testimony. ALJ Walsh then ruled that he would only allow the claimant to offer only the rebuttal testimony that he originally proffered at the time of the original hearing before ALJ Stuber. ALJ Walsh reasoned that the claimant previously did not mention the rebuttal testimony to Ms. Velasquez's testimony at the first hearing before ALJ Stuber. Tr. (July 22, 2014) at 18-26.

At the hearing before ALJ Walsh, the claimant called his wife to the stand as a rebuttal witness. The claimant's wife testified that she was present in the Parkview Medical Center ER on November 11, 2012, when the claimant sought treatment for his back. She testified that she heard the claimant tell the doctor about his back hurting and that it was hurting worse since he hurt it on November 9. She testified that the claimant did not say he had a chronic back problem that was getting worse. She also observed that when the Parkview Medical Center ER physician was talking to the claimant he was not taking notes.

ALJ Walsh subsequently entered his order. In his order, ALJ Walsh stated that he would address only those matters necessary pursuant to the order of remand and, otherwise, would apply those findings previously made by ALJ Stuber. ALJ Walsh ultimately found 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. ALJ Walsh found the rebuttal testimony of the claimant's wife to be less credible than the detailed notes in the Parkview Medical Center ER record. ALJ Walsh found the Parkview Medical Center ER record stated "I felt that the syndrome was consistent with an acute exacerbation of the back pain that they (sic) have had on a chronic basis. The location and description was the same as prior flare-ups. Since the pattern didn't change, I didn't feel that advanced imaging was necessary from the ER." ALJ Walsh ultimately found the Parkview Medical Center ER record supported Dr. Steinmetz's underlying reliance upon inconsistent histories as provided by the claimant. ALJ Walsh also found the opinions of Dr. Steinmetz as persuasive. ALJ Walsh found that the claimant had significant preexisting degenerative changes in his lumbar spine. Consequently, ALJ Walsh denied and dismissed the claimant's claim for compensation and benefits.

On review, the claimant argues that ALJ Walsh abused his discretion by limiting the rebuttal testimony from his wife to the initial offer of proof he made at the prior hearing before ALJ Stuber. The claimant argues that he should have been able to introduce all rebuttal testimony from his wife. Under the particular facts and circumstances here, we are not persuaded ALJ Walsh erred.

Section 8-43-210, C.R.S., contains the basic evidentiary provisions applicable to workers' compensation claims in Colorado. It states, in pertinent part, that the Colorado rules of evidence and requirements of proof for civil nonjury cases in the district courts shall apply in all hearings. *Department of Labor and Employment v. Esser*, 30 P.3d 189 (Colo. 2001). CRE 103(a)(2) provides that in order to preserve for review an objection to the exclusion of evidence, a proper offer of proof must be made. *Melton By and Through Melton v. Larrabee*, 832 P.2d 1069 (Colo. App. 1992). CRE 103(a)(2) specifically provides as follows:

> Offer of proof. In case the ruling is one excluding evidence, the substance of the evidence was made known to the court by offer or was apparent from the context within which questions were asked.

An offer of proof not only allows an ALJ to make an informed ruling on the admissibility of evidence, it also preserves a party's right of appeal. CRE 103(a)(2); *Itin v. Ungar*, P.C., 17 P.3d 129, 136 (Colo. 2000). An offer of proof is required because an appellate court needs an adequate basis for determining whether a trial court's error regarding an evidentiary matter is prejudicial or merely harmless. *See People v. Saiz*, 32 P.3d 441, 454 (Colo. 2001).

Further, pursuant to §8-43-207, C.R.S., the ALJ is vested with wide discretion in the conduct of evidentiary proceedings, including in the admission or exclusion of evidence. *IMPC Transportation Co. v. Industrial Claim Appeals Office*, 753 P.2d 803 (Colo. App. 1988). Thus, the decision of whether to admit rebuttal testimony is committed to the sound discretion of the ALJ, and we may not interfere with the decision to exclude testimony unless an abuse is shown. *Cf. In re Marriage of Antuna*, 8 P.3d 589 (Colo. App. 2000). An abuse of discretion is not shown unless the ALJ's ruling is beyond the bounds of reason, as where it is unsupported by the evidence or contrary to law. *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867 (Colo. App. 2001).

Here, the claimant has failed to demonstrate that ALJ Walsh abused his discretion by limiting rebuttal evidence from his wife to that offer of proof he originally made at the hearing before ALJ Stuber. As explained above, at the hearing before ALJ Stuber, the claimant limited his offer of proof to rebuttal testimony from his wife regarding her presence in the Parkview Medical Center ER, and that the claimant told the Parkview Medical Center ER physician about his November 9 injury. At no time before ALJ Stuber did the claimant make an offer of proof that his wife would offer rebuttal testimony to Ms. Velasquez's testimony that she had received a telephone call from Ms.

Velasquez on November 9, that Ms. Velasquez was concerned about the claimant, and that Ms. Velasquez was wondering how he was. Tr. (Aug. 28, 2013) at 174-176. As such, at the hearing before ALJ Walsh, the respondents did not have witnesses ready to provide surrebuttal testimony to the wife's rebuttal testimony in this regard. Because the claimant never made an offer of proof concerning this other evidence in rebuttal to Ms. Velasquez's testimony at the hearing before ALJ Stuber, ALJ Walsh did not abuse his discretion by foreclosing further questioning on the subject. We recognize that if the substance of the excluded evidence is apparent, no formal offer of proof is required. CRE 103(a)(2); *see also Roberts v. C & M Ready Mix Concrete Co.*, 767 P.2d 769 (Colo. App. 1988). But, we conclude that this was not the case here since the additional rebuttal evidence involved an entirely different witness. Thus, the claimant failed to make a sufficient offer of proof before ALJ Stuber concerning the nature of his wife's rebuttal testimony. Hence, error regarding the exclusion of this rebuttal testimony was not preserved for appeal. CRE 103(a)(2).

Additionally, prior to the hearing before ALJ Walsh, the claimant had adequate time to file a motion seeking to introduce the additional rebuttal testimony from his wife. The claimant was well aware that ALJ Stuber limited rebuttal evidence from his wife to that offer of proof he previously had made. That is, on April 28, 2014, ALJ Stuber entered an Order Pursuant to Remand, specifically ruling that the proffered testimony by the claimant's wife would rebut the Parkview Medical Center ER physician's recordkeeping and, therefore, the entire theory of the defense that the claimant provided inconsistent histories to his providers. Thus, ALJ Stuber ruled that a hearing should be set in order to present such rebuttal testimony from the claimant's wife. On May 14, 2014, a hearing was set to commence on July 22, 2014. Yet, the claimant waited until July 22, 2014, the date of the hearing before ALJ Walsh, to attempt to introduce the additional rebuttal testimony from his wife. This certainly resulted in undue surprise and the failure to give the respondents an opportunity to prepare adequately for the hearing. Consequently, given the particular facts of this case and ALJ Walsh's wide discretion in the conduct of evidentiary proceedings, we are unable to conclude that his ruling amounts to an abuse of discretion. Section 8-43-207(1), C.R.S.

IT IS THEREFORE ORDERED that ALJ Walsh's order dated August 21, 2014, is affirmed.

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

_____12/22/2014_____ by _____RP_____ .

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)
ALJ WALSH, % OFFICE OF ADMINISTRATIVE COURTS, ATTN: RONDA MCGOVERN, 1525 SHERMAN STREET, 4TH FLOOR, DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-620-669-14

IN THE MATTER OF THE CLAIM OF KATHLEEN SAVIDGE, Claimant, v. AIR WISCONSIN AIRLINES, INC, Employer, and INSURANCE CO. OF THE STATE OF PENNSYLVANIA, Insurer, Respondents.	FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Walsh (ALJ) dated July 18, 2014, that concluded the ALJ had no jurisdiction to order enforcement, or the relief from enforcement, of a Medicare Set Aside Agreement (MSA) attached to a previously approved settlement document. We decline to set aside the resolution of the ALJ.

The claimant sustained a work injury on March 21, 2004. In October, 2011, the parties reached a settlement agreement which was reduced to writing and approved by ALJ Stuber on October 19, 2011. The agreement provided that upon payment of $85,000 the claimant agreed to waive all claims to workers' compensation benefits. These included indemnity benefits, disfigurement benefits, penalties and future medical benefits. The settlement document also included a paragraph 9(A) and 9(B). The former advised the claimant there were risks to a settlement and that the settlement was binding on the parties. Paragraph 9(B) referenced an Exhibit A which is an agreement pertinent to the funding of an MSA. Exhibit A provided the respondents would negotiate with the Centers for Medicare and Medicaid Services (CMS) in regard to the future cost of medical care to treat the claimant's work related injuries over the course of her natural life.

Due to her disabilities, the claimant had been determined by Social Security authorities to be eligible for Social Security disability benefits. As a beneficiary, the

claimant was also eligible for Medicare benefits. However, the Medicare program will not accept liability for the cost of medical care required by state law or insurance contract to be paid by another entity. This includes workers' compensation medical expenses. In the event Medicare discovers it has paid for medical costs which are the liability of another party, it may recover its payments from either the responsible insurance carrier or the injured party. 42 U.S.C. §1395y(b)(2)(B)(iii) & (iv) and 42 C.F.R. 411.24(g). The recovery may include interest and substantial penalties. 42 U.S.C. §1395y(b)(2)(B)(ii) and (iii). An individual or insurance carrier may negotiate with the CMS an agreement in advance as to the likely cost of the future medical expenses attributable to an injury for which Medicare deems itself absolved of liability. Upon payment of the amount agreed to by CMS, the party or carrier may satisfy its future obligation for medical payments and be relieved of the need to answer to Medicare in the future for medical costs. The agreed payment is typically required to be deposited into a separate bank account or annuity which is drawn upon by the injured party to pay medical bills as they arise. So long as adequate records are kept to verify payments from the account are appropriate, Medicare is satisfied it is not being asked to pay for ineligible costs and it will not seek reimbursement from either the injured party or insurance carrier for any medical bills Medicare does pay. Medicare's assumption in that case is that the bills it is paying do not arise from the workers' compensation claim.

The Exhibit A attached to the settlement agreement in this case, stated that after agreement was secured from CMS, the respondents would fund an MSA account in the amount specified by CMS. The claimant was entrusted with the duty to pay her future work related medical bills from the account and to keep records of the payments. The Exhibit A also specified that once the account was funded, the parties would move an ALJ to amend the settlement agreement to state this agreement had been reached by the parties with CMS and it was being approved by the ALJ as part of the settlement.

On November 29, 2012, the respondents received approval from CMS to fund an MSA account in the amount of $101,785. In April, 2013, the respondents drafted a joint motion to be submitted by the parties to an ALJ to amend the settlement agreement to include the MSA as part of the settlement. They assert it is required by CMS that the MSA be a part of a settlement document. However, the claimant objected to submitting the joint motion. She complained that her disability had become worse and she was now unable to perform the bookkeeping functions for her MSA account. She demanded of the respondents that they pay for a professional service to administer the account.

The respondents filed an application for a hearing wherein they requested the ALJ to order the claimant to comply with the provision of Exhibit A pertinent to the filing of a

joint motion. The claimant submitted a response to the application asserting a "change of circumstances" and "impossibility" in regard to complying with the clerical duties associated with the MSA account.

The parties presented to the ALJ the deposition of the claimant, oral argument and written position statements. The ALJ prepared an order dated July 18, 2014, in which he determined he did not have jurisdiction to entertain the issues and relief requested by either party. The ALJ cited W.C. Rule of Procedure 7-2 (A)(1), Code Colo. Reg. 1101-2. That rule provides the parties are to use for settlement agreements the agreement form drafted by the Director. Rule 7-2 (A)(1) explains that a paragraph 9(A) in the form document is left blank and may be used by the parties to include terms specific to the agreement and that involves an issue that "falls within the Workers' Compensation Act." Paragraph 9(B) is also blank and may be used by the parties to refer to other agreements negotiated by the parties. These are said to include MSA agreements, agreements involving employment and waivers of bad faith claims. The rule then specifies "these other written agreements attached to a settlement agreement shall not be reviewed and approval of the settlement agreement does not constitute approval of any written agreement attached to the settlement agreement." The Exhibit A attached to the October 19, 2011, settlement agreement was specifically referenced in paragraph 9(B). The ALJ therefore, ruled ALJ Stuber did not approve Exhibit A when he approved the settlement documents and Exhibit A is not a part of the settlement agreement. The October 19, 2011, settlement agreement was found to include a waiver by the claimant of all her benefits in exchange for the payment of $85,000. The agreement was determined to be unambiguous and closed all issues under the Act. The ALJ concluded the dispute between the parties involved issues raised by the MSA agreement which did not arise out of articles 40 to 47 of title 8 of the C.R.S. The ALJ therefore ruled he had no jurisdiction to enter an order as requested by either party. § 8-43-201(1).

Both parties appealed the order. However, on October 7, 2014, the respondents advised the ALJ they were withdrawing their petition to review and were agreeing to the claimant's request to pay for the professional administration of the MSA account. Counsel for the respondents also informed the ALJ that the claimant declined to join in a joint motion to withdraw both parties' appeals.

On appeal, the claimant contends the ALJ committed error when he ruled he was without jurisdiction to decide the claimant's request to require the respondents to pay for the administration of the MSA account. We decline to disturb the ALJ's order for several reasons.

Once a settlement is approved through either an order of the Director or that of an ALJ, the claim is closed pursuant to the terms of the settlement agreement. It may be reopened only upon a showing of fraud or mutual mistake of material fact. § 8-43-204(1) and § 8-43-303(2)(a) & (b) C.R.S. Parties many times submit motions to amend a previously approved settlement agreement. When both parties are in agreement to the amendment it is not required that grounds for reopening be established. This is a recognition that there has been a voluntary reopening of the claim and the new settlement agreement will once again close the matter. W.C. Rule of Procedure 7-3 (A)(1), Code Colo. Reg. 1101-2. However, without an agreement between the parties, a settlement may only be reopened for fraud or mutual mistake.

Neither party in this case has filed a petition to reopen nor did they endorse reopening as an issue for hearing. Neither party has alleged fraud was involved in the inducement for the settlement nor have they claimed there was a mutual mistake of material fact that was present at the time of the settlement. Instead, the parties have requested that the ALJ approve a new settlement which includes an amendment that the claimant now waives her right to future medical benefits upon payment into an MSA account of $101,785 by the respondents, on the one hand and on the other, that the respondents be liable for the clerical administration of the MSA account. However, without either an agreement or a motion for reopening, the ALJ would not have jurisdiction to amend the previous settlement.

The settlement agreement of October 19, 2011, did not recite in either paragraph 2, nor in paragraph 9(A) that part of the consideration for the claimant's waiver of future medical benefits was the funding of an approved MSA account. Instead, the only reference to the MSA account was included in paragraph 9(B). The ALJ correctly noted that W.C. Rule of Procedure 7-2 (A)(1) excludes terms or agreements referenced in paragraph 9(B) from being a part of the settlement agreement. The Director has authority pursuant to § 8-43-204(8) to adopt regulations to implement the review and approval of settlement documents. In light of rule 7-2(A)(1), the ALJ would necessarily conclude the parties did not wish the MSA to be part of the agreement and did not, in fact, make it so. Accordingly, the ALJ would have no jurisdiction to construe or to amend the MSA agreement which was specifically excluded from the scope of ALJ Stuber's original order approving the settlement.

We previously made a similar analysis in *Pankratz v. Hancock Fabrics*, W.C. No. 4-653-869 (March 25, 2011). In *Pankratz*, the parties referenced in their settlement agreement an exhibit which pertained to the respondents' obligation to fund an MSA account in an amount required by CMS. When the respondents were advised by CMS

that the MSA account needed to be funded in an amount 16 times greater than the figure they proposed, the respondents sought to have the settlement agreement amended to simply leave future medical benefits open. Simultaneously, the claimant sought an award of penalties due to the respondents' violation of the Director's order approving the settlement agreement when they failed to fund the MSA account. The ALJ denied the request to amend the settlement agreement due to insufficient evidence of a mutual mistake of material fact. The ALJ also denied the request for penalties on the basis that Rule 7-2(A)(1) excluded the MSA from the Director's order approving the settlement. As a result, the respondents had not violated an order of the Director when they failed to fund the MSA. We upheld the ALJ's denial of a penalty noting that the Director's order of approval did not implicate the MSA agreement.

> In our view the Director, in promulgating the rules on settlement, has clearly provided that while other written agreements such as MSAs may be attached to a Workers' Compensation Settlement Agreement the MSA shall not be reviewed and approval of the settlement agreement does not constitute approval of such Workers' Compensation Medicare Set-Aside Arrangement. *Pankratz* at 4.

Here, the ALJ has come to the same conclusion. The ALJ's finding that the MSA agreement was not a part of the settlement agreement approved previously by ALJ Stuber is supported by a reasonable reading of Rule 7-2(A)(1) and by our decision in *Pankratz*.

The ALJ also observed that the parties' issues did not involve the terms of the settlement agreement, but, rather, the terms of the separate MSA. This finding is borne out by the terms of the settlement. The claimant waived all her rights to medical benefits in exchange for the payment of $85,000. No one alleged this amount was not paid. The only motivation the respondents would have to pay an additional $101,785 into an MSA account would be to avoid litigation and possible penalties from federal Medicare authorities. Because the claimant is subject to this same threat of litigation with Medicare, she would also be motivated to cooperate in the implementation of an MSA agreement with CMS. The obligation of the parties to keep track of medical expenditures made from the established MSA account is similarly motivated by a desire to avoid Medicare repayment litigation. The finding by the ALJ that the parties' issues do not arise out of the settlement agreement is supported by substantial evidence in the record.

The claimant insists the issue she raises, that it is impossible for her to conduct the clerical obligations imposed upon her by the MSA agreement, arises out of the workers' compensation act. Both § 8-43-201(1) and § 8-43-207(1) bestow upon an ALJ the authority to decide "all matters arising under articles 40 to 47 of this title" or "any controversy concerning any issue arising under articles 40 to 47 of this title." However, § 8-42-101(1)(a) only grants to an injured employee the right to medical treatment "as may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee from the effects of the injury." The ability to require the respondents to pay for the professional administration of an MSA account cannot reasonably be seen as a medical benefit described by § 8-42-101(1)(a). The ALJ would not have jurisdiction to entertain a dispute over this issue at a hearing. Accordingly, we also do not have authority to review any order pertinent to this issue because it, in turn, would not have the effect of granting or denying a benefit. This is a prerequisite to our ability to exercise appellate jurisdiction in the matter. § 8-43-301(2). *See Ortiz v. Industrial Claim Appeals Office*, 81 P.3d 1110 (Colo. App. 2003).

Finally, we note that if the respondents are indeed agreeing to pay for the professional administration of the MSA account, the claimant may no longer have standing as an aggrieved party to pursue an appeal. In order for a court to have jurisdiction over a dispute, the plaintiff must have standing to bring the case. Standing is a threshold issue that must be satisfied in order to decide a case on the merits. *Ainscough v. Owens*, 910 P.3d 851, 855 (Colo. 2004); *HealthONE v. Rodriguez ex rel. Rodriguez*, 50 P.3d 879, 892 (Colo.2002). In *Ainscough* the Supreme Court noted that the judicial doctrine of standing is premised on the presence of an actual injury to the interests of the appealing party.

> In *Wimberly v. Ettenberg*, we held that a plaintiff must satisfy two criteria in order to establish standing. 194 Colo. 163, 168, 570 P.2d 535, 539 (1977). First, the plaintiff must have suffered an injury-in-fact, and second, this harm must have been to a legally protected interest. *Id.* The first prong is necessary under the separation of powers doctrine in article III of the Colorado Constitution. *Conrad v. City and County of Denver*, 656 P.2d 662 at 668, (Colo. 1982). *Ainscough v. Owens*, *supra* at 855-56.

To the extent the claimant's request to be relieved of the duty to perform the clerical functions involved in use of the MSA account has been resolved by the respondents' agreement to arrange for another to accomplish that task, the claimant's request for judicial assistance has become moot and theoretical. She no longer has sustained an injury in fact and has no standing to maintain her appeal.

IT IS THEREFORE ORDERED that the ALJ's decision issued July 18, 2014, is left undisturbed.

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

12/29/2014 by RP .

STEVEN U. MULLENS, ESQ., Attn: STEVEN U. MULLENS, ESQ., 105 E. MORENO AVE., COLORADO SPRINGS, CO, 80901-2940 (For Claimant)
SENTER, GOLDFARB & RICE LLC, Attn: WILLIAM M. STERCK, ESQ., 1700 BROADWAY AVE., STE 1700, DENVER, CO, 80290 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-886-464

IN THE MATTER OF THE CLAIM OF MARY WALLACE, Claimant, v. CURRENT USA, INC., Employer, and PACIFIC INDEMNITY COMPANY, Insurer, Respondents.	FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Walsh (ALJ) dated August 15, 2014, that denied the claimant's request for permanent total disability benefits. We affirm the order of the ALJ.

The claimant injured her left elbow due to repetitive work for the employer. The date of onset for her injury occurred on January 27, 2012. On that date the claimant complained of sharp pain in her left elbow while using a scissors to cut material. The claimant was referred by the employer to the Centura Centers for Occupational Medicine where she was treated by Dr. Mary Dickson. Dr. Dickson diagnosed medial and lateral epicondyles in the left arm. The doctor's reports also recorded the claimant's complaints of pain in the left shoulder and wrist. However, Dr. Dickson found those complaints to not be related to the claimant's work injury.

The claimant eventually underwent surgery on two occasions. Dr. Weinstein performed a left lateral epicondylar repair on June 13, 2012. Dr. Larson later completed a cubital tunnel decompression in December, 2012. An MRI dated June 14, 2013, revealed the claimant had a tear in her left shoulder of the anterior central supraspinatus. An MRI of the claimant's cervical spine at that same time showed the claimant suffered from disc degeneration at the C-2 thorough C-5/ C-6 levels and osteoarthritis at C-7/ T1.

Dr. Dickson placed the claimant at maximum medical improvement (MMI) on July 9, 2013. She maintained the claimant's conditions at work did not implicate her left shoulder or her cervical spine. The doctor assigned a permanent impairment rating of 7% of the left upper extremity. The claimant requested a Division Independent Medical Examination (DIME) review. This was completed by Dr. John Bissell on October 30, 2013. Dr. Bissell agreed the date of MMI was June 13, 2012, and calculated the claimant's permanent impairment rating to be 8% of the upper extremity.

Both Dr. Dickson and Dr. Bissell recommended the claimant observe work restrictions limited to no lifting over ten pounds occasionally with the left arm and that repetitive use of the left arm be performed only relative to self-paced work. Dr. Dickson and Dr. Bissell also took the position that neither the claimant's labral tear of her left shoulder nor the claimant's multi-level cervical degenerative disc disease were caused or aggravated by the claimant's work or by her work related lateral epicondylosis or ulnar neuropathy.

The claimant's counsel arranged for the claimant to undergo a functional capacities exam conducted by Gail Gerig, physical therapist. Ms. Gerig was of the opinion the claimant's left shoulder and cervical condition were work related injuries as were the claimant's elbow symptoms. Ms. Gerig testified that her functional capacities exam included an evaluation of all these body parts and demonstrated that the claimant's use of her left and right arms were restricted to sedentary work, and specified no frequent work tasks, no reaching at shoulder level more than twice per hour, no lifting more than ten pounds, no left elbow flexion beyond 60 degrees, infrequent right arm motions, no left arm grasping or repetitive motion, and required the need to change posture every 30 minutes.

Two vocational evaluation reports were prepared in regard to the claimant's ability to earn wages considering her physical disabilities, her educational background and work history. The claimant commissioned a report from Michael Fitzgibbons. The respondents also obtained a report from Katie Montoya. Mr. Fitzgibbons relied upon the functional capacities exam of Ms. Gerig and concluded the claimant was unable to earn any wages. Ms. Montoya premised her analysis on the work restrictions assigned by Dr. Dickson and by Dr. Bissell. Ms. Montoya's opinion was that there were several types of jobs available to the claimant despite her restrictions. Ms. Montoya's evaluation noted the claimant had obtained an associate's degree from Pikes Peak Community College and that she had worked in graphic arts positions and in a number of customer service jobs. Her research identified jobs available to the claimant as including a hostess at a Red Robin restaurant, a cashier at a Boston Market restaurant, a clerk at a Wounded Warrior

facility and ten other jobs. However, she agreed with Mr. Fitzgibbons that if the restrictions supplied by Ms. Gerig were applied, it would be unlikely a suitable job could be located for the claimant.

The claimant filed an application for a hearing seeking to set aside the DIME physician's determination of MMI, in the alternative to award the claimant permanent total disability benefits and disfigurement benefits. The ALJ authored an order dated August 15, 2014. The ALJ found the diagnosis provided by Dr. Dickson and Dr. Bissell to be the most persuasive. It was determined the claimant's work injury was limited to her left elbow and did not include conditions in her shoulder, cervical spine, back or right arm. The ALJ observed the claimant was at MMI as of June 13, 2012, as noted by Dr. Bissell. The ALJ finally surmised the claimant was capable of earning wages and was not therefore, eligible for permanent total benefits. The ALJ did not find Ms. Gerig's opinion that other body parts were injured by work to be a credible conclusion. The ALJ also discerned the restrictions suggested by Ms. Gerig were not adopted or approved by any physician. The ALJ noted Ms. Gerig is not a physician, has not been trained pursuant to workers' compensation guidelines pertinent to causation, based her causation opinion upon an abstract of an article she has not read completely and upon a Wikipedia article. The ALJ characterized Ms. Gerig's opinion as that of a lay person and did not find it compelling. The findings in the order related that the claimant can use a computer, can clean her house, do grocery shopping, lift a gallon of milk with her left arm, that she is paid by the state to provide assistance for her elderly mother to fix her meals, dress her, help her with medications and with hygiene, that the claimant watches her grandson during the day and can drive her granddaughter to school. The ALJ also found that any restrictions caused the claimant's cervical spine, shoulder and right arm did not represent a disability proximately or significantly caused by her work injury. Accordingly, the ALJ denied the claimant's request for additional permanent disability benefits. The claimant was awarded $2,000 for disfigurement benefits.

On appeal, the claimant contends the ALJ failed to adequately consider the non-work related restrictions placed on the claimant by Ms. Gerig in evaluating the claimant's ability to find acceptable work. It is argued his reliance on the case of *Seifried v. Industrial Commission*, 736 P.2d 1262 (Colo. App. 1986) is misplaced and does not allow the ALJ to ignore the non-work restrictions. Finally, it is argued Ms. Montoya did not testify there were jobs available to the claimant within her commutable labor market. We disagree.

The ALJ devoted several findings to the restrictions assigned by Ms. Gerig. The ALJ did not find Ms. Gerig's functional capacity exam and her resulting

recommendations to be reliable. The ALJ pointed out that Ms. Gerig had a very limited amount of medical training. The ALJ questioned the medical literature she relied upon to justify her opinions. It was noted no physician verified the accuracy of Ms. Gerig's proposed limitations. Finally, the ALJ referenced evidence in the record which suggested the claimant was engaged in daily activities inconsistent with the limitations she displayed through the functional capacity exam. The ALJ clearly considered the opinions of Ms. Gerig and found them wanting.

To the extent the ALJ might have determined the claimant had additional restrictions caused by non-work related conditions, he did not err in relying on the *Seifried* case. In *Seifried v. Industrial Commission, supra*, the Court held an award of permanent total benefits should not be ordered if the work injury was not a significant contributing factor to the claimant's permanent disability. In *Seifried*, the claimant injured his right arm and his neck. He eventually found he could not continue to perform his preinjury job and requested permanent total disability benefits. The Claimant was evaluated by two doctors, Dr. Quigley and Dr. Briney. The Court noted that in regard to Dr. Quigley's opinion:

> He concluded that claimant's total disability was caused by a preexisting myositis condition and related therapy, which were unrelated to his occupational injuries. (736 P.2d at 1263).

The Court then summarized Dr. Briney's analysis.

> Dr. Briney opined that claimant's total disability was the result of pre-existing degenerative disc disease and degenerative arthritis. Although he acknowledged that these conditions would be aggravated or accelerated by a specific trauma such as those claimant had suffered, he stated that claimant's injuries were not the basis for his opinion that claimant was permanently and totally disabled. (736 P.2d at 1263).

The Court denied the claim for permanent total benefits.

> However, an injury nevertheless must be "significant" in that it must bear a direct causal relationship between the precipitating event and the resulting disability. (736 P.2d at 1263).

As in the *Seifried* case, the restrictions assigned by Ms. Gerig related to avoidance of the use of both arms and limited lifting to shoulder height, were found by the ALJ to be related to the claimant's arthritis and labral tear of the shoulder. The ALJ found that these are not work related injuries and they were intervening injuries that developed months after the onset of the admitted work injury.

In *Vercher v. Exabyte Corp*. W.C. No. 4-288-412 (May 5, 2003), the claimant had work injuries to both her arms in February, 1994, and to her low back in August, 1994. The claimant, as a result, was limited to repetitive use of the arms for only 50 minutes and from lifting more than 10 pounds. However, her request for permanent total disability benefits was denied when the ALJ determined that her total disability "resulted from the 1997 worsening of a preexisting bilateral knee condition." The ICAO affirmed the ALJ and stated that if the work injury only contributed to the disability, that this was not sufficient to justify an award of permanent total disability.

> Finally, the claimant argues the evidence establishes that her industrial injuries were a significant cause of the PTD. We reject this argument.
>
> Here, the ALJ found the industrial injuries were not sufficient to render the claimant PTD without regard to the subsequent worsening of the knee condition. Hence, the ALJ determined the worsening of the knee condition was an intervening cause of the PTD. In order for an industrial injury to be the cause of a PTD the injury must be "significant" in the sense that there is a direct causal relationship between the precipitating event and the resulting disability. *Seifried v. Industrial Commission*, 736 P.2d 1262 (Colo. App. 1987). However, if the PTD is the result of an efficient intervening cause, the PTD is

> not compensable. To resolve the issue the ALJ must ascertain the residual impairment from the industrial injury and determine whether it was sufficient to render the claimant PTD without regard to subsequent, unrelated impairments. (*Vercher* at pg. 4).

In this case the residual impairment from the left elbow injury was not found to preclude the Claimant from working. The opinion from Ms. Montoya that the claimant would not be able to work if Ms. Gerig's restrictions were applied is support for a finding that another, intervening, condition is the proximate cause of any total disability on the part of the claimant. The application of the *Siefired* precedent in relation to that finding is justified by the record.

The record does show that Ms. Montoya testified specifically that her research uncovered jobs suitable for the claimant and which were within the commutable labor market. On cross examination, claimant's counsel questioned her on this issue:

> Q: I understand those types of jobs, but do those types of jobs exist and are they available for employment at the present time in the Colorado Springs commuting area?
>
> A: Yes, in my opinion, they are. … From a sampling, Red Robin had customer service, host/hostess. Boston Market had cashier. Wounded Warrior Project was hiring …
>
> Q: Well, I'm talking about her commutable labor market in Colorado Springs and I'm asking you a specific question regarding those jobs that are Red Robin and Boston Market in Colorado Springs. What frequency are those jobs available?
>
> A: Red Robin and Boston Market are not necessarily employers that I will survey every single time. These kinds of jobs – what happens is I identify positions of job titles that I feel are appropriate and then I will do a labor market sampling. I don't call Boston Market in every labor market research that I do and I don't call Red Robin. But I – what I can state is these kinds of jobs across the board in Colorado Springs are positions that are more routinely available. And I do regularly complete labor market analysis

> in Colorado Springs and have done so since I started out here in 1990. Tr. at 34, 36-37.

This dialogue indicates Ms. Montoya did direct her research at the commutable labor market pertinent to this case. The ALJ accepted the testimony of Ms. Montoya as that of an expert in the field of vocational evaluation and rehabilitation. Her testimony represents substantial evidence to support the finding of the ALJ that there are jobs available to the claimant and in which she would successfully be able to earn wages.

Section 8-40-201(16.5)(a), C.R.S., defines permanent total disability as the claimant's inability "to earn any wages in the same or other employment." Under the statute, the claimant carries the burden of proof to establish permanent total disability. As noted, although the claimant is not required to establish that an industrial injury is the sole cause of her inability to earn wages, the claimant must nonetheless demonstrate that the industrial injury is a "significant causative factor" in her permanent total disability. *Seifreid v. Industrial Commission*, 736 P.2d 1262 (Colo. App. 1986). This means the claimant must establish a "direct causal relationship" between the industrial injury and the permanent total disability. *Id.*; *Lindner Chevrolet v. Industrial Claim Appeals Office*, 914 P.2d 496 (Colo. App. 1995), *rev'd on other grounds, Askew v. Industrial Claim Appeals Office*, 927 P.2d 1333 (Colo. 1996).

In determining whether a claimant is permanently and totally disabled, the ALJ may consider a wide range of factors including the claimant's age, work experience and training, the claimant's overall physical condition and mental abilities, and the availability of work the claimant can perform. The ALJ is given the widest possible discretion in determining the issue of permanent total disability, and ultimately the issue is one of fact. *Professional Fire Protection, Inc. v. Long*, 867 P.2d 175 (Colo. App. 1993). Because these issues are factual in nature, we must uphold the ALJ's resolution if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires that we consider the evidence in a light most favorable to the prevailing party, and defer to the ALJ's credibility determinations, resolution of conflicts in the evidence and plausible inferences drawn from the record. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003).

Our review of the record reveals there is substantial evidence to justify the findings of the ALJ. Ms. Montoya's report and testimony, as well as the claimant's own testimony, allowed the ALJ to consider a number of human factors pertaining to the claimant's ability to earn wages. The ALJ noted her education, her work history, her skills in regard to a computer and as a skilled worker with some management and training

experience. The ALJ also observed her level of day to day activities which revealed an individual able to function so as to perform a variety of tasks and who discharges important responsibilities in regard to her disabled mother, her grandchildren, to her husband and to herself. These factors constitute substantial evidence in the record which support the findings and the order of the ALJ. We do not detect any insufficiency in those findings. Section 8-43-301(8), C.R.S.

Accordingly, we find no compelling reason to attribute error to the decision of the ALJ and therefore affirm that decision.

IT IS THEREFORE ORDERED that the ALJ's order issued August 15, 2014, is affirmed.

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

12/24/2014 by RP .

STEVEN U. MULLENS, P.C., Attn: ROBERT W. TURNER, ESQ., P O BOX 2940, COLORADO SPRINGS, CO, 80901 (For Claimant)
THOMAS, POLLART & MILLER, LLC, Attn: BRAD J. MILLER, ESQ./STACY TARLER, ESQ., 5600 S. QUEBEC STREET, SUITE 220-A, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-472-849-11

IN THE MATTER OF THE CLAIM OF

TIMOTHY WILSON,

Claimant,

v.

H & S CONSTRUCTION a/k/a H & S INC,

Employer,

and

TRISTAR RISK MANAGEMENT,

Insurer,
Respondents.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Harr (ALJ) dated July 14, 2014, that denied the claimant's request for certain medical benefits finding them not reasonable, necessary and related to the claimant's industrial injury. We affirm the ALJ's order.

This matter went to hearing on the issue of medical maintenance benefits. The claimant requested that the insurer pay for a cervical MRI, neurocognitive testing and Botox injections for headaches. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant sustained a compensable workers' compensation injury when he was involved in a head on motor vehicle accident on March 26, 2000. As a result of the accident the claimant sustained a dislocation of the femoral head of the left hip and a fractured pelvis. The emergency room reports noted that the claimant had a "questionable loss of consciousness" and "no loss of consciousness." The claimant was flown to University Hospital in Utah where it was noted that the claimant's head lacked any evidence of trauma and the claimant had full range of motion in his neck. A subsequent evaluation noticed that the claimant's cognitive function and memory was grossly intact and insight and judgment were unimpaired.

The claimant's prior medical history revealed that the claimant sustained head injuries and some mild cognitive deficits related to "fights and brawls" and an abusive childhood background including drug and alcohol abuse. The claimant was diagnosed with major depression, anxiety, PTSD, remote alcohol and drug abuse, chronic headaches and left hip and left-sided pain.

On April 1, 2004, Dr. Shih performed an independent medical examination at the respondents' request. Dr. Shih noted the claimant's prior medical reports supported significant preexisting pain conditions including complaints of syncope, fatigue, complaints of flushing, history of concussions, frequent headaches and a "history of 32 accidents in his lifetime." Dr. Shih advised the claimant to seek medical attention for these difficulties from his primary care physician. The ALJ found Dr. Shih's opinions credible and persuasive.

Dr. Reiser evaluated the claimant's headache complaints on May 19, 2011. Dr. Reiser administered trigger point injections and noted that a 2009 brain MRI and a 2009 head MRA were unremarkable. A 2009 cervical spine MRI showed multi-level degenerative changes. According to Dr. Reiser, the claimant's headaches and neck injury could be worsened since the injury and recommended the treatment at issue. The ALJ was not persuaded by Dr. Reiser's opinions and remarked that Dr. Reiser did not appear to have reviewed the claimant's initial medical records which found no traumatic brain injury after assessments were performed.

Also in May of 2011, Dr. Fall performed an independent medical examination at the respondents' request. Dr. Fall testified, consistent with her report, that there is no medical evidence that the claimant sustained a head injury or a traumatic brain injury as a result of the compensable motor vehicle accident. In Dr. Fall's opinion, the claimant's headaches were more probably related to his pre-existing history of migraine headaches. She also determined that there was no persuasive medical record evidence to show that the claimant sustained a cervical spine injury as a result of the motor vehicle accident. The ALJ found Dr. Fall's opinion credible and persuasive.

Based on these findings the ALJ determined that the claimant failed to show it more probably true than not that Dr. Reiser's recommendations were reasonable and

necessary to cure and relieve the effects of the injury from the motor vehicle accident. The ALJ relied on the opinions of Dr. Fall and Dr. Shih to conclude that the only motor vehicle accident related diagnosis was an acetabular fracture status post-ORIF and that it is medically improbable that the claimant sustained a head injury or a traumatic brain injury or a cervical injury as a result of the motor vehicle accident. The ALJ therefore, denied and dismissed the claimant's request for the medical maintenance benefits at issue.

On appeal the claimant argues that the ALJ erred in denying his request for medical benefits because a November, 2001 ALJ order previously determined the claim to be compensable and ordered the respondents to pay all of the medical bills in the claim. The claimant further contends that the ALJ erred by again determining the compensability of the head injury and cervical injury. The claimant also asserts if his conditions are attributable to a pre-existing condition, then the evidence compels the conclusion that the claimant's condition was aggravated by the motor vehicle accident. We are not persuaded the ALJ erred.

I.

As we understand the claimant's argument he asserts that the ALJ erroneously determined the compensability of the head and neck injury. The claimant contends that the ALJ's consideration of relatedness of the requested treatment is barred by the doctrine of issue preclusion and estoppel because a 2001 ALJ order determined that the claimant sustained a compensable injury and a general award of medical benefits was entered. We note initially that this argument was not raised by the claimant before the ALJ, nor was the 2001 order entered into the record. *See* Claimant's Post Hearing Position Statement (May 13, 2014). *See also Johnson v. Industrial Commission*, 761 P.2d 1140 (Colo. 1988); *Robbolino v. Fischer-White Contractors*, 738 P.2d 70 (Colo. App. 1987). Therefore, we need not consider the argument for the first time on appeal. *Colorado Compensation Ins. Authority v. Industrial Claim Appeals Office*, 884 P.2d 1131 (Colo. App. 1994).

In any event, we perceive no error in this regard. Under the applicable law the claimant is entitled to maintenance medical benefits where there is substantial evidence in

the record to support a determination that future medical treatment will be reasonable and necessary to relieve the effects of an industrial injury or prevent further deterioration of the claimant's condition. *Stollmeyer v. Industrial Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995); *Milco Construction v. Cowan*, 860 P.2d 539 (Colo. App. 1992). Once the claimant establishes the probability of a need for future treatment, the claimant is entitled to a general award of future medical benefits, subject to the respondents' right to contest the compensability of any particular treatment on the grounds the treating physician is not authorized to treat the injury, or the treatment is not reasonable or related to the industrial injury. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997); *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999). The mere admission that an injury occurred and that treatment is needed cannot be construed as a concession that all conditions and treatment that occur after the injury were caused by the injury. *Cf. HLJ Management Group, Inc. v. Kim*, 804 P.2d 250 (Colo. App. 1990) (filing of a general admission does not vitiate respondents' right to litigate disputed issues on a prospective basis). In *Snyder v. Industrial Claim Appeals Office*, *supra*, the court explicitly held that "in a dispute over medical benefits after the filing of a general admission of liability, an employer can assert, based on subsequent medical reports, that the claimant did not establish the threshold requirement of a direct causal relationship between the on-the-job injury and the need for medical treatment. " 942 P.2d at 1339.

Here, it is not clear from the record whether the claimant was previously awarded maintenance medical benefits by order or whether the respondents admitted for maintenance medical benefits. It appears, however, that the claimant has been receiving maintenance medical benefits for which the respondents have paid. The claimant states in his brief that the parties stipulated that the claimant was “entitled to reasonable necessary medical treatment for his compensable injury that is causally related.” Tr. at 10. In either of these situations the respondents were free to challenge any particular proposed medical treatment on any grounds, including that the treatment was not necessitated by the admitted injury. The fact that the respondents may have paid for some treatment in the past for headaches does not change the result. We note that it has generally been held that payment of medical services is not in itself an admission of liability. *Ashburn v. La Plata School District*, W.C. No. 3-062-779 (May 4, 2007). This

is based on the sound public policy that carriers should be allowed to make voluntary payments without running the risk of being held thereby to have made an irrevocable admission of liability. *7 Larson, Workers' Compensation Law*, § 127.04(3). In addition the Colorado Rules of Evidence generally govern workers' compensation proceedings. Section 8-43- 210, C.R.S. C.R.E. 409 provides that evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses occasioned by an injury is not admissible to prove liability for the injury. It follows that we perceive no error in the ALJ's allowing the respondents to litigate the cause of the need for the requested maintenance medical benefits.

II.

Alternatively, the claimant contends that the evidence compels a conclusion that the requested treatment is related to the compensable motor vehicle accident. We perceive no reversible error.

It is the ALJ's sole prerogative to resolve conflicts in the medical evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). In so doing, the ALJ is free to credit one medical opinion to the exclusion of a contrary opinion. *Dow Chemical Co. v. Industrial Claim Appeals Office*, 843 P.2d 122 (Colo. App. 1992). We may not interfere with the ALJ's credibility determinations except where the testimony he credited is so overwhelmingly rebutted by "hard, certain" evidence that the ALJ would err as a matter of law in crediting the testimony. *Halliburton Services v. Mille*r, 720 P.2d 571 (Colo. 1986); *Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997), *cert. denied*, April 12, 1999. In our view, those circumstances do not exist here.

Here, the record contains a direct conflict between Dr. Reiser and Dr. Shih and Dr. Fall. Although Dr. Reiser recommended treatment and further diagnostic care for the claimant’s cervical and headache problems, Dr. Shih and Dr. Fall opined that these conditions were not caused by the motor vehicle accident. According to Dr. Fall, the medical records from the claimant’s compensable injury do not show that the claimant sustained a cervical spine injury or a traumatic brain injury as a result of the 2000 motor vehicle accident. According to Dr. Shih the medical records clearly support significant pre-existing pain conditions. Under these circumstances, the ALJ resolved the conflict in favor of Dr. Shih and Dr. Fall, and the record does not compel a contrary determination.

We have considered the claimant's remaining arguments and are not persuaded the ALJ committed any error. Most notably, the claimant contends the ALJ was biased against the claimant because of his time in prison. The claimant, however, cites no evidence that the ALJ had prejudged any issue relevant to resolution of this claim. *See Nesbit v. Industrial Commission*, 43 Colo. App. 398, 607 P.2d 1024 (1979)(substantial showing of bias necessary to support conclusion that hearing was unfair); *In Re Marriage of Johnson*, 40 Colo. App. 250, 576 P.2d 188 (Colo. App. 1977) (adverse ruling alone does not support conclusion that hearing officer biased). It follows that the claimant made no showing of facts to overcome the presumption of competency, and fairness, which resides with the ALJ. *Wecker v. TBL Excavating, Inc*., 908 P.2d 1186 (Colo. App. 1995). Because the ALJ's findings are supported by substantial evidence and those findings, in turn, support the ALJ's conclusion that the requested medical treatment is not reasonable, necessary or related to the industrial injury, we decline to disturb the ALJ's order on review. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated July 14, 2014, is affirmed.

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

12/22/2014 by RP .

ROBERT W. TURNER, LLC, Attn: ROBERT W. TURNER, ESQ., 3010 E. 6TH AVENUE, DENVER, CO, 80206 (For Claimant)
RITSEMA & LYON PC, Attn: MICHAEL A PERALES, ESQ., 999 18TH ST #3100, DENVER, CO, 80202 (For Respondents)

COLORADO COURT OF APPEALS

DATE FILED: January 8, 2015
CASE NUMBER: 2014CA348

Court of Appeals No. 14CA0348
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-893-767

Kathleen Bopp,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado; Garden Square Assisted Living; and Liberty Mutual Insurance Group,

Respondents.

ORDER AFFIRMED

Division III
Opinion by JUDGE DAILEY
Hawthorne and Dunn, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(f)
Announced January 8, 2015

Ira A. Sanders, Greeley, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Lee & Kinder, LLC, Joshua D. Brown, Denver, Colorado, for Respondents Garden Square Assisted Living; and Liberty Mutual Insurance Group

In this workers' compensation action, claimant, Kathleen Bopp, seeks review of a final order of the Industrial Claim Appeals Office (Panel), affirming the order of an administrative law judge (ALJ) dismissing her claim with prejudice. The ALJ determined that because claimant's claim had been fully and finally settled, her request for benefits for a related back injury was barred. We affirm.

I. Factual and Procedural Background

Claimant sustained a work-related injury to her right arm and shoulder in April 2009. In April 2012, she was referred to a chiropractor by her authorized treating physician (ATP) for treatment of her work-related injuries. She asserted that the chiropractor "adjusted [her] spine forcefully," causing her to sustain an injury to her "right lower back."

In July 2012, the parties entered into a settlement agreement resolving claimant's April 2009 workers' compensation claim. The parties specified that the settlement incorporated other, related injuries: "Other disabilities, impairments and conditions that may be the result of these injuries or diseases but that are not listed here are, nevertheless, intended by all parties to be included in and

resolved FOREVER by this settlement." Similarly, claimant acknowledged that the settlement encompassed all

> unknown injuries, conditions, diseases or disabilities as a consequence of these alleged injuries or occupational diseases, including the possibility of a worsening of the conditions. In return for the money paid or other consideration provided in this settlement, Claimant rejects, waives and FOREVER gives up the right to make any kind of claim for workers' compensation benefits against [employer] for any such unknown injuries, conditions, diseases, or disabilities resulting from the injuries or occupational diseases, whether or not admitted, that are the subject of this settlement.

In exchange for accepting employer's lump sum settlement payment, claimant "reject[ed], waive[d], and forever g[a]ve[] up the right to claim all compensation and benefits to which [she] might be entitled for each injury or occupational disease claimed here, including . . . chiropractic care." The parties intended the settlement to "FOREVER close[] all issues relating to this matter," and "stipulate[d] and agree[d] that this claim will never be reopened except on the grounds of fraud or mutual mistake of material fact." The settlement agreement was approved by an ALJ a week after the parties signed it.

On July 31, 2012, three weeks after finalizing the settlement agreement, claimant filed a new claim for workers' compensation benefits for the back injury she sustained in April 2012 while being treated by the chiropractor for her arm and shoulder injury.

Employer filed two motions for summary judgment, arguing that claimant's spine claim was barred by the parties' settlement agreement. Because claimant submitted a sworn affidavit with her response to the motion stating that the chiropractor was "adjusting [her] spine for an unrelated thoracic spine condition," the ALJ denied employer's motion.

Several months later, claimant answered interrogatories employer served on her. She conceded that the chiropractor "was apparently authorized to adjust [her] spine for her non-spinal injury of April 12, 2009." Employer then renewed its motion for summary judgment. It again argued that any injury she sustained while receiving chiropractic treatment for her arm and shoulder occurred within the "quasi-course of employment" and that any workers' compensation claim resulting from the chiropractic treatment was subsumed in and precluded by the parties' settlement agreement.

The ALJ agreed. He entered summary judgment in employer's favor and dismissed claimant's claim for her April 2012 back injury with prejudice. The Panel affirmed on review.

II. Analysis

On appeal, claimant contends that the "settlement was limited to a date of injury of April 12, 2009." She argues that by its terms the settlement "did not include her claims for a known lumbar spinal injury." To support her argument, she points out that the settlement agreement omits any mention of her spinal injury. She also criticizes the ALJ for a "180° reversal" of his denial of employer's earlier summary judgment motion. And, she maintains that her situation is "far more analogous" to *Employers Fire Insurance Co. v. Lumbermens Mutual Casualty Co.*, 964 P.2d 591 (Colo. App. 1998), which held that an accident the claimant suffered while driving to a medical appointment was a separate claim excluded from the settlement of that claimant's workers' compensation claim. We are not persuaded that the ALJ or Panel erred.

A. Governing Law

"[S]ummary judgment may be sought in a workers' compensation proceeding before the ALJ." *Fera v. Indus. Claim Appeals Office*, 169 P.3d 231, 232 (Colo. App. 2007). Under the Office of Administrative Courts' Rules of Procedure (OACRP) Rule 17, a party may move "for summary judgment seeking resolution of any endorsed issue for hearing." Dep't of Pers. & Admin. Rule 17, 1 Code Colo. Regs. 104-3. Like a motion for summary judgment pursued under C.R.C.P. 56, summary judgment may be granted in a workers' compensation case if "there is no disputed issue of material fact and . . . the party is entitled to judgment as a matter of law." OACRP Rule 17; *see also Nova v. Indus. Claim Appeals Office*, 754 P.2d 800, 802 (Colo. App. 1988) (noting that the Colorado Rules of Civil Procedure apply to workers' compensation proceedings unless inconsistent or in conflict with the procedures and practices followed under the Act).

We review an ALJ's legal conclusions on summary judgment de novo. *See A.C. Excavating v. Yacht Club II Homeowners Ass'n*, 114 P.3d 862, 865 (Colo. 2005). But, we may only set aside an ALJ's factual findings if they are unsupported by substantial

evidence in the record. § 8-43-308, C.R.S. 2014.

> We must therefore accept the ALJ's statements of undisputed facts . . . if substantial evidence in the record supports that statement of facts, but we must set aside the grant of summary judgment in an employer's favor if we determine that conflicts in the evidence are not resolved in the record or the order is not supported by applicable law.

Fera, 169 P.3d at 233.

B. Claim Barred by Settlement Agreement

A compensable injury is one that is causally connected to a workers' employment. *See Staff Adm'rs, Inc. v. Reynolds*, 977 P.2d 866, 868 (Colo. 1999) (injuries to worker who missed opportunity to carpool with other employees and was involved in automobile accident while traveling to jobsite were compensable). Injuries sustained while traveling to and from authorized medical care or while seeking authorized treatment are similarly compensable as a consequence of the original injury under the quasi-course of employment doctrine. *See Price Mine Serv., Inc. v. Indus. Claim Appeals Office*, 64 P.3d 936, 937-38 (Colo. App. 2003); *see also Turner v. Indus. Claim Appeals Office*, 111 P.3d 534, 538 (Colo. App. 2004).

Here, claimant does not dispute that her alleged back injury occurred while she was being treated for the work-related injury to her arm and shoulder. She argues instead that the parties never intended the back injury to be included in their settlement agreement and that she therefore was entitled to commence a new claim for the injury.

However, the parties' settlement agreement expressly incorporates "[o]ther disabilities, impairments and conditions that may be the result of these injuries or diseases but that are not listed here," and clarifies that such injuries "are, nevertheless, intended by all parties to be included in and resolved FOREVER by this settlement." By its express terms, this language is broad enough to encompass claimant's chiropractic injury within the parties' settlement agreement.

When the language used in a settlement agreement is "plain, clear and no absurdity is involved, a court must enforce the instrument as written." *Cary v. Chevron U.S.A., Inc.*, 867 P.2d 117, 119 (Colo. App. 1993). Enforcing the parties' settlement agreement as written, claimant's back injury, which she admittedly sustained

while receiving treatment for her compensable arm and shoulder injury, is encompassed in the settlement. Claimant is therefore barred by the terms of the settlement agreement from bringing a separate claim for the back injury.

C. Employers Fire Insurance Distinguishable

Claimant nevertheless argues that under *Employers Fire Insurance*, her back injury claim should not be barred. In *Employers Fire Insurance*, a claimant sustained an injury in a car accident while traveling to a medical appointment for treatment of a compensable injury. Shortly after the accident, the claimant and his employer settled his workers' compensation claim. Because the claimant was "unaware that the injuries he sustained in [the car] accident were compensable . . . he did not submit a further claim" for benefits with the workers' compensation insurer, and instead filed a claim with his automobile insurer. 964 P.2d at 593. A division of this court concluded that injuries the claimant sustained in the car accident "did not result from his original injury," and, consequently, were not foreclosed by the settlement agreement related to the original injury. *Id.* at 594.

Subsequently, a division of this court applied the quasi-course of employment doctrine to hold that injuries a claimant sustained in an automobile accident while traveling to authorized treatment for his workers' compensation injury were part of the same (and not, as the division in *Employers Fire Insurance* intimated, a separate) claim. *Price Mine*, 64 P.3d at 939.[1]

We find the quasi-course of employment doctrine articulated in *Price Mine* applicable and perceive no reason to stray from it here. Claimant never disputed that she was aware that the back injuries she sustained while treating with the chiropractor for her arm and shoulder injury could be asserted under the Act when she entered into a settlement agreement with employer. Indeed, she was represented when the chiropractor treated her and when she signed the settlement agreement. And, the terms of claimant's settlement agreement explicitly covered the situation here, that is, "injuries, conditions, diseases or disabilities as a consequence of [the original

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[1] The division further distinguished *Employers Fire Insurance* by noting that the claimant in that case did not know the injuries he sustained in the car accident could be compensable under the Act when he entered into the settlement agreement with his employer. *Price Mine Serv., Inc. v. Indus. Claim Appeals Office*, 64 P.3d 936, 938 (Colo. App. 2003).

compensable] injuries," including those occasioned during "chiropractic care." These factors distinguish this case from *Employers Fire Insurance*.

We therefore agree with the Panel and the ALJ that claimant's present claim is barred by the settlement agreement.

D. ALJ's Apparent Reversal of Decision

Lastly, to the extent claimant asserts that the ALJ's apparent "180° reversal" of his two earlier decisions denying employer's prior motions for summary judgment provides a basis for setting aside the ALJ's or Panel's final decision, we reject the argument. We note that an ALJ is not necessarily bound by earlier rulings. *See Sunny Acres Villa, Inc. v. Cooper*, 25 P.3d 44, 49 (Colo. 2001) (holding that the doctrine of collateral estoppel did not preclude a second ALJ from reaching a conclusion opposite that reached by the first ALJ who heard the case).

Moreover, having reviewed the record in its entirety, we agree with employer that its third, successful motion for summary judgment could not have been "identical" to its first two, as claimant contends. To the contrary, employer attached claimant's

answers to its interrogatories to its third motion for summary judgment. In those answers, claimant admitted that she sustained her back injury while undergoing chiropractic treatment for her compensable arm and shoulder injury. Because claimant only submitted the answers to employer in August 2013, employer did not have the benefit of the answers when it filed its earlier motions for summary judgment, and could not have attached them to its earlier motions.

III. Conclusion

Accordingly, we conclude claimant's April 2012 back injury was part of her compensable April 2009 arm and shoulder claim. We therefore perceive no error in the ALJ's or Panel's decisions that claimant's claim for workers' compensation benefits for the back injury was barred by the parties' settlement agreement.

The order is affirmed.

JUDGE HAWTHORNE and JUDGE DUNN concur.

14CA0640 Solis v ICAO 12-24-2014

COLORADO COURT OF APPEALS

Court of Appeals No. 14CA0640
Industrial Claim Appeals Office of the State of Colorado
WC Nos. 4-795-922 & 4-800-423

Margarita Solis,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado; Schwartz's Krautburger Kitchen, Inc.; and Truck Insurance Exchange,

Respondents.

ORDER AFFIRMED

Division III
Opinion by JUDGE HAWTHORNE
Dailey and Dunn, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(f)
Announced December 24, 2014

Ira L. Sanders, Greeley, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Hunter & Associates, Joe M. Espinosa, Denver, Colorado, for Respondents Schwartz's Krautburger Kitchen, Inc. and Truck Insurance Exchange

In this workers' compensation action, claimant, Margarita Solis, seeks review of a final order of the Industrial Claim Appeals Office (Panel). The Panel affirmed an administrative law judge's (ALJ) order awarding claimant benefits based on impairment ratings for claimant's back and right upper extremity lower than the impairment ratings issued by the physician who performed the division-sponsored independent medical examination (DIME). The ALJ determined that employer, Schwartz's Krautburger Kitchen, Inc., overcame the DIME's impairment rating. Because substantial evidence supports the ALJ's determination, we affirm.

I. Factual and Procedural History

Claimant sustained an admitted injury to her arm and wrist on June 6, 2009, when she caught her wrist in a dough machine while working for employer. She suffered a second work-related injury, this one to her low back, approximately one week later, on June 15, 2009, when she was rear-ended while delivering food for employer. She filed claims for workers' compensation benefits for both injuries.

In September 2010, her authorized treating physician (ATP) placed her at maximum medical improvement (MMI) with ratable

impairments of both her cervical and lumbar spinal segments, as well as impairment of her right upper extremity. He calculated her total impairment rating at nineteen percent of the whole person.

Employer then sent claimant to a physician it retained for an independent medical examination (IME). In addition to examining claimant, the IME physician reviewed claimant's prior medical records and learned that claimant was taking a narcotic, Vicodin, for back pain at least two months before the automobile accident. He also watched a surveillance video which showed claimant "using her right hand," rotating her neck fully, and walking around without any difficulty. Based on his records review, the video, and his examination of claimant, employer's IME physician opined that claimant's back problems were preexisting. He rated her right upper extremity impairment at ten percent.

After reviewing the IME report and the surveillance video, claimant's ATP agreed that claimant's back pain was most likely preexisting and not caused by the work-related motor vehicle accident. He opined that the records indicating claimant took Vicodin for back pain two months before the accident "negate[d] all spinal impairment." While treating claimant, he also repeatedly

noted that her pain behaviors did not corroborate her verbal pain complaints, evidencing "substantial signs of symptom magnification" and inconsistencies in her reporting.

The DIME physician examined claimant on three occasions. After the first exam, in March 2010, the DIME physician concluded that claimant was not yet at MMI, and sent her back to the ATP for more treatment. Nearly eighteen months later, in August 2011, after claimant had received additional treatment, the DIME physician placed her at MMI and rated her right upper extremity injury at thirteen percent, or eight percent of the whole person. Although claimant had undergone a spinal fusion in June 2011, "on her own" outside the workers' compensation system, the DIME physician did not provide a rating for claimant's back injury in the August 2011, report.

Claimant was sent back to the DIME physician for a third examination in April 2012. In this third report, the DIME physician incorporated a rating for claimant's back injury, calculating that her impeded range of back motion and spinal fusion combined to give her a rating of twenty-one percent of the whole person for her spine. When the previously-calculated upper extremity rating of

eight percent of the whole person was included, the DIME physician concluded that claimant had sustained a total impairment rating of twenty-seven percent of the whole person.

Employer's IME physician criticized the DIME's inclusion of claimant's back injury. He pointed out that the surgery was performed outside the workers' compensation system, that the injury was most likely preexisting, and that claimant had an extensive history of symptom magnification. Based on this evidence, the IME physician opined that the DIME physician's impairment rating was too high and should not have combined the wrist injury with the back injury. He suggested that "at most" claimant could be given an impairment rating of five percent for her lower back pain and thirteen percent for her right upper extremity injury.

After conducting a hearing, reading the IME physician's deposition transcript, and reviewing the available medical records, the ALJ found that employer had overcome the DIME's impairment rating. The ALJ found that the opinions of employer's IME physician were "credible, persuasive, and rise to the level of clear and convincing evidence that the DIME is incorrect in her

impairment of [c]laimant's spine." The ALJ therefore adopted the IME physician's suggested impairment rating: thirteen percent of the right upper extremity and five percent of the low back, ordering that claimant's benefits be calculated based on these impairment ratings. The Panel affirmed, holding that the ALJ's decision was supported by substantial record evidence.

II. Substantial Evidence Supports the ALJ's Factual Findings

A DIME physician's opinions concerning MMI and impairment of the whole person are binding unless overcome by clear and convincing evidence. § 8-42-107(8)(b)(III), C.R.S. 2014. Whether a party has overcome the DIME physician's opinion is a question of fact to be resolved by the ALJ. *Id.* Consequently, we may not set aside the ALJ's determination that a party has or has not overcome the DIME if the finding is supported by substantial record evidence. *See* § 8-43-308, C.R.S. 2014; *Benuishis v. Indus. Claim Appeals Office*, 195 P.3d 1142, 1144-45 (Colo. App. 2008). "Substantial evidence is that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage*, 914 P.2d at 414.

Substantial evidence supports the ALJ's finding that the DIME erred in calculating claimant's impairment rating. Employer's IME physician questioned the rating and discussed perceived errors in the impairment rating calculation at his deposition. He observed that: (a) claimant exhibited pain exaggerating behaviors; (b) her reporting of symptoms and causes was inconsistent; (c) claimant's back surgery was not authorized; and, (d) medical records confirmed that claimant had been prescribed narcotics for back pain before the motor vehicle accident that allegedly caused her back injuries. Moreover, the IME physician's views were corroborated by claimant's ATP, who agreed that the back surgery was not indicated, that claimant's reporting was inconsistent, and that she exaggerated her pain behaviors during medical examinations. These physicians also viewed video surveillance of claimant going about her daily life exhibiting minimal, if any, discomfort from pain.

Claimant asserts that evidence shows that her "lumbar range of motion has likely increased" after surgery. She also implies that the DIME physician's "range of motion calculations" and "additional permanent impairment" must have been accurate because the

employer did not "point to any error" in these ratings. However, claimant cites to neither legal authority nor record evidence supporting these contentions. Her arguments are therefore unpersuasive.

We are also unpersuaded by her suggestion that the DIME properly rated her back impairment because there was an "absence of any lumbar impairment having ever been previously assigned thereto." Claimant admitted at hearing that she had sustained a prior injury in 2001, and medical records reflect that she was previously injured and on pain medication for her back before the June 15, 2009, automobile accident. Nor are we persuaded to set aside the ALJ's or the Panel's order based on claimant's unsupported assertion that employer failed to challenge the adequacy of the DIME physician's review of her medical records.

Our standard of review does not permit us to set aside the Panel's or the ALJ's order on these grounds. *See* § 8-43-308; *Metro Moving & Storage*, 914 P.2d at 414. Despite claimant's assertion that the evidence supported a higher impairment rating, "we may not substitute our judgment for that of the ALJ." *Cordova v. Indus. Claim Appeals Offic*e, 55 P.3d 186, 191 (Colo. App. 2002). Because

the evidence discussed above and addressed in the ALJ's factual findings amply supports the ALJ's determination that employer had overcome the DIME's impairment rating by clear and convincing evidence, we, like the Panel, are bound by the findings and may not set them aside. § 8-43-308; *Metro Moving & Storage*, 914 P.2d at 414. The Panel, therefore, appropriately affirmed the ALJ's decision.

III. Claimant's Remaining Contentions Provide No Basis for Setting Aside Order

The other issues claimant raises in her briefs likewise do not provide a basis for setting aside the Panel's order. In particular, claimant challenges employer's "failure" to depose the DIME physician or produce medical records for the DIME physician's review, and questions employer's failure to provide the DIME with "all related medical records." To the extent claimant perceives the record as incomplete in these aspects, the record establishes that any omissions were the result of her inaction, not employer's errors.

Indeed, the record confirms that *claimant* requested, *and was granted*, the opportunity to depose the DIME physician. However, claimant apparently never scheduled the deposition and never

submitted a transcript of it to the ALJ. Never having received the anticipated transcript of the DIME physician's deposition, the ALJ imposed a deadline of June 10, 2013, to file any outstanding transcripts. No transcript appears in the record and we must therefore assume that claimant failed to take the necessary steps either to obtain the DIME physician's deposition or to submit it to the ALJ. She therefore cannot now complain that employer failed to depose the DIME physician. *See Reserve Life Ins. Co. v. Dist. Ct.*, 126 Colo. 217, 221-22, 247 P.2d 903, 905 (1952) (plaintiff who failed to file motion for protective order "waived any right" she may have had to object to the deposition's location).

Lastly, claimant has waived any contention she may have had that employer failed to provide "all relevant medical records" to the DIME physician. Under the applicable rule, employer should provide the DIME physician with relevant medical records, but claimant has recourse if employer fails to do so. The rule states:

> The insurer shall concurrently provide to the IME physician and all other parties, a complete copy of all medical records in their possession pertaining to the subject injury, postmarked or hand-delivered no fewer than fourteen (14) calendar days prior to the IME examination. If the insurer or its representative fails to timely

> submit medical records to the designated IME physician, the claimant may request the Division cancel the IME; or the claimant may submit all medical records he/she has available no later than ten (10) calendar days prior to the IME examination; or as otherwise arranged by the Division with the IME physician.

Dep't of Labor & Emp't Rule 11-3(J), 7 Code Colo. Regs. 1101-3. It appears undisputed that claimant neither canceled the DIME nor submitted the medical records to the DIME physician herself. Consequently, she has waived any argument she may otherwise have had that employer failed to provide the DIME physician with all necessary medical records.

IV. Conclusion

Because substantial evidence supports the ALJ's factual finding that employer overcame the DIME report, we may not set it aside. *See* § 8-43-308; *Wilson v. Indus. Claim Appeals Office*, 81 P.3d 1117, 1119 (Colo. App. 2003). The Panel therefore properly affirmed the ALJ's order awarding claimant benefits based on an impairment rating of thirteen percent of the right upper extremity and five percent for her low back.

The order is affirmed.

JUDGE DAILEY and JUDGE DUNN concur.