

BROWN BAG SEMINAR

Thursday, January 17, 2013

(third Thursday of each month)

Noon - 1 p.m.

633 17th Street

2nd Floor Conference Room
(use elevator near Starbucks)

1 CLE (including .4 ethics)

Presented by

Craig Eley

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

Sponsored by the Division of Workers' Compensation

Free

This outline covers ICAP and Appellate decisions issued from December 15, 2012 through January 11, 2013

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-724-791

IN THE MATTER OF THE CLAIM OF

MATTHEW CREAGAN,

Claimant,

v.

FINAL ORDER

ALBERTINI CONSTRUCTION,

Employer,

and

TRUCK INSURANCE EXCHANGE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge (ALJ) Mottram dated February 22, 2012, to the extent it denied him payment of medical bills. We affirm.

This matter went to hearing to consider the issues of whether the claimant sustained a compensable injury or occupational disease, temporary total disability benefits, average weekly wage, disfigurement, and whether the respondents were responsible to pay certain medical benefits. The ALJ was persuaded that the claimant sustained an occupational disease concerning his thoracic outlet syndrome and deep venous thrombosis on his right side and awarded the claimant temporary total disability benefits, together with disfigurement benefits. The ALJ denied the claimant's request for payment of medical bills related to his occupational disease.

The ALJ recited the claimant's testimony and appears to have relied on it for several of his findings. According to the ALJ's decision, the claimant helped the respondent employer build a residence. The claimant also worked elsewhere part-time as a bartender. The claimant's duties for the respondent employer included lifting beams made of laminated veneer lumber. The claimant noticed his bicep getting tender. He initially thought he pulled a muscle in his arm. Over a period of five days the claimant noticed desensitization and discoloration of his right hand that increased in severity. On or about June 22, 2006, the claimant showed his arm to his immediate supervisor. The supervisor suggested the claimant seek medical attention, but did not refer the claimant to any specific physician. Mr. Albertini testified that the claimant did not report his issues to be work-related.

An ultrasound taken on June 22 revealed a deep vein thrombosis. The claimant was given medication and told not to work. The claimant was referred to Dr. Brantigan on June 27, 2006. Dr. Brantigan diagnosed a right thoracic outlet syndrome and noted that an unusually shaped rib contributed to a narrowing of the claimant's anterior costoclavicular space. He performed surgery for the thoracic outlet syndrome. Dr. Brantigan later performed another procedure on November 1, 2006, on the claimant's left side as a preventative measure. The claimant was off work until January 5, 2007.

The claimant returned to work with the employer and after discussing his condition with Dr. Brantigan, the claimant filed a claim for benefits on March 31, 2007. The ALJ was persuaded that the claimant was not aware of the compensable nature of his injury until he conferred with Dr. Brantigan. The ALJ was further persuaded that the claimant reported his injury to the employer on March 31, 2007.

The ALJ credited Dr. Brantigan's opinions and found that the claimant's right thoracic outlet syndrome was caused or aggravated by his work with the respondent employer. The ALJ was not persuaded that the claimant's work-related condition included the subsequent surgery for the left thoracic outlet syndrome. He awarded limited temporary total disability benefits and a disfigurement payment. The ALJ denied payment of the claimant's medical bills related to the claimant's right thoracic outlet syndrome, however, because he determined that the claimant's symptoms would not cause a reasonably conscientious manager to realize the compensable nature of the claimant's condition. Moreover, the ALJ was not persuaded that the claimant's medical treatment was in the nature of emergency treatment.

I.

The claimant argues that the respondents waived their ability to assert the issue of medical authorization. *See Kuziel v. Pet Fair, Inc.*, 948 P.2d 103, 105 (Colo. App. 1997) (failure to assert issue before ALJ constitutes waiver). We disagree.

Pursuant to § 8-43-102(2), C.R.S., an employer with an occupational disease must give the employer written notice of his contraction of the disease "within thirty days after the first distinct manifestation thereof" or face the reduction of his compensation. The imposition of a late reporting penalty is discretionary because the statute states the ALJ "may" reduce the claimant's compensation. *Emigh v. Wal-Mart Stores, Inc.*, W.C. No. 4-151-148 (April 14, 1995).

At the outset of the hearing the parties discussed the affirmative defense of late reporting of the injury. The respondents' counsel acknowledged that the matter of late reporting was not endorsed as a penalty or otherwise and advised the ALJ that it would not be an issue. Tr. at 5-6.

Medical authorization, on the other hand, was identified by the claimant in his application for hearing and by both parties in their respective case information sheets. The claimant had the burden of proof to establish that the medical treatment was authorized as well as reasonable and necessary. *See* § 8-43-201, C.R.S. (claimant has burden of proof to establish entitlement to benefits). Here, the respondents denied liability for the disputed medical benefits and the claimant had the burden of proof to demonstrate entitlement. Therefore, the claimant was required to prove that the disputed treatment was authorized as well as reasonable and necessary. *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002); *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999); *Mason Jar Restaurant v. Industrial Claim Appeals Office*, 862 P.2d 1026 (Colo. App. 1993).

The claimant tendered a proposed decision in which he attempted to establish his entitlement to medical benefits by asserting that medical benefits were both authorized and reasonable and necessary. He argued various bases for his contentions, including the receipt of alleged emergency treatment and the respondents' failure to refer him for treatment when a reasonably conscientious manager would be aware of the potential claim. We are not persuaded that the issue of authorization of treatment was effectively waived as an issue for litigation.

II.

The claimant argues that he did not have to report his injury because the employer failed to post notice of how to report injuries as required by § 8-43-102(1)(b), C.R.S. According to subsection (1)(a) of the statute if the employer fails to display notice the period for the employee to report his injury is tolled. The claimant asserts that the employer's alleged failure to post notice about his reporting duties relieved him of the need to report the injury. The claimant therefore reasons that the employer was not entitled to refer him for medical treatment in the first instance. *See* § 8-43-404(5)(a), C.R.S. (2006) (employer or insurer has right in first instance to select the physician who attends injured employee, but if the services of physician are not tendered at time of injury employee shall have right to select physician). In his proposed order the claimant asserted that the employer's failure to post notice was undisputed. He also referred to § 8-43-102(1)(b). He did not articulate any legal argument concerning the effect of the employer's alleged failure to post notice about reporting injuries. We conclude, however, that the claimant made sufficient reference to § 8-43-102 to warrant its consideration by the ALJ. *See Munoz v. Industrial Claim Appeals Office*, 271 P.3d 547 (Colo. App. 2011)(stay issue sufficiently preserved for review).

In any event, § 8-43-102(1)(a) serves to toll the time period in which the claimant should report his injury to the employer and avoid a potential loss of compensation for

failing to report the injury. The ALJ found, however, that the claimant reported his injury to the employer on March 31, 2007. Respondents are generally liable for medical treatment provided by a provider legally authorized to treat the claimant and they are obligated to designate a treating physician upon notice of the claimant's injury. *See* § 8-43-404(5)(a), C.R.S. (giving respondents first right in first instance to select claimant's physician); *see also Bunch v. Industrial Claim Appeals Office*, 148 P.3d 381, 383-84 (Colo. App. 2006) (reviewing employers' and insurers' obligations to provide medical treatment and right of selection of physician). Since the ALJ found that the employer had notice of the claimant's injury on March 31, 2007, and the disputed medical treatment was provided prior to this date, we find no relief to be afforded to the claimant based on § 8-43-102, C.R.S.

III.

The claimant argues that substantial evidence does not support the ALJ's finding that the claimant did not receive treatment on an emergency basis. The court of appeals has recognized an exception for emergency treatment to the employer's right to choose the treating physician. *See Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990) (after emergency treatment ended claimant "required to notify her employer and give it a reasonable opportunity to furnish" subsequent treatment).

The question of whether there is an emergency situation and whether there has been a medical referral are ordinarily questions of fact for determination by the ALJ. *See Amorelli v. Amorelli Plumbing and Heating, Inc.*, W.C. No. 4-436-946 (Sept. 26, 2001) (question of whether employer timely tendered services of physician after notice of an injury is one of fact). Thus, we must uphold the ALJ's determination if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; *Gonzales v. Crowley County*, W.C. No. 4-250-651, (Nov. 27, 2000).

The ALJ determined that the claimant's treatment by Dr. Wilson on June 22, 2006, at Steamboat Urgent Care, as well as follow-up treatment by Dr. Brantigan and Presbyterian/St. Luke's Medical Center on and after June 27, 2006, was not emergency care. The ALJ made findings about how the claimant did not identify his condition as being work-related, but more importantly, he found the claimant's condition concerning his deep venous thrombosis developed over several days. The claimant indicated in his testimony that his right arm exhibited symptoms for five or six days prior to June 22, 2006. Tr. at 18-19. In other portions of his findings the ALJ noted that the claimant was given medication for his thrombosis after the claimant reported his arm becoming more swollen over a four-day period at work. The ALJ also observed that Dr. Brantigan performed a right rib resection for the claimant's right thoracic outlet syndrome. The record includes a medical report indicating that Dr. Brantigan performed the surgery on

July 1, 2006, which was several days after the claimant was first found to comment to co-workers about his condition. Exhibit 5.

The question of whether a bona fide emergency exists is one of fact and is dependent on the circumstances of the particular case. *Timko v. Cub Foods*, W. C. No. 3-969-031 (June 29, 2005). Therefore, we must uphold the ALJ's determination if supported by substantial evidence. Moreover, we may not reweigh the evidence before the ALJ. The ALJ's findings are based on substantial evidence and are sufficient to support the determination that the claimant did not receive medical treatment on an emergency basis, notwithstanding evidence from which contrary inferences could be made. Section 8-43-301(8), C.R.S.

IV.

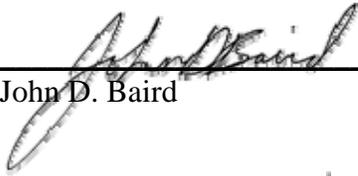
In order to maintain the right to designate a provider in the first instance, the employer has an obligation to name the treating physician upon receiving notice of the compensable injury. *See Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565 (Colo. App. 1987). The employer's duty to designate is triggered once the employer or insurer has some knowledge of facts that would lead a reasonably conscientious manager to believe the case might involve a claim for compensation. *Bunch v. Industrial Claim Appeals Office, supra; Jones v. Adolph Coors Co.*, 689 P.2d 681 (Colo. App. 1984).

The claimant asserts that as found by the ALJ the employer was aware of the compensable nature of the claimant's condition in March 2007. Thus, the claimant asserts that the employer had a duty at that time to designate a medical provider. That may be, but it appears from the ALJ's decision and from the record that the particular medical benefits at issue were provided prior to March 2007. For example, the record includes a bill related to Dr. Wilson's services that were rendered in June 2006. Exhibit 6. The record also includes a letter from Dr. Brantigan to the claimant's private insurance carrier discussing payment for his services rendered in 2006. Exhibit E. Furthermore, the ALJ reserved for future determination all matters not determined by his decision. We therefore find no basis for relief on review.

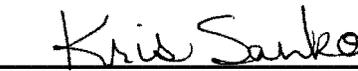
The respondents request attorney fees under § 8-43-301(14), C.R.S. and asserts that the claimant's petition to review was filed to delay and increase costs for litigation. We decline to assess attorney fees.

IT IS THEREFORE ORDERED that the ALJ's order dated February 22, 2012, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



John D. Baird



Kris Sanko

MATTHEW CREAGAN

W. C. No. 4-724-791

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CERTIFICATE OF MAILING

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

_____ 12/21/2012 _____ by _____ RP _____ .

ALBERTINI CONSTRUCTION, Attn: NANCY ALBERTINI, P O BOX 775768,
STEAMBOAT SPRINGSS, CO, 80477 (Employer)

TRUCK INSURANCE EXCHANGE, Attn: LISA WATKINS, C/O: WORKERS'
COMPENSATION BCO, P O BOX 108843, OKLAHOMA CITY, OK, 73101 (Insurer)

WILLIAM C. HIBBARD, P.C., Attn: WILLIAM C. HIBBARD, ESQ., P O BOX 773959,
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BOULDER, CO, 80302 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-823-944-01

IN THE MATTER OF THE CLAIM OF

SHERYL FRIESZ,

Claimant,

v.

WAL-MART STORES, INC.,

Employer,

and

AMERICAN HOME ASSURANCE,

Insurer,
Respondents.

FINAL ORDER

The respondents seek review of an order of Administrative Law Judge Henk (ALJ) dated July 26, 2012, that granted the claimant's petitions to reopen her claims. We affirm.

The ALJ found that on November 29, 2007, the claimant suffered an admitted industrial injury to her left foot in claim number 4-823-944. On April 1, 2008, the claimant suffered an admitted industrial injury to her right foot in claim number 4-756-067. On April 26, 2011, the claimant's authorized treating physician, Dr. McKenna, placed the claimant at maximum medical improvement (MMI) for both her right foot and left foot. Dr. McKenna assessed a 0% impairment rating for the claimant's left foot, and a 2% right lower extremity rating for her right foot. Dr. McKenna also opined that he did not feel any ongoing maintenance therapy was indicated.

On June 8, 2011, the claimant filed an objection to the final admission of liability (FAL) and a proposal to select a division independent medical examination (DIME) in both claim numbers. The claimant, however, did not pursue the DIME.

On January 4, 2012, the Director for the Division of Workers' Compensation entered an order to show cause in both claim numbers. The claimant did not respond.

On February 14, 2012, the claimant filed two petitions to reopen attaching a medical report authored by Dr. Hartlove, dated February 1, 2012, which opined that the claimant has sustained a worsening of her medical condition:

. . . It appears that these fractures have healed but she has developed severe ongoing unremitting pain, burning and numbness along with color and temperature changes in both feet. She has had diagnostic sympathetic nerve blocks that gave her temporary help but never lasted more than a few days. She also has been placed on Lyrica, Cymbalta, [F]entanyl and pain medications. These gave her some improvement but the Worker's Compensation physician has refused to continue these medications. Since she stopped, her symptoms have significantly worsened. She also has undergone significant physical therapy without any help. She has been told that her problems may be all mental.

* * * *

Because of her ongoing symptoms, her signs of coolness in her feet despite adequate pulses, trophic skin changes, temporary improvement with diagnostic sympathetic nerve blocks and her light red hair, I feel she is experiencing Complex Regional Pain Syndrome bilaterally. This is a debilitation (sic) condition and I feel if she is not treated appropriately with a chronic pain specialist, she will continue to deteriorate and this will affect her both physically and mentally to a significant degree.

The claimant also filed two applications for hearing, requesting that the claimant's closed workers' compensation claims be reopened, that medical benefits including a change of physician be granted, and that the claimant be paid temporary total disability (TTD) benefits from February 1, 2012, and ongoing. The claimant's two hearing applications were consolidated for the hearing.

Prior to hearing, the respondents failed to authorize or permit the claimant to return to her authorized treating provider, Dr. McKenna.

After hearing, the ALJ granted the claimant's petitions to reopen her claims. Finding the claimant's testimony credible and persuasive, the ALJ determined that the claimant had established her condition had worsened since MMI. The ALJ found that the claimant credibly testified she was experiencing more severe pain in both her left and right extremities than she was when placed at MMI, and that her activities of daily living were more restricted than when she was released at MMI. The ALJ also found that the claimant's increased pain made it difficult for her to find employment, that she now was experiencing numbness in her feet eight to ten hours per day, that she now can only stand for approximately five minutes at a time, that she now has to lie down most of the day, and that she now is experiencing pain at a level of nine out of ten, whereas her pain level was at four to six out of ten when Dr. McKenna released her at MMI on April 26, 2011. Additionally, the ALJ found that from February 1, 2012, and ongoing, the

claimant has been unable to return to any job due to the effects of her foot injuries. Thus, the ALJ concluded that the claimant's weakened condition is a proximate cause of her further deterioration. The ALJ also concluded that the claimant is disabled under §8-42-105, C.R.S. and entitled to TTD beginning February 1, 2012, until terminated by law. The ALJ further found that even though the respondents were on notice of the claimant's request for medical benefits, they failed to authorize or permit her to return to Dr. McKenna for treatment. Consequently, the ALJ granted the claimant's request for a change of physician to Dr. Hartlove.

I.

On review, the respondents argue that the ALJ erred in finding that the claimant suffered a worsened condition thereby justifying reopening her claims. The respondents contend that the claimant's request to reopen based on a new diagnosis of CRPS, for symptoms Dr. McKenna opined were not work-related, must be denied and dismissed. The respondents argue that Dr. McKenna determined that the only ratable impairments from the claimant's industrial injuries were bilateral foot fractures, and that he and several other authorized treating physicians "ruled out" the work-relatedness of the claimant's alleged CRPS. According to the respondents, since the claimant allowed her claims to close without proceeding through the DIME process to dispute Dr. McKenna's opinions on causation, MMI, impairment, and treatment post-MMI, jurisdiction was lost.

Conversely, the claimant argues that she was not challenging the finding by her original treating doctors that she did not have CRPS. Rather, the claimant argues that she was alleging a worsening of condition related to her original fractures in her feet, and the complications from the fractures, which worsening may now be CRPS. The claimant further argues that since she was not challenging the treating providers' MMI determination, she was not required to pursue a DIME. We perceive no reversible error in the ALJ's order.

Section 8-43-303(1) C.R.S. authorizes an ALJ to reopen any award within six years after the date of injury on a number of grounds, including error, mistake, or a change in condition. *Heinicke v. Industrial Claim Appeals Office*, 197 P.3d 220 (Colo. App. 2008); *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). A change in condition refers either "to a change in the condition of the original compensable injury or to a change in claimant's physical or mental condition which can be causally connected to the original compensable injury." *Chavez v. Industrial Comm'n*, 714 P.2d 1328, 1330 (Colo. App. 1985); *accord Anderson v. Longmont Toyota, Inc.*, 102 P.3d 323, 330 (Colo. 2004).

The reopening authority granted ALJs by §8-43-303, C.R.S. “is permissive, and whether to reopen a prior award when the statutory criteria have been met is left to the sound discretion of the ALJ.” *Cordova v. Industrial Claim Appeals Office*, 55 P.3d at 189. The party seeking reopening bears “the burden of proof as to any issues sought to be reopened.” Section 8-43-303(4), C.R.S. In the absence of fraud or clear abuse of discretion, the ALJ’s decision concerning reopening is binding on appeal. *Jarosinski v. Industrial Claim Appeals Office*, 62 P.3d 1082 (Colo. App. 2002). An abuse of discretion occurs when the ALJ’s order is beyond the bounds of reason, as where it is unsupported by the evidence or contrary to law. *Id.*

Here, we are unable to say that the ALJ’s order is beyond the bounds of reason or is unsupported by the evidence or contrary to the law. To the extent the respondents argue that causation of the claimant’s “CRPS-like” symptoms cannot be challenged in reopening or post-reopening proceedings, we are not persuaded to disturb the ALJ’s order on this ground. *Cf. Berg v. Industrial Claim Appeals Office*, 128 P.3d 270 (Colo. App. 2005). While the respondents correctly assert that the DIME physician’s opinion concerning causation is an inherent part of a rating, it is clear from her order that the ALJ was not persuaded by the respondents’ argument regarding CRPS. *See Uptime Corp. v. Colorado Research Corp.*, 161 Colo. 87, 420 P.2d 232 (1966) (ALJ is not required to explicitly discuss defenses or theories she rejected as unpersuasive); *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000) (ALJ not held to crystalline standard in articulating her findings of fact and findings which are necessarily implied by the ALJ’s order may be considered). In her order, the ALJ did not explicitly find that the claimant suffered from CRPS or that her request to reopen was based on a new diagnosis of CRPS. Rather, the ALJ found, with record support, that the claimant’s condition has worsened because she now experiences more severe pain in both her left and right extremities than when she was placed at MMI, and because her activities of daily living are more restricted than when she was released at MMI. Findings of Fact at 4 ¶¶14, 15, 19.

During the hearing, the claimant testified that on the day she was released to MMI, the pain level in her left foot was five to six. The claimant further testified that after her case was closed on January 14, 2012, her pain started worsening to an eight to nine. She further explained that she now cannot stand for more than about five minutes, it bothers her to sit, and most of the time she has to lie down. Moreover, the claimant testified that after MMI, her ability to walk, stand, and sit have become more limited. She explained that this is so because of the pain, numbness and tingles that she now is experiencing. Tr. at 11-12, 16-17, 43. We further note that the ALJ found that Dr. McKenna did not evaluate the claimant after MMI. The ALJ found, however, that the claimant treated with Dr. Hartlove after MMI or on February 1, 2012, and he recommended the claimant

continue treatment with a chronic pain specialist in order to prevent further deterioration of her bilateral foot problems. Ex. 10 at 36-40.

Moreover, in their brief in support, the respondents point to medical reports from Drs. Schakaraschwili, Hammerberg, and Thacker which indicate that the claimant is not suffering from CRPS. The mere fact that such evidence might have supported contrary findings and conclusions, however, affords the respondents no basis for relief on appeal. *May D & F v. Industrial Claim Appeals Office*, 752 P.2d 589 (Colo. App. 1988). The weight and credibility to be assigned expert testimony is a matter within the sole discretion of the ALJ and we may not substitute our judgment for that of the ALJ. *Cordova v. Industrial Claim Appeals Office*, *supra*.

Similarly, we are not persuaded by the respondents' argument that the claimant's condition cannot have worsened because the claimant testified that her symptoms only worsened after being taken off medications. The respondents' argument notwithstanding, the ALJ did not find that the claimant's condition only worsened after being taken off of medications. Again, as noted above, the ALJ found that the claimant's condition has worsened because she now experiences more severe pain in both her left and right extremities, and because her activities of daily living are more restricted than when she was released at MMI. Findings of Fact at 4 ¶¶14, 15, 19. Section 8-43-301(8), C.R.S. Consequently, under these circumstances, we are not persuaded to disturb the ALJ's order.

II.

Next, the respondents argue that the ALJ erred in awarding TTD benefits because the claimant's worsened condition did not cause additional wage loss. The respondents reason that on the date of MMI, the claimant was restricted from all work activity, and she remains restricted from all work activity. Once again, we are not persuaded.

The respondents primarily rely upon the holding in *City of Colorado Springs Disposal v. Industrial Claim Appeals Office*, 954 P.2d 637 (Colo. App. 1997). In *City of Colorado Springs*, the claimant sustained an admitted industrial injury to his back and was placed at MMI. As part of claimant's ongoing therapy, his treating physician prescribed the use of an exercise machine. Some four months after reaching MMI, the claimant's use of this machine caused him to develop tendinitis in his shoulders. Nevertheless, the ALJ found that this latter condition did not result in any further physical restrictions and that there was no credible evidence that this condition caused any greater temporary wage loss than claimant sustained as a result of his initial back injury alone.

We previously have read *City of Colorado Springs* as standing for the proposition that a worsening of condition after MMI may entitle the claimant to additional temporary

disability benefits if the worsened condition caused a “greater impact” on the claimant’s temporary work capacity than existed at the time of MMI. *Root v. Great American Insurance Company*, W.C. No. 4-534-254 (April 15, 2009). Further, the Panel has ruled that *City of Colorado Springs* does not require the claimant to establish an “actual wage loss” where, for example, the claimant was not working immediately before the worsened condition. *Moss v. Denny’s Restaurants*, W.C. No. 4-440-517 (September 27, 2006). In *Lively v. Digital Equipment Corporation*, W.C. No. 4-330-619 (June 14, 2002) the Panel stated that “[a]s we read *City of Colorado Springs*, in order to establish entitlement to additional temporary disability benefits the claimant must show the worsened condition resulted in increased physical restrictions (over those which existed on the original date of MMI), and that the increased restrictions caused a ‘greater impact’ on the claimant’s temporary ‘work capability’ than existed at the time of MMI.”

Thus, the critical issue in cases controlled by *City of Colorado Springs* is not whether the worsened condition actually resulted in additional temporary wage loss, but whether the worsened condition has had a greater impact on the claimant’s temporary work “capacity.” See *El Paso County Department of Social Services v. Donn*, 865 P.2d 877 (Colo. App. 1993); *Ridley v. K-Mart Corp.*, W.C. No. 4-263-123 (May 27, 2003). We are not persuaded to depart from the Panel’s prior conclusions. It therefore follows that it is the impact of the claimant’s work “capacity,” not proof of an actual wage loss, which determines whether the claimant has established entitlement to TTD benefits in connection with a worsening of condition after MMI.

The question of whether the claimant proved increased disability, as measured by a reduction in her capacity to earn wages, was a question of fact for determination by the ALJ. See *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). Consequently, we must uphold the ALJ’s findings if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires us to view the evidence in a light most favorable to the prevailing party, and defer to the ALJ’s resolution of conflicts in the evidence, credibility determinations, and plausible inferences drawn from the record. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

Here, the ALJ found that the claimant’s testimony and Dr. Hartlove’s February 1, 2012, medical report established that the claimant has suffered a disability as a result of her industrial injury and has suffered an impairment of her earning capacity. The ALJ found that the claimant has suffered both medical incapacity and restrictions to bodily function and has been unable to return to any job due to the effects of her injuries. The ALJ further found, with record support, that the claimant’s increased pain has made it difficult to find employment. Findings of Fact at 4 ¶15; Tr. at 11-12. As noted above, the claimant testified that her pain started worsening to an eight to nine, she now cannot stand for more than about five minutes, her ability to walk, stand, and sit have become more limited, and most of the time she has to lie down. Tr. at 11-12, 16-17, 43. While it

is true that the claimant's open labor market options were quite limited before Dr. McKenna placed her at MMI and excluded her from working for her employer, her options are even more limited after her worsening and the reopening. Thus, the ALJ's findings demonstrate that the claimant's worsened condition has resulted in additional physical restrictions and has had a greater impact on the claimant's temporary work "capacity" beyond that which existed at MMI. In our view, therefore, the ALJ's order is supported by substantial evidence and by the correct application of the law, and we will not disturb it. Section 8-43-301(8), C.R.S.

III.

Last, the respondents argue that the ALJ erred in ordering a change of physician. The respondents assert that the right of selection never passed to the claimant because Dr. McKenna discharged her for medically related reasons or because he did not believe that the claimant had a treatable injury. We are not persuaded.

Section 8-43-404 (5)(a)(VI), C.R.S. allows a claimant to obtain a change of physician by making a written request to the insurer. If the insurer fails to respond to the written request within twenty days, the insurer is deemed to have waived the right to object to the change and the physician selected by the claimant is authorized to treat the injury. *Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996).

Here, the respondents' argument notwithstanding, we conclude that the ALJ's order granting the change of physician to Dr. Hartlove is consistent with applicable law and supported by the evidence in the record. Section 8-43-404(5)(a)(VI), C.R.S. specifically states that a claimant may make a written request for a change of physician at any time during the claim. The ALJ found, with record support, that the respondents were placed on notice that the claimant was alleging a change of condition and in need of medical treatment, but they did not offer a medical provider. Tr. at 13, 19. Contrary to the respondents' assertion, they were required to respond to the claimant's request under §8-43-404(5)(a)(VI), C.R.S. As such, the right to select a medical provider passed to the claimant and she chose Dr. Hartlove. Section 8-43-404(5), C.R.S.; *see also Wright v. City and County of Denver*, W.C. No. 4-172-924 (Dec. 4, 1995)(when a claim has been closed, and the claimant seeks to reopen based on a worsened condition, it falls to the employer or insurer to designate an authorized treating physician for purposes of providing additional treatment; if employer or insurer fails to authorize a physician, the right to select the physician passes to the claimant). We further note that the claimant testified she had lost faith and confidence in Dr. McKenna. Tr. at 12. As such, the ALJ found that there no longer is a therapeutic relationship between the claimant and Dr. McKenna and she granted the request for a change of physician. Thus, under these

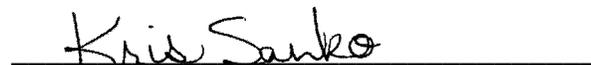
circumstances, we are not persuaded to disturb the ALJ's order. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated July 26, 2012, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



Kris Sanko

CERTIFICATE OF MAILING

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

_____ 12/21/2012 _____ by _____ RP _____ .

SHERYL FRIESZ, 831 17TH AVE. #39, LONGMONT, CO, 80501 (Claimant)
WAL-MART STORES, INC., 2514 N. MAIN STREET, LONGMONT, CO, 80504 (Employer)
AMERICAN HOME ASSURANCE, Attn: LISA SMITH, C/O: CMI, P O BOX 1288,
BENTONVILLE, AR, 72712 (Insurer)
LAW OFFICE OF O'TOOLE & SBARBARO, PC, Attn: JOHN A. SBARBARO, ESQ., 226
WEST TWELFTH AVENUE, DENVER, CO, 80204-3625 (For Claimant)
CLIFTON, MUELLER & BOVARNICK, PC, Attn: M. FRANCES MCCRACKEN, ESQ., 789
SHERMAN STREET, SUITE 500, DENVER, CO, 80203 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-886-148-01

IN THE MATTER OF THE CLAIM OF

STAN HAHN,

Claimant,

v.

ORDER OF REMAND

TOWN OF VAIL,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge (ALJ) Cannici dated August 22, 2012, granting summary judgment for the respondents on the ground that the claim is time-barred. We set aside the decision and remand this matter for the ALJ's further consideration.

According to the ALJ's findings, the claimant alleged he sustained a work-related back injury on September 4, 2008, when he slipped and fell. The claimant received conservative treatment for a lumbar strain and the authorized treating physician placed him at maximum medical improvement on October 8, 2008, with no impairment rating and no work restrictions. The claimant did not lose any time from work. No compensation or benefits were payable and the claimant did not file a claim for workers' compensation benefits. On May 9, 2012, the respondent insurer filed a notice of contest, asserting that the claimant failed to file a claim within the statute of limitations. The claimant's counsel entered an appearance and the claimant filed an application for hearing on June 6, 2012, seeking various benefits. The respondents filed a response endorsing the statute of limitations as an affirmative defense. The ALJ found that the claimant's application for hearing on June 6, 2012, is the first date providing notice that he was claiming benefits or compensation in relation to the alleged incident on September 4, 2008.

The respondents moved for summary judgment on the ground that the claim for benefits was barred by the applicable statute of limitations. Section 8-43-103(2), C.R.S. requires claims for injuries (not concerning certain toxic exposures) to be filed within two years after the injury. The time limit may extend to three years if there is a reasonable

excuse for failing to file a “notice claiming compensation and if the employer’s rights have not been prejudiced thereby.” The claimant responded that the time for his claim to run did not commence until he reasonably recognized the compensable character of his injury. The claimant asserted that he knew he may have had an injury after undergoing back surgery more than two and one-half years after the initial incident at work concerning his back. The respondents noted that the claimant did not miss three days of work.

The ALJ entered an order granting summary judgment to the respondents. The ALJ’s decision contains findings of fact and conclusions of law, and constitutes a full order for purposes of review. *See* § 8-43-215(1), C.R.S. (full order is final award and subject to review).

The ALJ was persuaded that the claim is time-barred and concluded that under the circumstances the claimant had to file his claim within three years from his alleged work incident on September 4, 2008, in order to be timely.

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

Summary judgment is a drastic remedy and is not warranted unless the moving party demonstrates that it is entitled to judgment as a matter of law. *Van Alstyne v. Housing Authority of Pueblo*, 985 P.2d 97 (Colo. App. 1999). All doubts as to the existence of disputed facts must be resolved against the moving party, and the party against whom judgment is to be entered is entitled to all favorable inferences that may be drawn from the facts. *Kaiser Foundation Health Plan v. Sharp*, 741 P.2d 714 (Colo. App. 1987). Once the moving party establishes that no material fact is in dispute, however, the burden of proving the existence of a factual dispute shifts to the opposing party. The failure of the opposing party to satisfy its burden entitles the moving party to summary judgment. *Gifford v. City of Colorado Springs*, 815 P.2d 1008 (Colo. App. 1991).

In the context of summary judgment, we review the ALJ's legal conclusions de novo. *See A.C. Excavating v. Yacht Club II Homeowners Association*, 114 P.3d 862 (Colo. 2005). Pursuant to §8-43-301(8), C.R.S., however, we have authority to set aside an ALJ's order only where the findings of fact are not sufficient to permit appellate review,

conflicts in the evidence are not resolved, the findings of fact are not supported by the evidence, the findings of fact do not support the order, or the award or denial of benefits is not supported by applicable law.

The claimant asserts that a dispute remains as to when the statute of limitations began to run in his case. According to the claimant he did not reasonably learn that he may have a compensable injury until he missed three days of work after undergoing surgery in May 2011. The claimant argues that these assertions present disputed issues of material fact. We conclude that summary judgment was not appropriate under the circumstances.

The ALJ essentially viewed the statute of limitations as posing an absolute bar to any claim filed beyond three years from the alleged work incident. The statute of limitations does not begin to run until the claimant recognizes the “nature, seriousness and probable compensable character of his injury.” *City of Boulder v. Payne*, 162 Colo. 345, 351-52, 426 P.2d 194, 197 (1967). Moreover, the statute of limitations runs from the time of injury as opposed to always running from date of the initial incident or accident. *Id.*

The requirement that the claimant recognize the “seriousness” of the injury contemplates the claimant will recognize the gravity of the medical condition. Furthermore, a “compensable” injury is one which is disabling and entitles the claimant to compensation in the form of disability benefits. *Id.*; *Romero v. Industrial Commission*, 632 P.2d 1052 (Colo. App. 1981). Therefore, to recognize the “probable compensable character” of an injury, the injury must be of sufficient magnitude that it causes a disability which would lead a reasonable person to recognize that he may be entitled to compensation benefits. *Romero v. Industrial Commission, supra* (claimant was not obligated to report an injury until its seriousness was discovered and she was forced to stop work); *Hoaglund v. B & B Excavating*, W.C. No. 4-465-123 (September 13, 2001). In this regard, we previously have stated that “[f]or purposes of the statute of limitations, a ‘compensable’ injury is one which is disabling, and entitles the claimant to compensation in the form of disability benefits.” *Emrich v. Jackson Hewitt Tax Service*, W.C. No. 4-241-443 (October 27, 1998). *See also Sopp v. City of Colorado Springs*, W.C. No. 4-443-162 (January 10, 2002).

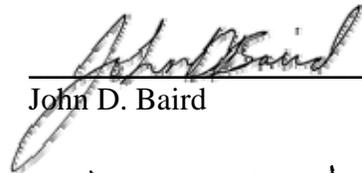
Thus, our courts have held that where a claimant was aware of an industrial back injury, but unaware the injury might later cause a disc herniation, the claimant did not recognize the seriousness of the injury until the herniation was discovered. *See City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997); *Intermountain Rubber Industries v. Valdez*, 688 P.2d 1133 (Colo. App. 1984); *see also Burnes v. United Airlines*, W.C. No. 4-725-046 (Apr. 17, 2008) (upholding compensability of claim filed about five years

after incident based on doctor's subsequent testimony about injury contributing to claimant's impairment).

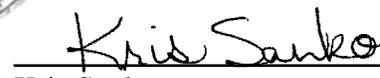
The question of when the claimant recognized the nature, seriousness, and probable compensable nature of the injury is one of fact for determination by the ALJ. *See Industrial Commission v. Canfield*, 172 Colo. 18, 469 P.2d 737 (1970). The claimant raised these factual issues before the ALJ, who erred by not making corresponding findings. It is therefore necessary to remand this matter to the ALJ for further proceedings to determine when the claimant recognized the nature, seriousness, and probable compensable nature of the injury at issue. Whether the ALJ needs to consider any additional issues for hearing endorsed by the parties depends on his resolution of the timeliness of the claim for benefits.

IT IS THEREFORE ORDERED that the ALJ's order dated August 22, 2012, is set aside and this matter is remanded to the hearing officer for additional findings and a new decision, accordingly.

INDUSTRIAL CLAIM APPEALS PANEL



John D. Baird



Kris Sanko

CERTIFICATE OF MAILING

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

12/18/2012 by RP.

STAN HAHN, 591 E. NICHOLS DRIVE, LITTLETON, CO, 80122 (Claimant)
TOWN OF VAIL, 75 S FRONTAGE ROAD, VAIL, CO, 81657 (Employer)
PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ., 7501 E. LOWRY
BLVD., DENVER, CO, 80230 (Insurer)
STEVEN R. SCHUMACHER, P.C., Attn: STEVEN R. SCHUMACHER, ESQ., 3320 STUART
STREET, DENVER, CO, 80212 (For Claimant)
RUEGSEGGER SIMONS SMITH & STERN, LLC, Attn: BRADLEY J. HANSEN, ESQ., 1401
SEVENTEENTH STREET, SUITE 900, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-843-356-02

IN THE MATTER OF THE CLAIM OF

WILLIAM MILLER,

Claimant,

v.

FINAL ORDER

CENTURYLINK,

Employer,

and

SEDGWICK CLAIMS MANAGEMENT
SERVICES, INC.,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Henk (ALJ) dated August 21, 2012, that determined the respondents failed to overcome the Division Independent Medical Examination (DIME) physician's opinion on permanent impairment. We affirm.

A hearing was held on the issue of permanent partial disability benefits. The respondents argued that the claimant's rating should be paid based on the schedule of disabilities in §8-42-107(2), C.R.S. or alternatively, that the DIME physician's seven percent whole person rating was overcome by clear and convincing evidence. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant sustained an admitted left shoulder injury on September 8, 2010, when he fell while working as a broadband technician for the respondent-employer. As a result of this injury, the claimant underwent left shoulder surgery on April 21, 2011, which included an arthroscopic subacromial depression and arthroscopic distal clavicle resection and an arthroscopic bicep tendinosis.

The authorized treating physician placed the claimant at maximum medical improvement (MMI) on August 11, 2011, with no permanent impairment. The claimant requested a DIME which was performed by Dr Stieg on December 6, 2011. The DIME physician determined that the claimant sustained a 12 percent upper extremity impairment which converts to a seven percent whole person rating. The DIME physician rated the claimant for his left shoulder based on his type-II acromion AC partial separation, bicep tendinosis and arthroscopic decompressive surgery with residual pain

and loss of motion. The DIME physician agreed that the claimant was at MMI without permanent restrictions and recommended maintenance medical treatment.

The ALJ found that the DOWC Impairment Rating Tips provide for an impairment of 10 percent upper extremity for a distal clavicle resection. The DOWC Impairment Rating Tips provide:

Shoulder Surgery: Resection arthroplasty referred to in the *AMA Guides 3rd Edition (rev.)* is to be used only for partial resection of the humeral head, a procedure rarely performed currently. Neither resection nor implant arthroplasty values should be used for a distal clavicular resection. If providing a rating for a distal clavicular resection, the upper extremity value is 10%. The *AMA Guides 4th* and *5th* Editions continue to suggest that subacromial arthroplasty should be rated using ROM, and when appropriate, ‘joint crepitation with motion’ from the “Other Disorders” section. In general, when any additional rating for subacromial arthroplasty is deemed appropriate in a case with or without crepitus because “. . . other factors have not adequately rated the extent of the impairment,” it should not exceed 10%. (*AMA Guides 3rd Ed. Rev.* p. 48).

The respondents took the DIME physician’s deposition and questioned him on his determination to give the claimant an additional 10 percent upper extremity rating for the claimant’s distal clavicle resection based on the Division of Workers’ Compensation’s (DOWC) Impairment Rating Tips. The DIME physician acknowledged that the AMA Guides do not specifically provide for an additional 10 percent extremity rating for a distal clavicle resection under §3.1(j), but agreed that an additional impairment rating could be given when appropriate. The DIME physician also testified that based on his attendance at the last training session from the DOWC, his understanding of the DOWC’s position was that “somebody who had a resection arthroplasty got an automatic 10 percent regardless of residual symptoms, regardless of whether there were associated restrictions for work given.” The DIME physician further stated that he confirmed this with a telephone call to Dr. Kathryn Mueller, the Medical Director at the DOWC. The ALJ further found that the DIME physician agreed that the rating tips do not mandate an additional impairment rating for distal clavicle resection but reiterated his opinion that this was appropriate for the claimant’s distal clavicle resection.

Dr. Nicholas Olsen performed an independent medical examination of the claimant at the respondents’ request. Dr. Olsen expressed the opinion that the additional 10 percent extremity rating was not appropriate in this case because the claimant had a

full recovery without functional limitations. Dr. Swarsen in contrast, concluded that the DIME physician's rating was performed consistently with the instructions for Level II doctors and the Rating Tips and that together, these give the DIME physician discretion to include an additional rating for distal clavicle resection when it would properly delineate the extent of impairment that a particular claimant is suffering. In Dr. Swarsen's opinion, there was adequate medical support for the DIME physician's opinion that the claimant sustained a seven percent whole person rating for his left shoulder. The ALJ credited the opinions of the DIME physician and Dr. Swarsen over the opinion of Dr. Olsen.

Based on these findings that ALJ determined that the claimant sustained functional impairment not limited to the schedule of disabilities in §8-42-107(2), C.R.S., and therefore, was entitled to permanent disability benefits based on a whole person rating. The ALJ further found that the respondents failed to overcome the DIME physician's impairment rating by clear and convincing evidence.

On appeal, the respondents do not contest the award of whole person impairment. Rather, as we understand the respondents' argument, they are asserting that the DIME physician's rating was overcome by clear and convincing evidence because he did not exercise his independent judgment in awarding the additional 10 percent and only gave the claimant the additional 10 percent because he was told to do so by Dr. Mueller from the DOWC. Although the DIME physician's testimony was unclear on this issue in some respects, we are not persuaded that the ALJ erred in her interpretation of the evidence.

Section 8-42-107(8)(c), C.R.S., provides that the DIME physician's finding of medical impairment "shall be overcome only by clear and convincing evidence." The party challenging the DIME physician's impairment rating bears the burden of proof. "Clear and convincing" evidence has been defined as evidence which demonstrates that it is "highly probable" the DIME physician's opinion is incorrect. *Qual-Med, Inc., v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). The question of whether a party has overcome the DIME physician by clear and convincing evidence is one of fact for the ALJ's determination. *Id.* The standard of review is whether the ALJ's findings of fact are supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; *Metro Moving & Storage Co. v. Gussert, supra.*

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. *Id.* This standard of review is deferential, and the scope of our review is "exceedingly narrow." *Id.* We may not substitute our judgment by reweighing the evidence to reach inferences different from those the ALJ drew from the evidence.

See *Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31 (Colo. App. 1990) (reviewing court is bound by resolution of conflicting evidence, regardless of the existence of evidence which may have supported a contrary result); *Rockwell Int'l v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990)(ALJ, as fact-finder, is charged with resolving conflicts in expert testimony). The weight and credibility to be assigned expert medical opinion is a matter within the fact-finding authority of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.2d 186 (Colo. App. 2002). Moreover, the ALJ may accept all, part, or none of the testimony of a medical expert. *Dow Chemical Co. v. Industrial Claim Appeals Office*, 843 P.2d 122 (Colo. App. 1992)(ALJ may credit one medical opinion to the exclusion of a contrary medical opinion).

The ALJ credited the opinions of the DIME physician and Dr. Swarsen over the opinion of Dr. Olsen. The evidence in the record supports the ALJ's findings in this regard. The respondents' arguments notwithstanding, to the extent that the DIME physician's testimony conflicts with his report and could be construed as stating that he did not follow the AMA Guides or the DOWC Impairment Rating Tips, it is for the ALJ to resolve any ambiguity and determine the DIME physician's true opinion as a matter of fact. *Magnetic Engineering Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000) (if the DIME physician offers ambiguous or conflicting opinions concerning MMI, it is for the ALJ to resolve). In so doing, the ALJ should consider all of the DIME's written and oral testimony. *Lambert & Sons, Inc. v. Industrial Claim Appeals Office*, 984 P.2d 656 (Colo. App. 1998).

Here, the ALJ determined that the DIME physician's true opinion was that the claimant was entitled to an additional 10 percent for the distal clavicle resection. ALJ Order at 6 ¶30. The DIME physician testified that although he would not have given the additional 10 percent by just looking at the AMA Guides, he also recognized that a physician could provide the additional 10 percent if deemed appropriate. Dr. Stieg Depo. at 18 and 20. The DIME physician further expressed disagreement with Dr. Olsen's opinion that the additional rating was not appropriate in this case and reiterated his opinion that it was appropriate for a distal clavicle resection. Dr. Stieg Depo at 17. The DIME physician also recognized that the claimant would likely have future medical problems given the nature of his work and expected deterioration over time in shoulder function and that the claimant can expect a recurrence of pain and dysfunction in his left shoulder. Dr. Stieg Depo. at 21-22.

Additionally, Dr. Swarsen testified that even though the AMA Guides and the Impairment Rating Tips do not require an evaluating physician to automatically provide an additional impairment rating simply because a patient had a shoulder surgery, the additional rating was appropriate here. Tr. at 44. Dr. Swarsen testified that even though the claimant did not have permanent restrictions there was still evidence of functional

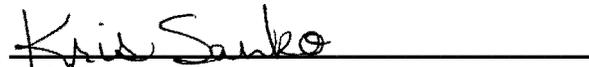
limitations on his activities. Tr. at 44. The testimony of the DIME physician and Dr. Swarsen is evidence from which the ALJ could plausibly infer that the DIME physician's additional 10 percent rating was appropriate in this case. Because the ALJ's inferences are supported by a reasonable interpretation of the evidence, we perceive no basis to disturb the order. Section 8-43-301(8), C.R.S.

To the extent the respondents argue that the DIME should be overcome because the DIME physician's opinions were not "independent" because of his conversations with Dr. Mueller, we reject these arguments based on the fact that the ALJ determined that the DIME physician's opinion to provide the additional 10 percent rating was supported by evidence other than his discussions with Dr. Mueller. ALJ Order at 6 ¶ 30.

IT IS THEREFORE ORDERED that the ALJ's order dated August 21, 2012, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


Kris Sanko

CERTIFICATE OF MAILING

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

_____ 1/11/2013 _____ by _____ RP _____ .

WILLIAM MILLER, 3069 S. JEBEL WAY, AURORA, CO, 80013 (Claimant)
CENTURYLINK, Attn: CAROLE DINAN-FINCH, C/O: QWEST CORPORATION, 1801
CALIFORNIA STREET, SUITE 1150, DENVER, CO, 80202 (Employer)
SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., Attn: DEBBIE BAIRD, P O BOX
14494, LEXINGTON, KY, 40512 (Insurer)
LAW OFFICE OF O'TOOLE & SBARBARO, P.C., Attn: NEIL D. O'TOOLE, ESQ., 226
WEST 12TH AVENUE, DENVER, CO, 80204-3625 (For Claimant)
DWORKIN, CHAMBERS, WILLIAMS, YORK, BENSON & EVANS, P.C., Attn: GREGORY
K. CHAMBERS, ESQ., 3900 E. MEXICO AVENUE, SUITE 1300, DENVER, CO, 80210 (For
Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-886-126-01

IN THE MATTER OF THE CLAIM OF

MARK ORIST,

Claimant,

v.

FINAL ORDER

G4S SECURE SOLUTIONS (USA), INC.,

Employer,

and

NEW HAMPSHIRE INSURANCE COMPANY,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Walsh (ALJ) dated August 17, 2012, that ordered the claimant's claim compensable. We reverse.

A hearing was held on the issue of compensability. After the hearing, the ALJ found that the claimant was hired as a security officer for the respondent employer. The claimant eventually was reassigned to work as a custom protection officer (CPO) at a hospital in Colorado Springs. He worked as a shift supervisor, and his duties involved patrolling the facility, which included the grounds, parking garage, and interior of the buildings.

When the claimant was hired, he underwent a one-week training period, which included an emphasis on safety. The claimant received an additional two to three days training when reassigned to the hospital, which included training in patrolling the facility. The claimant's training included the requirement that he become familiar with the employer's safety handbook, to abide by the safety rules covering the job assigned, not to leave the assigned work area without first notifying a supervisor, and not to engage in horseplay. The respondent employer's G4S Safety Handbook includes the opening statement that "Safety is a 'Core Value' of our company." The claimant was familiar with the standards contained in the G4S Safety Handbook and the G4S Security Officer Handbook. The Security Officer Handbook lists grounds for immediate dismissal, which include "[h]orseplay or other activity with potentially serious consequences such as personal injury. . . ."

On April 29, 2012, the claimant was patrolling the hospital. At approximately 1:30 p.m., the claimant jumped or climbed down from an open window-like space on the 3rd floor of the parking garage onto the 3rd floor roof of the Cancer Center, an approximate 10 foot drop. The claimant was not injured during this descent. The claimant then jumped from the 3rd floor Cancer Center roof to the 2nd floor Cancer Center rooftop below, which was an approximate eight foot drop. During this descent, the claimant sustained injuries, including a tibial fracture of the left knee.

The April 29, 2012, emergency department report states that the claimant “was jumping down off approximately 10-foot embankment onto the top of a roof. . . He sat at the end with his feet dangling down and then jumped down.”

The ALJ entered his order finding that the claimant established his injuries arose out of and in the course of his employment. The ALJ found that the claimant’s actions on April 29, 2012, did not arise to the level of horseplay and did not constitute a deviation from his assigned work duties. The ALJ noted that Mr. Bowe, the facility manager and the claimant’s immediate supervisor, testified that part of the claimant’s training involved giving the claimant keys to facility doors and using those keys to explore. Mr. Bowe testified that there were times when it would be necessary for the CPO to be on the roofs when workers such as window washers or repairmen needed to access the roofs of the east and west towers. Mr. Bowe testified that patrol duties included opening windows or doors with keys provided so that those workers could obtain rooftop access. The ALJ found that Mr. Bowe did not specifically advise the claimant not to jump off ledges onto roof tops. The ALJ also noted that shortly before the claimant’s accident, the claimant advised another employee, Mr. Almuwali, that he was “bored” and would be going to explore out on patrol. The ALJ further noted that Mr. Abdulridha had worked for the respondent employer at the hospital for five months and testified that jumping on roofs and off ledges were not part of a patrol officer’s job duties. When Mr. Abdulridha arrived at the accident scene, the claimant advised that he had done something “stupid” and hurt himself. The ALJ concluded that the claimant was carrying out his responsibilities as instructed by the respondent employer, especially with respect to proactively assessing the building and surroundings, and also concluded that the claimant was not acting for his sole benefit. Thus, the ALJ ordered the claimant’s claim compensable.

The respondents argue that the ALJ’s order determining compensability is not supported by the findings and applicable law. According to the respondents, the claimant’s actions which lead to his injuries constituted a significant deviation from the course and scope of his employment. The respondents assert that the claimant was engaged in horseplay which removed him from the sphere of employment. We agree

with the respondents that the ALJ's findings do not support his order that the claimant's claim is compensable.

To be compensable, an employee's injury must have been sustained while performing services arising out of and in the course of the employment at the time of the injury. Section 8-41-301(1), C.R.S.; *Panera Bread, LLC v. Industrial Claim Appeals Office*, 141 P.3d 970 (Colo. App. 2006). An injury "arises out of" employment when it has its origin in an employee's work-related functions and is sufficiently related to those functions to be considered part of the employee's services to the employer in connection with the contract of employment. The "course of employment" requirement is satisfied when it is shown that the injury occurred within the time and place limits of the employment relation and during an activity that had some connection with the employee's job-related functions. *Popovich v. Irlando*, 811 P.2d 379 (Colo.1991). It is not essential to compensability that the activities of an employee emanate from an obligatory job function or result in some specific benefit to the employer, as long as they are sufficiently incidental to the work itself as to be properly considered as arising out of and in the course of employment. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985).

If an employee substantially deviates from the mandatory or incidental functions of his employment, however, such that he is acting for his sole benefit at the time of an injury, then the injury is not compensable. *Kater v. Industrial Commission*, 728 P.2d 746 (Colo. App. 1986). When a personal deviation is asserted, the issue is whether the activity giving rise to the injury constituted a deviation from employment so substantial as to remove it from the employment relationship. *Panera Bread, LLC v. Industrial Claim Appeals Office, supra*. In *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995) the Colorado Court of Appeals announced a four-part test to be applied when analyzing whether horseplay constitutes a deviation: (1) the extent and seriousness of the deviation; (2) the completeness of the deviation, i.e., whether it was commingled with the performance of a duty or involved an abandonment of duty; (3) the extent to which the practice of horseplay had become an accepted part of the employment; and (4) the extent to which the nature of the employment may be expected to include some horseplay. See also §8-40-201(8), C.R.S. (defining "employment" but specifically providing that employment shall not include "the employee's participation in a voluntary recreational activity or program"); §8-40-301(1), C.R.S. (defining scope of the term "employee" as excluding any person "while participating in recreational activity").

Moreover, pursuant to §8-43-301(8), C.R.S., we have authority to set aside an ALJ's order only where the findings of fact are not sufficient to permit appellate review, conflicts in the evidence are not resolved, the findings of fact are not supported by the

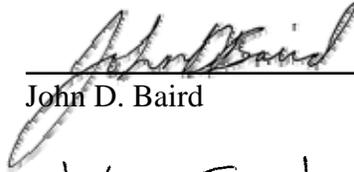
evidence, the findings of fact do not support the order, or the award or denial of benefits is not supported by applicable law.

Here, we conclude that the ALJ's findings do not support his order that the claimant's claim is compensable. Section 8-43-301(8), C.R.S. While the ALJ found that part of the claimant's job duties involved exploring the facility and being proactive in evaluating the building and grounds that he was responsible for protecting, he made no finding that part of his exploratory or proactive job duties included jumping from one rooftop to another rooftop. Similarly, while the ALJ found that there were times when it was necessary for a CPO to be on the roofs, such as when window washers or repairmen needed to access the roofs of the towers, he made no finding that this is what the claimant was doing at the time he was injured, or that part of being on the roof for such window washers and repairmen involved jumping from one rooftop to another. We further note that during the hearing, Mr. Bowe testified that jumping off of ledges from rooftops was not part of the claimant's job duties. Tr. at 60, 72-73. Likewise, Mr. Almuwali testified that he had no training which involved jumping onto rooftops, that he did not consider it part of his duties to patrol the rooftop where the claimant was injured since there was no access to that area, and that he would not jump off of a ledge the way the claimant did because it was not safe. Tr. at 77-78, 83, 87. Also, Mr. Abdulridha testified that he did not consider it part of his job duties to jump off a ledge onto a roof, or jump out of an opening onto a roof. Tr. at 94. We also note that the ALJ found that after his injury, the claimant advised that he had done something "stupid" and hurt himself. The ALJ also found that the claimant was familiar with the G4S Safety Handbook, that safety was a "Core Value" of the respondent employer, and that the claimant was to abide by the safety rules covering the job assigned, which included not engaging in horseplay. Thus, we conclude that the ALJ's findings support the conclusion that the claimant was engaged in "horseplay" at the time he was injured, and that the claimant's actions at the time he was injured were not related to the conditions and circumstances under which he usually performed his employment so as to justify a finding of a causal relationship between his injury and employment.

Rather, the claimant's act of jumping from rooftop to rooftop constituted a deviation which was not commingled with the performance of any duty. *See Kater v. Industrial Commission, supra*. Consequently, the claimant's substantial deviation effectively removed him from the employment relationship and, therefore, his claim is not compensable. Since the ALJ's findings do not support his order that the claimant's claim is compensable, we therefore reverse. Section 8-43-301(8), C.R.S.; *see also Schrieber v. Brown & Root, Inc.*, 888 P.2d 274 (Colo. App. 1993)(Panel may review conclusion of law for error).

IT IS THEREFORE ORDERED that the ALJ's order issued August 17, 2012, is reversed.

INDUSTRIAL CLAIM APPEALS PANEL

A handwritten signature in cursive script, appearing to read "John D. Baird", written above a horizontal line.

John D. Baird

A handwritten signature in cursive script, appearing to read "Kris Sanko", written above a horizontal line.

Kris Sanko

CERTIFICATE OF MAILING

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

1/4/2013 by RP.

MARK ORIST, 15636 DAWSON CREEK DRIVE, MONUMENT, CO, 80132 (Claimant)
G4S SECURE SOLUTIONS (USA), INC., Attn: JANICE FISER, 1395 UNIVERSITY
BOULEVARD, JUPITER, FL, 33458 (Employer)
NEW HAMPSHIRE INSURANCE COMPANY, Attn: SUZI LIMPPPO, C/O: GALLAGHER
BASSETT SERVICES, P O BOX 4068, ENGLEWOOD, CO, 80155-4068 (Insurer)
IRWIN & BOESEN, Attn: CHRIS W. GORDON, ESQ., 4100 EAST MISSISSIPPI AVENUE,
19TH FLOOR, DENVER, CO, 80246 (For Claimant)
RITSEMA & LYON, P.C., Attn: ELIOT J. WIENER, ESQ., 999 18TH STREET, SUITE 3100,
DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-860-214

IN THE MATTER OF THE CLAIM OF

SUSAN PETTIBONE,

Claimant,

v.

FINAL ORDER

QWEST CORPORATION,

Employer,

and

AMERICAN INSURANCE GROUP
PLAN,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Cain (ALJ) dated August 29, 2012, that determined the claimant sustained a compensable injury and ordered the respondents to pay for certain medical benefits. We affirm the ALJ's order.

A hearing was held on the issue of compensability. After hearing the ALJ made factual findings that for purposes of review can be summarized as follows. The ALJ noted that the parties submitted a "Stipulation of Parties" at the hearing, agreeing to certain facts. The parties stipulated that the claimant worked for the employer at its office in Littleton and that the claimant's performance of her regular job activities included working on her computer and on the telephone at her desk and also leaving her desk to walk to various locations within the workplace to use office equipment and to meet and confer with co-employees and supervisors.

On June 24, 2011, the claimant fractured her fibula at her workplace, during regular working hours. On this date, the claimant rose from her desk to confer with a colleague and visit the restroom after working at her desk for about two hours. The claimant reported that her legs had been crossed for a substantial portion of that time and her left foot and ankle had "fallen asleep," becoming numb. As the claimant walked

from her desk, the numbness in her left foot caused her to roll her left ankle and fall to the floor with an audible “pop,” breaking the fibula.

The parties also stipulated that if the ALJ found the claim compensable the respondents were liable to pay for the emergency room treatment that the claimant received at St. Anthony Hospital/Centura Health Emergency Department on June 24, 2011.

The ALJ found that the claimant’s stipulated testimony concerning the circumstances of her fall at work was credible and was corroborated by the subsequent histories she provided to medical providers. Based upon these findings the ALJ concluded that the claimant’s injury arose out of and in the course and scope of her employment. The ALJ determined that the claimant sat with her legs crossed for a prolonged period of time while performing the duties of the employment and that the action of sitting in this posture caused numbness in the claimant’s left foot and ankle. The ALJ further found that as the claimant then rose from her desk to perform activities directly and incidentally related to her employment, the numbness combined with standing up to walk, resulted in the claimant falling and breaking her fibula. The ALJ specifically rejected the respondents’ assertion that the claimant’s injury was the result of an unexplained fall, noting that the evidence established the reasons for the fall and that those reasons were causally related to the claimant’s employment.

On appeal the respondents renew the arguments made at hearing and contend that the ALJ applied the wrong legal standard in evaluating the issue of compensability. We are not persuaded that the ALJ erred.

A work-related injury is compensable if the injury arose out of and in the course and scope of the injured worker's employment. Section 8-41-301(1)(b), C.R.S. “For an injury to occur ‘in the course of’ employment... the claimant must demonstrate that the injury occurred within the time and place limits of [her] employment and during an activity that had some connection with [her] work-related functions.” *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999). To establish that an injury arose out of an employee’s employment, “the claimant must show a causal connection between the employment and injury such that the injury has its origins in the employee’s work-related functions and is sufficiently related to those functions to be considered part of the employment contract.” *Id.* To prove that the injury arose out of the employment, the claimant must establish “a direct causal relationship between [her] employment and [her] injury.” *Finn v. Industrial Commission*, 165 Colo. 106, 109, 437 P.2d 542, 544 (1968).

The determination of whether there is a sufficient causal relationship between the claimant's employment and the injury is generally one of fact, which the ALJ must determine based on the totality of the circumstances. Section 8-43-301(8), C.R.S.; *In re Question Submitted by the United States Court of Appeals*, 759 P.2d 17 (Colo. 1988); *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995). This standard of review requires us to defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002).

The respondents contend that although the claimant provided a reason why she fell, the ALJ "applied too lenient a standard," and erred in determining that the claimant established that her employment played any causative role in her fall. The respondents argue that although the mechanism of the fall was understood, there was no work factor that contributed to her fall. The respondents' arguments notwithstanding, the ALJ made detailed findings, supported by the evidence, that the claimant's injury was caused by a combination of work related factors. As noted above, the ALJ found that the claimant experienced numbness brought on by working at her desk for a prolonged period which in turn caused her to roll her ankle as she stood up to perform other work related functions.

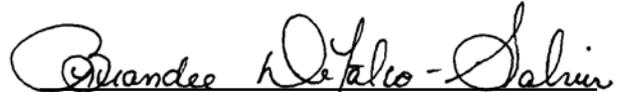
The respondents argue that this case is analogous to *Blunt v. Nursecore Management Services*, W.C No. 4-725-754 (February 15, 2008), in which the claimant was found to have sustained an "unexplained fall" when she twisted her ankle and fell while walking around a patient's bed. The claimant in *Blunt*, however, was not able to offer any reason why she fell. The claimant speculated that she may have stepped on something, but the ALJ did not credit that evidence. The panel upheld the ALJ's conclusion that the fall was unexplained.

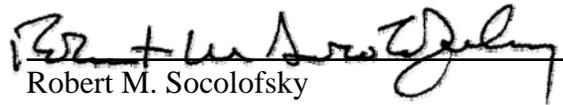
Here, in contrast, the ALJ credited the claimant's testimony that that there was a reason for her fall and that reason was related to her employment duties. We find no basis for interfering with the ALJ's determination that the claimant sustained a compensable injury. The findings are supported by substantial evidence and plausible inferences drawn from the record and therefore, are binding on review. Section 8-43-301(8), C.R.S.; *Arenas v. Industrial Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000).

IT IS THEREFORE ORDERED that the ALJ's order dated August 29, 2012, is affirmed.

SUSAN PETTIBONE
W. C. No. 4-860-214
Page 4

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


Robert M. Socolofsky

SUSAN PETTIBONE
W. C. No. 4-860-214
Page 6

CERTIFICATE OF MAILING

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

_____ 1/10/2013 _____ by _____ RP _____ .

SUSAN PETTIBONE, 129 WARD ROAD, LAKEWOOD, CO, 80228 (Claimant)
QWEST CORPORATION, Attn: CAROLE DINAN-FINCH, 1801 CALIFORNIA STREET,
SUITE 1150, DENVER, CO, 80202 (Employer)
AMERICAN INSURANCE GROUP PLAN, Attn: DEBBIE BAIRD, C/O: SEDGWICK CMS -
DENVER QWEST, P O BOX 14494, LEXINGTON, KY, 40512-4494 (Insurer)
THE MCCARTHY LAW FIRM, PC, Attn: JOHN D. MCCARTHY, ESQ., 7884 RALSTON
ROAD, ARVADA, CO, 80002 (For Claimant)
DWORKIN, CHAMBERS, WILLIAMS, YORK, BENSON & EVANS, Attn: DAVID J.
DWORKIN, ESQ., C/O: 3900 E. MEXICO AVENUE, SUITE 1300, DENVER, CO, 80210 (For
Respondents)
THE ELLIOTT LAW OFFICES, Attn: MARK ELLIOTT, ESQ., 7884 RALSTON ROAD,
ARVADA, CO, 80002 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-835-166-04

IN THE MATTER OF THE CLAIM OF

KIMBERLY REVES,

Claimant,

v.

FINAL ORDER

MCCORMICK EXCAVATION &
PAVING, LLC,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Walsh (ALJ) dated July 19, 2012, that denied and dismissed her request for penalties for alleged violations of §8-42-102, C.R.S. and §8-42-101, C.R.S. We affirm the ALJ's order.

A hearing was held on the claimant's request for penalties. The claimant alleged that the respondent insurer violated §8-42-102 C.R.S., by incorrectly calculating her average weekly wage (AWW) and violated §8-42-101, C.R.S., for the claims adjuster's alleged failure to investigate whether the claimant required transportation to medical appointments. After hearing the ALJ made factual findings that for purposes of review can be summarized as follows. The claimant sustained an admitted injury on September 13, 2010, while she was working as a traffic flagger for the respondent employer. The claimant was riding on a trailer which was not properly affixed to a truck and became unattached, going down an embankment and traveling through barbed wired. The claimant sustained multiple lacerations to her face, arms and legs and an orthopedic injury to her finger on her left hand.

Immediately following the injury the adjuster for respondent insurer contacted the respondent employer and requested wage information. The adjuster received a letter from the respondent employer dated September 14, 2010, stating that the claimant's job was a temporary position to last ten days, with five days work, two days off and then five more days of work, working approximately 13 hours per day at \$12 per hour.

The adjuster spoke with the claimant's father on September 16, 2010, and explained the claimant's workers' compensation benefits. The adjuster also requested the claimant's wage information for 2010. On September 21, 2010, the adjuster spoke with the claimant and explained the claimant's benefits and notified her that he would use her 2010 earnings to determine her AWW. The ALJ found that the adjuster credibly testified that the claimant did not question his method or raise concern about any error in his calculation at that time. On or about September 21, 2010, the adjuster received a letter dated September 16, 2010, from the claimant's prior employer, Taco Bell. This letter said that the claimant earned \$12,824.77 from January 10, 2010, to July 1, 2010.

The adjuster spoke with the claimant on September 24, 2010, and explained his method of calculating the AWW and the claimant did not register any disagreement. The respondent insurer filed a general admission of liability on September 27, 2010, admitting for an AWW of \$276.63 and a temporary disability rate of \$184.42. To reach this amount, the adjuster multiplied the claimant's daily hours by her daily rate for ten days without the inclusion of overtime and then added those wages to the earnings from Taco Bell and divided by 52 weeks. The adjuster testified that he was trying to reach a fair approximation of the claimant's earnings because he believed she was a seasonal employee and her length of employment was too short to determine her actual earnings. The claimant stipulated that she was paid timely temporary disability benefits consistent with the September 27, 2010, general admission of liability.

On November 29, 2010, the claimant contacted the adjuster to register her concerns with the AWW and advised the adjuster of her position that only her earnings with the respondent employer should be included in the AWW calculation and not the earnings from Taco Bell. The ALJ found that the adjuster credibly testified that this was his only conversation with the claimant where she raised a concern about her AWW. The ALJ found the claimant's testimony to the contrary was not credible.

Counsel for the claimant entered his appearance on December 8, 2010, and the parties entered into a stipulation on January 11, 2011, increasing the AWW to \$840. The stipulation was approved by order and a general admission of liability was filed on January 18, 2011. The claimant testified that she received all payments pursuant to the January 18, 2011, general admission.

The ALJ also made the following findings on the issue of the alleged failure of the adjuster to investigate whether the claimant required transportation to medical appointments. After the injury, the claimant initially was restricted from driving for two weeks. The claimant agreed that no doctor restricted her from driving after October 2, 2010. When the adjuster spoke with the claimant's father on September 16, 2010, the adjuster explained that if the claimant needed transportation to her doctor's visits, the

respondent insurer would provide transportation. The claimant testified that her father conveyed this information to her. The ALJ found that the adjuster credibly testified that the claimant never requested transportation; but the claimant's counsel requested it one time and it was provided. The adjuster testified that he spoke with the claimant about mileage reimbursement but that she never requested transportation to any of her appointments and never gave any indication she was struggling with getting to appointments or was displeased with transportation issues. The ALJ determined that the claimant's testimony that she repeatedly contacted the adjuster and requested transportation was not credible.

On October 7, 2010, the adjuster entered a notepad entry indicating that he received a voicemail from the claimant wanting to know if he would pay her driver to take her to doctor visits. The notepad entry indicated that the adjuster explained to the claimant that he would only pay mileage reimbursement and that the claimant had no other questions. The adjuster testified that it was his understanding that the claimant was merely asking if the respondent insurer would pay a family member or a friend to take her to her appointments and he did not understand the claimant to be saying that she needed transportation or that she was struggling to get to her appointment. The adjuster reviewed the claimant's medical records when they came in and no doctor stated that the claimant could not drive her personal vehicle, with the exception of the two weeks after she was discharged from the hospital in October of 2010. The claimant's first request for transportation was made through counsel in July 2011, and transportation was provided. The adjuster further testified that the claimant was paid in full for all mileage submitted.

Based on these factual findings, the ALJ determined that the claimant failed to establish that the respondents violated either §8-42-102, C.R.S. or §8-42-101, C.R.S., but that even if a violation occurred, the claimant failed to prove that the respondent insurer acted unreasonably. The ALJ further found that even assuming the respondent insurer acted unreasonably, the respondent insurer cured the violation and the claimant failed to establish by clear and convincing evidence that the respondent insurer knew or should have known that they were in violation of the statute. Therefore, the ALJ denied and dismissed the claimant's request for penalties.

On appeal the claimant contends that the ALJ's determinations are not supported by substantial evidence and applicable law. We are not persuaded by the claimant's arguments that the ALJ committed reversible error.

I.

Section 8-43-304(1), C.R.S., provides for the imposition of penalties of up to \$1000 per day against an insurer "who violates any provision of articles 40 to 47 of this

title.” In order to impose penalties under this statute the ALJ must first determine that the disputed conduct constituted a violation of an express duty or prohibition established by the Workers’ Compensation Act. *Allison v. Industrial Claim Appeals Office*, 916 P.2d 623 (Colo. App. 1995); *Villa v. Wayne Gomez Demolition & Excavating, Inc.*, W.C. No. 4-236-951 (January 7, 1997). If the ALJ finds there was a violation of the Act, penalties may be imposed only if the ALJ concludes the insurer's actions were not reasonable under an objective standard. The reasonableness of the insurer's actions depends upon whether the actions were predicated on a rational argument based in law or fact. *Diversified Veterans Corporate Center v. Hewuse*, 942 P.2d 1312 (Colo. App. 1997). Determination of whether the insurer's conduct was reasonable is generally an issue of fact for resolution by the ALJ. *Pueblo School District No. 70 v. Toth*, 924 P.2d 1094 (Colo. App. 1996).

We agree with the ALJ that the record does not reveal a violation of any specific provision of the Act. The validity of the claimant's argument depends on a determination that the respondent insurer was legally obligated to admit liability for a higher average weekly wage. The panel, however, previously has held that the statute does not prescribe a precise method for calculating the average weekly wage, and an insurer does not violate the Act when it fails to admit for a specific wage. *See Gallegos v. Officemax*, W.C. No. 4-397-575 (December 10, 1999); *Sanchez v. Pueblo Medical Investors*, W.C. No. 3-942-960 (December 14, 1998) (respondents have no statutory duty to admit liability for an average weekly wage based on earnings from concurrent employments in order to avoid penalties).

Although §8-42-102, C.R.S., provides a mechanical formula for calculating the average weekly wage when the claimant is paid by the hour, §8-42-102(3), C.R.S. permits the ALJ to depart from the formula when necessary to calculate a fair average weekly wage. *See Drywall Products v. Constuble*, 832 P.2d 957 (Colo. App. 1991). The mere fact that issues of law and fact may later be resolved adversely to the respondents does not establish that the respondents’ calculation of AWW and subsequent admission constituted a violation of the Act. *Allison v. Industrial Claim Appeals Office, supra*. This is particularly true where, as here, the respondent insurer established that it obtained information from the employer providing a factual basis for the insurer's calculation of the average weekly wage.

The court of appeals previously has held that the respondents' failure to admit liability for the correct temporary disability benefits did not support the imposition of penalties under §8-43-304, C.R.S. *See Id.* In our view, it follows that if penalties cannot be imposed for an incorrect admission of temporary disability benefits, penalties cannot be imposed for an incorrect admission of AWW. In *Allison* the respondents filed an admission of liability for temporary total disability benefits, but reduced the weekly

disability payment based upon an asserted offset for the claimant's receipt of proceeds from a structured settlement. The claimant sought penalties for the respondents' withholding of the full weekly benefit. However, the court concluded that the temporary total disability statute does not create an express duty to pay benefits without regard to any applicable offsets. Therefore, the *Allison* court held that the claimant failed to establish a violation of the Act which would subject the respondents to a penalty under §8-43-304(1), C.R.S.

Section 8-43-304(1), C.R.S., makes no reference to implied duties or prohibitions, and we cannot read non-existent provisions into the Act. *Kraus v. Artcraft Sign Co.*, 710 P.2d 480 (Colo. 1985). Relying on *Allison*, the panel concluded in *Villa v. Wayne Gomez Demolition Excavating*, *supra*, that the respondents' failure to admit liability for temporary disability benefits did not support the imposition of penalties under §8-43-304(1), C.R.S. In the analogous situation here, because the statute does not mandate an admission for a specific AWW, penalties cannot be imposed for failure to admit for a specific wage.

The claimant further argues that under §8-42-102(3), C.R.S., the respondents were required to seek a determination from the Director and could not unilaterally employ the discretionary method for calculating AWW. We disagree with the claimant's interpretation of the statute. The respondents have no statutory duty under the Act to admit liability for a claim. Section 8-43-203(1), C.R.S. gives the respondents the option to admit or deny liability and demand that the claimant establish her entitlement to benefits. Further, the Act specifically imposes on the claimant the burden to prove her entitlement to benefits. Section 8-43-201, C.R.S. Under this statutory scheme, we reject the claimant's contention that if a respondent admits liability, the amount of the admitted liability must be correct to avoid penalties. *Gonzales v. Advanced Components*, 949 P.2d 569 (Colo. 1997)(statutes are to be construed in a manner which achieves consistent, harmonious and sensible effect to all its parts). Moreover, the claimant's construction requiring the approval from the Director does not comport with the legislative intent to provide the quick and efficient delivery of benefits. Section 8-40-102, C.R.S.

Additionally, substantial evidence supports the ALJ's determination that even assuming the respondent insurer violated the Act by admitting for an incorrect average weekly wage, the claimant failed to prove the respondent insurer's actions were unreasonable. As the ALJ recognized, the information provided by the employer and the 2010 wage information, combined with the testimony of the adjuster and the adjuster's supervisor constituted evidence from which the ALJ could reasonably infer that the insurer did not act unreasonably. Therefore, we may not disturb the order on appeal. Section 8-43-301(8), C.R.S.

II.

The claimant also contends that the ALJ erred in finding that she failed to prove that the insurer violated §8-42-101, C.R.S., because the adjuster failed in his alleged duty to investigate whether the claimant required actual transportation to medical appointments. We are not persuaded by the claimant's arguments.

While it is true that §8-42-101, C.R.S., requires that the insurer provide reasonable and necessary medical benefits, under the circumstances of this case, we do not understand this statute to mandate that the insurer affirmatively investigate whether the claimant required transportation to obtain medical care. *Compare Pena v. Industrial Claim Appeals Office*, 117 P.3d 84 (Colo. App. 2004)(insurer penalized for unreasonably failing to provide medical treatment where authorized treating physician requested taxi vouchers for claimant's transportation to medical treatment.). The claimant cites to *Klein v. State Farm Mut. Auto Ins. Co.*, 948 P.2d 43 (Colo. App. 1997) and *Giddings v. Industrial Claim Appeals Office*, 39 P.3d 1211 (Colo. App. 2001) as support for her contention that penalties should be assessed for the respondent insurer's failure to investigate the claimant's need for transportation. However, these cases are distinguishable in that there was an actual request or claim for benefits, or in the case of *Giddings*, an order to provide benefits. Here, in contrast, the ALJ determined that there was no request for transportation.

The ALJ was not persuaded that the claimant actually requested transportation to medical appointments and there was no credible evidence that transportation was refused. The ALJ also found that the medical providers did not prescribe transportation. On the one occasion that the claimant called to discuss transportation, the ALJ inferred from the adjuster's testimony and documentation that the claimant was calling to ask if the insurer would pay for her family or friends to drive her and that this was not a request for medically necessary transportation. The ALJ's inference is supported by substantial evidence in the record from the adjuster's testimony and we may not disturb it on appeal. Section 8-43-301(8), C.R.S. The claimant's other arguments essentially ask us to reweigh evidence to reach a conclusion contrary to the ALJ. However, we have no authority to substitute our judgment for that of the ALJ concerning the sufficiency and probative weight of the evidence that was presented and we decline the claimant's invitation to do so. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000).

Because the claimant failed to prove the respondent insurer committed any violation, the claim for penalties must fail. *Allison v. Industrial Claim Appeals Office*, *supra*. In any event, the ALJ determined that even if the respondent insurer violated §8-42-101, C.R.S., the claimant failed to prove that the insurer acted unreasonably. The ALJ credited the adjuster's testimony that he reviewed the claimant's medical records when

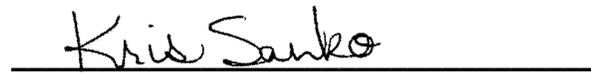
they came in and no doctor stated that the claimant could not drive her personal vehicle. We cannot say that the ALJ erred in his determination that the respondent insurer acted reasonably in this case.

We have considered the claimant's remaining arguments and are not persuaded by them. The ALJ's order is supported by applicable law and substantial evidence and we see no basis to disturb the order on review. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated July 19, 2012, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


Kris Sanko

CERTIFICATE OF MAILING

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

_____ 1/2/2013 _____ by _____ RP _____ .

KIMBERLY REVES, 20725 SAHARA DRIVE, PEYTON, CO, 80831 (Claimant)
MCCORMICK EXCAVATION & PAVING, LLC, Attn: JIM MCCORMICK, 30887
HIGHWAY 24, STRATTON, CO, 80836 (Employer)
PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ., 7501 E. LOWRY
BLVD., DENVER, CO, 80230 (Insurer)
STEVEN U. MULLENS, P.C., Attn: STEVEN U. MULLENS, ESQ., 105 EAST MORENO
AVENUE, COLORADO SPRINGS, CO, 80901 (For Claimant)
RITSEMA & LYON, PC, Attn: DAWN M. YAGER, ESQ., 999 18TH STREET, SUITE 3100,
DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-774-375-02

IN THE MATTER OF THE CLAIM OF

NICOLE SANDERS,

Claimant,

v.

FINAL ORDER

ADAMS COUNTY,

Employer,

and

SELF-INSURED,

Insurer,
Respondent.

The respondent seeks review of an order of Administrative Law Judge Felter (ALJ) dated July 24, 2012, that granted the claimant's petition to reopen for worsening of condition, found the surgery performed by Dr. Hahn reasonable and necessary as a maintenance medical benefit and awarded medical and temporary disability benefits. We affirm the ALJ's order.

A hearing was held on the issues of the claimant's petition to reopen, medical benefits and temporary disability benefits. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. On September 16, 2008, the claimant sustained an admitted injury to her right foot. The claimant's authorized treating physician, Dr. Christopher Ryan, referred the claimant to Dr. David Hahn, to determine whether surgery on the foot would be helpful. Dr. Hahn eventually recommended surgery to fuse the claimant's talonavicular joint. The respondent denied the recommendation. The matter went to hearing and in an order dated June 30, 2010, ALJ Friend denied the request for surgery.

The claimant continued conservative treatment with her authorized treating physicians. When the conservative treatment failed Dr. Ryan again recommended the surgery proposed by Dr. Hahn. The surgery was denied by the respondent and the issue again went to hearing. In an order dated July 15, 2011, ALJ Friend denied the request for surgery.

The claimant continued to treat with Dr. Ryan and was placed at maximum medical improvement (MMI) on October 4, 2011. The respondent filed a Final Admission of Liability (FAL) admitting for ongoing maintenance treatment. The claimant continued maintenance treatment with Dr. Ryan. In his report dated November 10, 2011, Dr. Ryan noted that the claimant was experiencing increasing pain in the talonavicular joint which he believed to be the pain generator in her case. On December 13, 2011, Dr. Ryan stated that the claimant's pain was worse and nothing about her pain management was working. Dr. Ryan further stated that he considered all of Dr. Goldman's recommendations and followed most of them but, the claimant was regressing instead of progressing. Dr. Ryan was concerned that she may have loose hardware or the talonavicular joint continues to be the culprit in her pain generation.

On February 2, 2012, Dr. Ryan stated that a rocker-bottom shoe and brace were not helping the claimant and in his opinion the claimant required a talonavicular joint fusion. Dr. Ryan was removed as the authorized treating physician in the claimant's claim on February 12, 2012.

On February 28, 2012, Dr. Hahn performed a "right talonavicular and navicular cuneiform foot arthrodesis with internal fixation." In Dr. Hahn's opinion, the fusion surgery was reasonable, necessary and related because of the natural progression of the claimant's September 16, 2008 injury and there were no other options available to treat the claimant's symptoms due to the fact that all non-invasive procedures had been exhausted. The ALJ determined that unlike the previous denials of surgery prior to MMI that were based on a determination that the surgery would not *improve* the claimant's condition; the surgery was necessary to *maintain* the claimant's MMI status and prevent deterioration of her condition as a maintenance medical benefit.

Dr. Barton Goldman performed multiple independent medical examinations at the respondent's request. In Dr. Goldman's opinion the talonavicular fusion was not reasonable or necessary and attributed any worsening of the claimant's condition to a recent increase in body weight and the claimant's focus on disability. The ALJ rejected Dr. Goldman's opinions, finding Dr. Hahn's opinions more persuasive and credible.

The ALJ also credited the claimant's testimony that she believed she had exhausted every avenue of conservative care and had nothing more to lose by undergoing the surgery. The claimant also testified that immediately following the surgery, the claimant's pain level was more severe and her mobility was more limited. On April 18, 2012, Dr. Hahn wrote a prescription for transportation to and from the doctor's appointments to accommodate the claimant for crutches. Based on this evidence, the ALJ inferred that the claimant's condition became worse.

Relying on the opinions of Dr. Hahn and the claimant's testimony, the ALJ determined that the fusion surgery was reasonable, necessary and related as an ongoing maintenance medical benefit. The ALJ further found that after the surgery, the claimant experienced a worsening of condition. Consequently, the ALJ reopened the claim and awarded medical and temporary total disability benefits from February 28, 2012, and continuing.

On appeal the respondent contends that the ALJ's determinations are unsupported by the evidence and applicable law. We are not persuaded that the ALJ committed reversible error.

I.

The respondent first contends that the ALJ erred in reopening the claimant's claim. In order to reopen a claim pursuant to §8-43-303(1), C.R.S., the claimant must prove a worsening of her condition that is causally related to the industrial injury. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). The reopening authority under the provisions of §8-43-303, C.R.S., is permissive, and whether to reopen a prior award when the statutory criteria have been met is left to the sound discretion of the ALJ. *Renz v. Larimer County School District Poudre R-1*, 924 P.2d 1177 (Colo. App. 1996). Absent fraud or a clear abuse of that discretion, we may not disturb the ALJ's order. *Osborne v. Industrial Claim Appeals Office*, 725 P.2d 850 (Colo. App. 1986). An abuse of discretion is only shown where the order exceeds the bounds of reason, such as where it is unsupported by substantial evidence or is contrary to law. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993).

Further, the findings of fact upon which the ALJ bases his determination must be upheld if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. In applying the substantial evidence test, we must defer to the ALJ's resolution of conflicts in the evidence, his credibility determinations, and the plausible inferences that he drew from the evidence. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. 2003). To the extent medical evidence is presented, it is solely the ALJ's responsibility to assess the weight of that evidence and resolve any conflicts or inconsistencies. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990).

Here, the ALJ found that the claimant underwent the fusion surgery as a reasonable, necessary, maintenance medical benefit and that as a result of this surgery, the claimant's condition worsened. The respondent contends that the claimant's condition did not "worsen" and that it has always been the same. However, the ALJ credited Dr. Hahn's and Dr. Ryan's opinions concerning the claimant's worsened condition. The ALJ also found that the claimant credibly testified that immediately

following surgery her pain level was more severe and her mobility was more limited than prior to surgery. ALJ Order at 9 ¶29. The claimant specifically testified that her pain level was worse after surgery and that she has to use two crutches more frequently instead of the one crutch she was using prior to the surgery. Tr. at 29, 32. The claimant also testified that her use of medications increased after the surgery. Tr. at 37. This evidence provides substantial evidence and valid support for the ALJ's determination that the claimant's condition did indeed worsen.

The respondent next contends that the claimant's worsened condition was the result of an unreasonable and unnecessary surgery and not from the industrial injury. The ALJ, however, found that the claimant's surgery was reasonable and necessary based on the reports of Dr. Hahn and Dr. Ryan and the claimant's testimony. The question of whether a proposed treatment is reasonable and necessary is one of fact for determination by the ALJ. *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002); *Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (whether medical treatment is reasonable and necessary is a question of fact which must be upheld if supported by substantial evidence). Dr. Hahn was the claimant's authorized treating physician who recommended the surgery on more than one occasion to help the claimant deal with her pain. Dr. Hahn specifically stated that the talonavicular and navicular cuneiform joint should be fused or the claimant's condition "would go on to become further painful." Claimant's Exhibit 8 at 28.

The respondent points to evidence in the record which if credited would support a different result. However, this does not afford a basis for relief on appeal. *Cordova v. Industrial Claims Appeals Office*, *supra*; *See also Mountain Meadows Nursing Center v. Industrial Claim Appeals Office*, 900 P.2d 1090 (Colo. App. 1999)(the existence of conflicting evidence does not lessen the import of substantial evidence in support of a finding). We may not substitute our judgment for that of the ALJ concerning the credibility of the expert witnesses or the inferences to be drawn from the evidence. *Cordova v. Industrial Claim Appeals Office*, *supra*.

The respondent also asserts that the claimant's surgery could not be authorized because the physician failed to obtain prior authorization under Workers' Compensation Rule of Procedure 16-9, 7 Code Colo. Reg. 1101-3. In our review of the record, it does not appear that the respondent presented this argument at hearing and we may not address it for the first time on appeal. *Apache Corp. v. Industrial Claim Appeals Office*, 717 P.2d 1000 (Colo. App. 1986). In any event, the failure of the physician to obtain prior authorization pursuant to WCRP 16-9 does not bar the claimant from obtaining an order which requires the respondent to pay for treatment, which is what the claimant did here. *See Arszman v. Target Corporation*, W. C. No. 4-798-406 (July 19, 2011); *See Bray v.*

Hayden School Dist. RE-1, W.C. No. 4-418-310 (April 11, 2000) (respondents held liable for surgery where doctor failed to seek pre-authorization required by rule); *See also* WCRP 16-9(H)(if, after the service was provided, the payer agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment).

II.

The respondent also argues that the ALJ erred in awarding temporary disability benefits upon reopening because the claimant failed to show that she experienced a greater impact on her temporary work capacity after the worsening of her condition because she was already on social security benefits prior to the worsening. We perceive no error in the ALJ's conclusion.

Pursuant to *City of Colorado Springs v. Industrial Claim Appeals Office*, 954 P.2d 637 (Colo. App. 1997), a worsening of condition after MMI may entitle the claimant to additional temporary disability benefits if the worsened condition caused a "greater impact" on the claimant's temporary work capacity than existed at the time of MMI. *See Root v. Great American Insurance Company*, W.C. No. 4-534-254 (April 15, 2009). The panel has not read *City of Colorado Springs* to require that the claimant establish an "actual wage loss" where the claimant was not working immediately before the worsened condition. *Moss v. Denny's Restaurants*, W.C. No. 4-440-517 (September 27, 2006). For example, in *Lively v. Digital Equipment Corporation*, W.C. No. 4-330-619 (June 14, 2002), the panel stated that "[a]s we read *City of Colorado Springs*, in order to establish entitlement to additional temporary disability benefits the claimant must show the worsened condition resulted in increased physical restrictions (over those which existed on the original date of MMI), and that the increased restrictions caused a 'greater impact' on the claimant's temporary 'work capability' than existed at the time of MMI." *See also El Paso County Department of Social Services v. Donn*, 865 P.2d 877 (Colo. App. 1993); *Ridley v. K-Mart Corp.*, W.C. No. 4-263-123(May 27, 2003).

The question of whether the claimant proved increased disability, as measured by a reduction in her capacity to earn wages, was a question of fact for determination by the ALJ. *See Lyburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). Consequently, we must uphold the ALJ's findings if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. Here, as noted above, the ALJ found that the claimant testified that immediately following her surgery her mobility was more limited than prior to surgery. The ALJ further found that the claimant did not re-register for school for fear that her mobility would be more severely limited by having to use two crutches all of the

time, whereas prior to surgery she could, on occasion, use one crutch. ALJ Order at 9 ¶ 30.

Prior to surgery, the claimant attended Front Range Community College but did not go back to school after her surgery. The claimant testified that she was in too much pain to go to school after her surgery and that because of the surgery she gets tired more often and has to lay down. Tr. at 44 and 50. This evidence supports the ALJ's determination that the claimant's worsened condition resulted in additional physical restrictions and had a greater impact on the claimant's temporary work capacity beyond that which existed at MMI. In our view, therefore, the ALJ's order is supported by substantial evidence and by the correct application of the law, and we will not disturb it. Section 8-43-301(8), C.R.S.

III.

Relying on *Donald B. Murphy Contractors, Inc. v. Industrial Claim Appeals Office*, 916 P.2d 611 (Colo. App. 1995), the respondent contends that the ALJ erred in awarding ongoing temporary disability benefits because the claimant had exceeded the \$75,000 cap in §8-42-107.5, C.R.S. As the respondent states, in cases where the claim is reopened based on a worsening of condition and the claimant previously received an impairment rating of 25 percent or less, *Donald B. Murphy* allows respondents to offset the obligation to pay temporary disability benefits against previously paid permanent disability benefits.

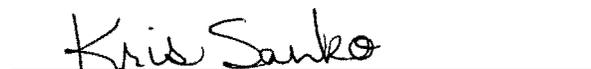
The respondent's reliance on *Donald B. Murphy* in this case, however, is misplaced. Here, there is no evidence that the respondent paid any permanency in this claim. The final admission of liability in evidence indicates that the respondent admitted for zero percent impairment and does not show that any permanent disability benefits were paid. (Claimant's Exhibit at 5). Consequently, there are no previously paid permanent disability benefits to offset against the respondent's obligation to pay temporary total disability benefits. Thus, the ALJ properly concluded that the respondent was liable for temporary total disability benefits.

IT IS THEREFORE ORDERED that the ALJ's order dated July 24, 2012, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



Kris Sanko

CERTIFICATE OF MAILING

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

_____ 12/31/2012 _____ by _____ RP _____ .

NICOLE SANDERS, 1754 LINDEN STREET, LONGMONT, CO, 80501 (Claimant)
ADAMS COUNTY, Attn: CHARLES DU SCHA, C/O: RISK MANAGEMENT, 450 S. 4TH
STREET, 3RD FLOOR, BRIGHTON, CO, 80601 (Employer)
LAW OFFICE OF O'TOOLE & SBARBARO, PC, Attn: JOHN A. SBARBARO, ESQ., 226
WEST 12TH AVENUE, DENVER, CO, 80204 (For Claimant)
CLISHAM, SATRIANA & BISCAN, LLC, Attn: PATRICIA J. CLISHAM, ESQ., 1525
LARIMER ST., SUITE 400, DENVER, CO, 80202 (For Respondents)
JEFFERSON COUNTY SCHOOLS RISK MANAGEMENT, Attn: LISSA PIERCE, P O BOX
4001, GOLDEN, CO, 80401-0001 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-826-648-02

IN THE MATTER OF THE CLAIM OF

JAMES SEIBERT,

Claimant,

v.

ORDER

QWEST CORPORATION,

Employer,

and

SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Mottram (ALJ) dated July 11, 2012, that ordered the claimant to attend a functional capacity examination (FCE) requested by the respondents' independent medical examiner (IME). We dismiss the petition to review without prejudice for lack of a final, reviewable order.

The ALJ found that the claimant suffered a work-related injury on May 28, 2010, when he fell approximately six to seven feet from a ladder. The claimant sustained a fractured left foot and right wrist, a lumbar compression fracture, cervical injury, depression, and chronic pain as a result. The claimant received medical treatment for his admitted injuries from various medical providers. The claimant also underwent surgery for his wrist and left ankle.

Following his surgeries, the claimant continued to treat with Dr. Stagg, his authorized treating physician. On April 4, 2011, the claimant underwent an FCE at the recommendation of Dr. Stagg. The claimant testified that the day after this FCE, he was sore all over.

On November 3, 2011, Dr. Stagg placed the claimant at maximum medical improvement with a combined 38% whole person impairment. Dr. Stagg also provided the claimant with a 15 pound limit lifting and carrying, with no crawling, kneeling, squatting, or climbing. On January 25, 2012, Dr. Stagg filled out a medical source statement limiting the claimant to zero pounds frequently or continuously, and to 10 pounds occasionally.

On February 23, 2012, Dr. Stagg indicated that if the claimant underwent another FCE that he should limit his lifting and carrying to a maximum of 5 pounds, and should comply with all assigned work restrictions. Dr. Stagg noted that his restrictions had changed after MMI based on his extensive discussions with the claimant. Dr. Stagg also opined that a second FCE was not medically necessary, and that it was his opinion that the claimant did not require a second FCE in order to determine permanent medical restrictions.

The claimant underwent an independent medical examination with Dr. Olsen at the request of the respondents. Dr. Olsen testified that a second FCE would provide him with additional data to finally determine the claimant's permanent limitations.

The claimant subsequently filed an application for hearing, listing permanent total disability (PTD) benefits, medical benefits, and reasonably necessary as issues to be heard at the hearing. The hearing was scheduled to take place on May 2, 2012.

On April 5, 2012, a pre-hearing conference was held before prehearing ALJ Purdie. PALJ Purdie ordered that the hearing scheduled for May 2, 2012, before ALJ Mottram shall be used to address the issues of whether the claimant shall be required to attend a FCE and, if so, what prior limitations shall be placed on the FCE.

The hearing subsequently was held before ALJ Mottram, and he entered his order on July 11, 2012. Finding the testimony and reasoning of Dr. Olsen persuasive and credible, ALJ Mottram ordered the claimant to undergo a second FCE. ALJ Mottram determined that the FCE was an "examination by a physician" as contemplated by §8-43-404(1)(a), C.R.S. and could be considered as a form of a "vocational evaluation." ALJ Mottram further found that the respondents' request for the second FCE was based on the claimant's claim for PTD benefits. ALJ Mottram found that it was reasonable for the respondents to request an updated FCE in preparing their defense. ALJ Mottram also concluded that the claimant failed to provide sufficient evidence of the need for any restrictions placed upon the performance of the FCE. In his order, ALJ Mottram noted that if the claimant failed to attend the FCE, this "will only potentially affect" his right to PTD benefits. Conclusions of Law at 5 ¶6.

Thereafter, the claimant petitioned to review ALJ Mottram's order. The respondents then filed a motion to dismiss the claimant's petition on the basis that it was interlocutory and not subject to review. On August 22, 2012, ALJ Mottram denied the respondents' motion. In his order, ALJ Mottram stated that he did not make a determination as to whether his prior order conferred a benefit upon a party or ordered either party to pay a benefit, but that "an argument could be made that the Order [was]

not interlocutory because Claimant's application for hearing on the issue of permanent total disability benefits could be stricken if he fail[ed] to attend the FCE."

The respondents subsequently renewed their motion to strike, arguing that since the claimant attended the FCE on August 15, 2012, to the extent that ALJ Mottram's July 11, 2012, order could have denied the claimant a benefit, that potential denial of a benefit became moot. The claimant filed a response to the renewed motion, arguing that the issue under review remained appealable. ALJ Mottram subsequently denied the respondents' renewed motion to dismiss on the basis that issues continued to exist, including whether he had jurisdiction to order the claimant to attend the FCE.

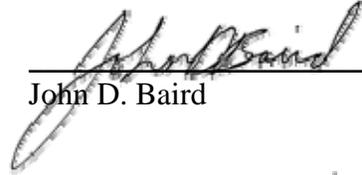
The claimant has petitioned to review ALJ Mottram's order. On review, the claimant argues, in part, that ALJ Mottram erred in determining that the respondents could unilaterally schedule a FCE. The respondents, on the other hand, reiterate that the claimant's appeal is not a final order and not subject to review.

Section 8-43-301(2), C.R.S., provides that a party dissatisfied with an order "that requires any party to pay a penalty or benefits or denies a claimant any benefit or penalty," may file a petition to review. An order which does not satisfy one of the finality criteria of this statute is interlocutory and not subject to immediate review. *See Ortiz v. Industrial Claim Appeals Office*, 81 P.3d 1110 (Colo. App. 2003) (final order grants or denies benefits or penalties). Procedural orders generally are not final and appealable. *See Reed v. Industrial Claim Appeals Office*, 13 P.3d 810 (Colo. App. 2000). The legislative purpose underlying the restrictions on appellate review is to avoid piecemeal litigation. *BCW Enterprises, Ltd. v. Industrial Claim Appeals Office*, 964 P.2d 533 (Colo. App. 1997).

Here, we conclude that ALJ Mottram's order requiring the claimant to undergo the second FCE does not deny the claimant any benefits or penalties, nor does it require the respondents to pay any benefits or penalties. It therefore follows that ALJ Mottram's order is not final and reviewable, and the claimant's appeal currently is interlocutory. *See Director of Division of Labor v. Smith*, 725 P.2d 1161 (Colo. App. 1986) (order not requiring or denying payment of benefits or penalties is interlocutory). Based on these circumstances, therefore, we lack jurisdiction. *Ortiz v. Industrial Claim Appeals Office, supra*. As such, we dismiss the claimant's petition to review without prejudice for lack of a final, reviewable order.

IT IS THEREFORE ORDERED that the ALJ's order dated July 11, 2012, is dismissed without prejudice for lack of a final, reviewable order.

INDUSTRIAL CLAIM APPEALS PANEL



John D. Baird



Kris Sanko

CERTIFICATE OF MAILING

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

_____ 1/3/2013 _____ by _____ RP _____ .

JAMES SEIBERT, 677 30 ROAD, GRAND JUNCTION, CO, 81504 (Claimant)
QWEST CORPORATION, Attn: CAROLE DINAN-FINCH, C/O: NKA CENTURYLINK,
1801 CALIFORNIA STREET, SUITE 1150, DENVER, CO, 80202 (Employer)
SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., Attn: DEBBIE BAIRD, P O BOX
14494, LEXINGTON, KY, 40512-4494 (Insurer)
WITHERS SEIDMAN RICE & MUELLER, P.C., Attn: DAVID B. MUELLER, ESQ., 101 S.
THIRD STREET, SUITE 265, GRAND JUNCTION, CO, 81501 (For Claimant)
DWORKIN CHAMBERS WILLIAMS, Attn: GREGORY K. CHAMBERS, ESQ., C/O: YORK
BENSON & EVANS, P.C., 3900 E. MEXICO AVENUE, SUITE 1300, DENVER, CO, 80210
(For Respondents)

12CA0459 Zolman v. ICAO 12-27-2012

COLORADO COURT OF APPEALS

Court of Appeals No. 12CA0459
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-636-044

Charlotte Zolman,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado; Horizon Home Care,
LLC; and Pinnacol Assurance,

Respondents.

ORDER AFFIRMED

Division III
Opinion by JUDGE STERNBERG*
Dailey and Richman, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(f)
Announced December 27, 2012

Bisset Law Firm, Jennifer E. Bisset, Englewood, Colorado, for Petitioner

No Appearance for Respondents Industrial Claim Appeals Office

Harvey D. Flewelling, Denver, Colorado, for Respondents Horizon Home Care,
LLC and Pinnacol Assurance

*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art.
VI, § 5(3), and § 24-51-1105, C.R.S. 2012.

Petitioner, Charlotte Zolman (claimant), seeks review of the final order issued by the Industrial Claim Appeals Office (Panel) upholding the denial of her request for a change of physician and epidural steroid injections. We affirm.

In 2004, claimant sustained a compensable injury to her lower back. A detailed account of claimant's injury and the medical history predating her claims here appears in *Zolman v. Pinnacol Assurance*, 261 P.3d 490 (Colo. App. 2011), a civil case, where a division of this court affirmed the summary judgment entered against claimant on her bad faith insurance claim. We rely on the facts recited in *Zolman* to the extent they are relevant and reiterate only those facts that are necessary to understand the issues claimant raises on appeal.

In 2005, Dr. Primack, claimant's authorized treating physician (ATP), placed her at maximum medical improvement (MMI). In 2006, Horizon Home Care, LLC and its insurer, Pinnacol Assurance (collectively employer), filed a final admission of liability for post-MMI medical benefits.

In 2007, claimant returned to Dr. Primack for an evaluation. Following a CT scan, which found calcification of claimant's aorta,

Dr. Primack encouraged claimant to see her primary care physician to determine whether she also had claudication (a symptom of peripheral artery disease which most often affects the blood vessels in the legs) because it could cause low back or leg pain and interfere with her walking. Dr. Primack indicated that he did not need to see claimant for a follow-up as her condition had not changed and he “did not feel as though there [was] a work-related component to her back pain.” He noted that she had been given a home exercise program, but he did not believe “medication or further followup . . . would be considered work-related.” He also opined that degenerative changes found on the CT scan were independent of claimant’s work injury.

Claimant then sought treatment with Dr. Yamamoto, whom she had consulted in 2006 for a second opinion. Dr. Yamamoto recommended referral to a specialist for evaluation of possible epidural steroid injections.

Claimant also returned to Dr. Danahey, her original ATP, for evaluation. He found that claimant was better and opined that she needed no further care or treatment.

Dr. Danahey evaluated claimant again in 2009, noting that

she was seeking authorization for additional injections. It appears that sometime before this evaluation, Dr. Yamamoto had referred claimant to Dr. Schwettmann, an anesthesiologist, who had treated her with injections that were covered by Medicare. Dr. Danahey reported in the 2009 evaluation that claimant was “fine” with him as her physician and the care he had provided. However, he also opined that additional injections were not necessary, as they would provide only transient benefit. He recommended only that claimant continue with an exercise program.

In a second evaluation two months later, Dr. Danahey reviewed the results of an EMG study and advised against a repeat injection. He had no further treatment recommendations for claimant other than for her to continue with an exercise program.

In January 2010, approximately five months later, Dr. Primack performed a comprehensive evaluation of claimant. He noted that claimant’s peripheral vascular disease and claudication had not been worked up and indicated that it could be contributing to her walking difficulty and leg pain. Dr. Primack also noted that Dr. Schwettmann had administered two epidural injections to claimant. Dr. Primack opined that a third injection could be done,

but that it would be unlikely to yield more than a low benefit. He further observed that if claimant did have poor circulation, her symptoms would be ongoing. Dr. Primack concluded that claimant would not be a reasonable candidate for further injections.

An evidentiary hearing was held on claimant's request for the steroid injections and a change of physician to Dr. Yamamoto. The Panel upheld the ALJ's order in part, and remanded for further proceedings based on the ALJ's improper application of issue preclusion to prevent claimant from pursuing her claim for medical benefits and a change of physician based on an alleged worsening of her condition. Following dismissal of a premature appeal to this court, the ALJ modified portions of his prior order and, again, denied claimant's requests.

The Panel affirmed on review.

II. No Change of Physician

Claimant contends that Dr. Yamamoto became an ATP in one of two ways: (1) because Dr. Primack referred claimant to him, or (2) as the result of her exercise of the right of selection after Dr. Primack and Dr. Danahey refused to treat her for non-medical reasons. The record does not support either the occurrence of a

referral or a transfer of the right of selection, and, therefore, claimant was not entitled to a change of physician.

Treatment is compensable under the Act when an ATP provides it; but if an employee obtains unauthorized treatment, the employer or its insurer is not required to pay for it. *Cabela v. Indus. Claim Appeals Office*, 198 P.3d 1277, 1280 (Colo. App. 2008).

Section 8-43-404(5)(a), C.R.S. 2012, affords the employer or insurer the right, in the first instance, to select the physician who attends the injured employee. The right of selection passes to the claimant only if the employer fails to tender a physician's services at the time of the injury. *Lutz v. Indus. Claim Appeals Office*, 24 P.3d 29, 31 (Colo. App. 2000). Therefore, if the physician selected by the employer refuses to treat the claimant for non-medical reasons, and the employer fails to appoint a new treating physician, the right of selection passes to the claimant, and the physician selected by the claimant becomes authorized. *See Ruybal v. Univ. of Colo. Health Scis. Ctr.*, 768 P.2d 1259, 1260 (Colo. App. 1988).

Employers are also liable for the expenses incurred when, as part of the normal progression of authorized treatment for a compensable injury suffered by a claimant, an ATP refers a

claimant to one or more other physicians. *Greager v. Indus. Comm'n*, 701 P.2d 168, 170 (Colo. App. 1985). Thus, ATPs include not only those physicians to whom an employer directly refers a claimant, but also those physicians to whom an ATP has referred a claimant. *Bestway Concrete v. Indus. Claim Appeals Office*, 984 P.2d 680, 684 (Colo. App. 1999).

Whether an ATP has refused to treat the claimant for non-medical reasons or whether a provider saw the claimant within the chain of referral are questions of fact for the ALJ's resolution. See *Cabela*, 198 P.3d at 1280; *Lutz*, 24 P.3d at 31. Thus, the ALJ's determinations in that regard must be upheld if substantial evidence supports them. § 8-43-308, C.R.S. 2012.

Consistent with his reports, Dr. Primack testified that he recommended that claimant be evaluated by her primary care physician to determine whether other conditions unrelated to her injury may be causing or contributing to her symptoms. He explained that he remained reluctant to treat her until she had the necessary diagnostic studies to confirm or eliminate such non-occupational conditions as a cause or contributor to her pain. He also stated that he needed to have claimant's possible osteoporosis,

peripheral vascular disease, and peripheral neuropathy evaluated before he could recommend maintenance medical care for the 2004 work injury. Dr. Primack indicated that, if the workup was positive, he would want those conditions treated to see if that treatment course would alleviate her pain complaints.

Dr. Primack's reports and testimony support the ALJ's finding that he did not refer claimant to her primary care physician for treatment of her work-related lower back condition. It is clear from Dr. Primack's concerns over the calcification of the iliac aorta seen on the CT scan that any referral he made to claimant's primary care physician related only to the evaluation and treatment of any potential non-work related conditions. Therefore, whether or not claimant had established that Dr. Yamamoto was her primary care physician at the time of Dr. Primack's evaluations, nothing in the record supported her position that Dr. Yamamoto became authorized to treat her work-related condition through the chain of referral.

Similarly, the record, through the reports and testimony of Dr. Primack and Dr. Danahey, substantially supports the ALJ's determination that neither ATP refused to treat claimant for non-

medical reasons. Both Dr. Primack and Dr. Danahey declined to provide further care or treatment because they felt that claimant's work-related back injury had resolved and no further care or treatment was needed to maintain her post-MMI condition.

Although Dr. Primack acknowledged that he did not ask claimant to come back after he saw her in 2010 and that he did not offer her any treatment at that time, he specifically explained that he discharged her for the purpose of seeing her primary care physician for evaluation of possible non-occupational conditions to determine whether they were causing her chronic back pain.

Like Dr. Primack, Dr. Danahey concluded in his 2007 evaluation that claimant required no further care or treatment for her work-related condition. As noted, he also indicated claimant was satisfied with him as her physician and the care he had provided. Further, in the later evaluation, Dr. Danahey opined that the additional injections claimant sought were not necessary because they would provide no significant relief.

In view of each ATP's opinion that claimant's work-related condition had not worsened and that no post-MMI medical treatment was required, the Panel correctly recognized that the ALJ

had reasonably inferred that there had been no refusal to treat by either ATP. That determination was binding on review.

Consequently, the right of selection did not pass to claimant and neither Dr. Yamamoto nor Dr. Schwettmann acquired the designation of ATP through the normal progression of authorized treatment. *See Yeck v. Indus. Claim Appeals Office*, 996 P.2d 228, 230 (Colo. App. 1999) (employer retained right of selection where ATP did not refuse to treat the claimant, but the claimant simply refused to return to the ATP despite ongoing symptoms).

Claimant's reliance on *Cabela* to argue that Dr. Yamamoto and Dr. Schwettmann became ATPs as a matter of law is misplaced. There, the employer's physician referred the claimant to her personal physician solely for the purpose of treating her knee after she injured it at work. *Cabela*, 198 P.2d at 1281. The division in *Cabela* agreed with the claimant that the employer was responsible for the cost of the personal physician's treatment because it was reasonably needed to cure and relieve the effects of the injury, which was found to be compensable. *Id.* The division reasoned that the risk of mistake by an ATP in concluding that an injury is noncompensable lies with the employer. *Id.*

Because here, the substantial evidence sustained the ALJ's finding that Dr. Primack and Dr. Danahey referred claimant to her primary care physician for evaluation of potential non-occupational conditions, we agree with the Panel that *Cabela* is distinguishable.

Claimant also argues that declining to provide further medical treatment based on a determination that the condition causing the need for treatment is no longer work-related and, therefore, not compensable, constitutes a refusal for non-medical reasons. The case she cites is factually distinguishable, and, in any event, is unpublished and therefore has no precedential value. *See Welby Gardens v. Adams Cnty. Bd. of Equalization*, 71 P.3d 992, 999 (Colo. 2003) (unpublished cases have no precedential value). Similarly, we are not bound by the Panel's decisions in other cases. *See Olivas-Soto v. Indus. Claim Appeals Office*, 143 P.3d 1178, 1180 (Colo. App. 2006).

Furthermore, Dr. Primack and Dr. Danahey determined that claimant needed no further treatment for her work injury, not that the condition caused by her work injury was no longer compensable. In any event, as the ALJ observed, statutory remedies exist, such as the procedure for requesting a change of

physician, for challenging an ATP's medical determination that further treatment is not warranted.

III. Post-MMI Medical Benefits

Claimant next contends that because the undisputed evidence supports her need for ongoing pain management, the ALJ erred by denying such medical care for her injury-related low back pain, including the steroid injections. Again, we disagree.

A claimant is entitled to future medical benefits when 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 to prevent further deterioration of the claimant's condition. *Stollmeyer v. Indus. Claim Appeals Office*, 916 P.2d 609, 611 (Colo. App. 1995). However, even when a claimant receives a general award of future medical benefits, it remains subject to the employer's right to contest compensability, reasonableness, or necessity for each maintenance treatment requested. *Hanna v. Print Expeditors Inc.*, 77 P.3d 863, 865-66 (Colo. App. 2003).

Whether medical treatment is reasonably necessary to cure and relieve the effects of the injury is a factual question to be

resolved by the ALJ, *Snyder v. Indus. Claim Appeals Office*, 942 P.2d 1337, 1339 (Colo. App. 1997), and we must defer to the ALJ's credibility determinations and resolution of any conflicts in the evidence, including the medical evidence, *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995).

Here, Dr. Primack and Dr. Danahey opined that the steroidal injections either would not relieve claimant's symptoms, particularly if they were caused by vascular claudication, or would be of little and fleeting benefit. Dr. Schwettmann's suggestion that claimant could continue to obtain injections of up to six per year, without limitation, was rejected by Dr. Primack and Dr. Reiss, another medical expert claimant consulted. Further, although Dr. Reiss had opined that an additional epidural injection may be of benefit, he based that conclusion upon his assessment that claimant's symptoms resulted from nerve compression in the spinal column caused by the combined effect of claimant's compression fracture and her degenerative spinal disease. He acknowledged, however, that he had not evaluated claimant's vascular status and could not comment on her circulation or how that would affect her condition.

Based on the foregoing evidence, the ALJ credited the opinions of Dr. Primack and Dr. Danahey and resolved the conflicts in the medical evidence to find that claimant failed to prove that the steroid injections were reasonable and necessary to maintain her post-MMI condition. As the Panel noted, the opinions of Dr. Schwettmann and Dr. Reiss did not constitute the type of hard and certain evidence that would have compelled a contrary determination. *See Halliburton Servs. v. Miller*, 720 P.2d 571, 577-78 (Colo. 1986) (the fact finder errs as a matter of law when it credits testimony that is overwhelmingly rebutted by hard certain evidence to the contrary). Nor did claimant's testimony that the injections greatly improved her symptoms require the ALJ to reject the opinions of Dr. Primack and Dr. Danahey. *See Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186, 191 (Colo. App. 2002) (the weight and credibility to be assigned expert testimony is a matter within the ALJ's discretion).

Indeed, because the opinions of Dr. Primack and Dr. Danahey provided substantial support for the conclusion that the injections were not reasonable or necessary post-MMI maintenance treatment, the ALJ's denial of authorization for the injections may not be set

aside.

Because the only post-MMI maintenance treatment addressed at the hearing involved the steroid injections, and the ALJ reserved all matters that were not decided for future determination, claimant's general request for pain management remains open. See *Hire Quest, LLC v. Indus. Claim Appeals Office*, 264 P.3d 632, 635 (Colo. App. 2011) (general reservation clause in order reserving the issue of post-MMI medical benefits for future determination).

We do not reach the claimant's argument that the denial and dismissal of her request for pain management, including the injections, failed to fulfill the humanitarian purposes of the Act, as she raised that argument for the first time on appeal in her reply brief. See *Meadow Homes Dev. Corp. v. Bowens*, 211 P.3d 743, 748 (Colo. App. 2009).

The order is affirmed.

JUDGE DAILEY and JUDGE RICHMAN concur.