COLORADO
Department of
Labor and Employment

Division of Workers' Compensation
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January Case Law Update

Presented by Judge John Sandberg and Judge John Steninger

This update covers ICAO and COA decisions issued between November 13, 2017 to January 12, 2018

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-979-208-04

IN THE MATTER OF THE CLAIM OF:

SANDI ARNHOLD,

Claimant,

v.

FINAL ORDER

UNITED PARCEL SERVICE,

Employer,

and

LIBERTY MUTUAL INSURANCE,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Turnbow (ALJ) dated April 10, 2017, that determined the claimant's authorized treating physician (ATP) did not place the claimant at maximum medical improvement (MMI) and that held the respondents liable for the claimant's knee replacement surgery. We affirm in part and set aside in part.

The claimant worked as a package driver for the respondent. The claimant sustained a compensable work injury to her left knee on March 20, 2015. On that date, she was using a replacement vehicle with a manual transmission. She made approximately 320 stops over a two day period, which required repetitive clutching. Afterwards, the claimant experienced significant pain and swelling in her left knee. The claimant had no prior history of left knee pain or swelling.

ATP, Dr. Williams, diagnosed a medial meniscal tear and "reactive arthritis from clutching repetitively over 2 days." He opined that the acute work activity of repetitive clutching likely caused the claimant's meniscal tear and also caused a flare of her significant but asymptomatic pre-existing condition of chondromalacia, or the arthritic condition of her knee that involves thinning of the cartilage caps of the bones in the knee over time.

Conservative therapy ultimately failed to improve the claimant's condition. Dr. Williams concluded that the aggravation of the previously non-symptomatic chondromalacia had not subsided with conservative treatment and eventually became permanent.

Dr. Williams referred the claimant to an orthopedic surgeon, Dr. Robinson. After providing an unsuccessful steroid injection, he counseled the claimant that knee replacement surgery may be necessary in the future. Dr. Williams also referred the claimant to Dr. Patel, another orthopedic surgeon, for a second opinion. Dr. Patel concurred with Dr. Robinson and recommended a series of synthetic cartilage injections as a means to stave off knee replacement. However, the injections did not work and the claimant's condition worsened. Dr. Patel requested authorization for knee replacement surgery.

The respondents denied Dr. Patel's request for authorization to perform the knee replacement surgery and also filed an application for hearing to challenge Dr. Patel's request.

After denial of the surgery, Dr. Williams saw the claimant on May 17, 2016, and opined as follows:

> [Claimant h]as had no interval improvement. She is not making any gains for her left knee. She was unable to complete work hardening, so she has not been able to return to work.

Further, in completing the Division's Physician's Report, Dr. Williams checked the MMI box, but also explained in his narrative report as follows:

> No further conservative treatments indicated. I do not think she will have reasonable recovery until such time as she completes knee replacement surgery on the left. She and her attorney will continue moving forward with their claim against the insurance carrier. In the meantime, I feel she is at MMI because no further recovery is expected without surgery.
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> ***
>
> Additionally, she was unable to complete work hardening, and could not overcome her current temporary work restrictions. Therefore, I feel she has permanent work restrictions. These could perhaps be rescinded after knee replacement surgery and subsequent rehabilitation.

The respondents filed a Final Admission of Liability (FAL), attaching Dr. Williams' note from May 17, 2016. A hearing on the respondents' application was set for August 11, 2016, on the issues of medical benefits, reasonable and necessary, and relatedness, among other issues.

The claimant filed an objection and notice and proposal for a Division-sponsored independent medical examination (DIME).

In August 2016, the claimant ultimately went forward with the knee replacement surgery outside of the workers' compensation system. Her surgeon, Dr. Patel, released the claimant for work with no restrictions beginning on December 1, 2016.

Pre-hearing Conference Orders

1. Pre-hearing Conference on July 27, 2016

At a pre-hearing conference held on July 27, 2016, the respondents moved to hold in abeyance the August 11, 2016, hearing they had requested on medical benefits. The respondents reasoned that the hearing could not go forward because the claimant had requested a DIME and it had not been completed. In response, the claimant argued that since Dr. Williams' MMI determination was ambiguous, the hearing should go forward for a factual determination on whether the claimant was actually placed at MMI, as addressed in *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002).

Pre-hearing ALJ Gallivan ultimately found that ambiguity in Dr. Williams' medical report provided a basis for an objection to the FAL and for a hearing regarding factual issues raised by the ambiguity. However, because the MMI issue had not been endorsed, he held the August 11, 2016, hearing in abeyance with regard to medical benefits. He found that the issue was not ripe unless and until there is a finding that the claimant is not at MMI.

In response to PALJ Gallivan's order, the claimant filed an application for hearing on July 28, 2016, which was amended on August 18, 2016, to limit the hearing to the MMI issue. In response to the claimant's amended application for hearing, the respondents identified medical benefits, reasonably necessary, and other issues. A hearing originally was set for on December 1, 2016, but was continued to December 6, 2016.

2. Pre-hearing Conference on August 25, 2016

On August 12, 2016, the claimant filed an opposed motion to hold the DIME process in abeyance until an ALJ resolved the issue of the claimant's MMI status. A pre-hearing conference was held before PALJ Barbo on August 25, 2016.

PALJ Barbo granted the claimant's motion. He reasoned that the DIME process could not proceed until it is determined that the claimant is at MMI. He explained that the DIME process contemplates that an ATP has made a definitive determination on MMI.

3. Pre-hearing Conference on September 13, 2016

On September 13, 2016, a pre-hearing conference was held before PALJ Steninger. The respondents had moved to strike the MMI issue from the claimant's hearing application. They argued that the MMI ambiguity issue was not ripe because the DIME had exclusive jurisdiction to resolve ambiguities in the ATP's report once the DIME process starts. PALJ Steninger rejected the respondents' argument, holding that under *Town of Ignacio*, an ALJ has jurisdiction to resolve factual ambiguities in an ATP's MMI determination.

ALJ's order

In her subsequent order, the ALJ held that the issues she was to decide included whether the claimant's ATP, Dr. Williams, made a valid MMI determination under §8-40-201 (11.5), C.R.S. and *Town of Ignacio*, whether the respondents' FAL should be stricken based on an invalid MMI determination, whether the MMI issue was ripe, and whether the ALJ had jurisdiction to resolve the issue. The ALJ found that she had jurisdiction to resolve the factual ambiguities raised by Dr. Williams' May 17, 2016, note. She further found that Dr. Williams' May 17, 2016, note created a factual ambiguity by both checking the MMI box in the Division's Physician's Report form and by opining in his narrative report that knee replacement surgery was necessary for the claimant to obtain a full recovery from her work injury. The ALJ concluded that Dr. Williams' May 17, 2016, note indicated he believed further treatment, specifically knee replacement surgery, would likely improve the claimant's work related injury. The ALJ found that Dr. Williams did not determine the claimant was at MMI. As a consequence of her finding that Dr. Williams did not determine the claimant was at MMI, the ALJ held that the respondents' FAL was premature and must be stricken.

The ALJ also found that the respondents had raised the issue of medical benefits in their response to the claimant's application for hearing. She found that substantial evidence proved that the claimant tore her left medial meniscus and aggravated a previously non-symptomatic arthritic condition. Since she found the claimant's arthritic condition did not resolve with conservative treatment and eventually became permanent, she held the respondents were liable for the knee replacement surgery performed by Dr. Patel, as well as related treatment, medication, supplies and equipment.[1]

The respondents have petitioned to review the ALJ's order and have raised numerous arguments of error.

I.

The respondents argue that under §8-40-201 (11.5), C.R.S. and *Town of Ignacio*, the ALJ erred in finding that Dr. Williams did not place the claimant at MMI on May 17, 2016. They reason that the ALJ did not have jurisdiction to decide MMI as the DIME process had been initiated. They further argue that the ALJ misapplied the law as to ambiguities she found in Dr. Williams' medical report and note. We disagree.

MMI is that point in time when "any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition." Section 8-40-201(11.5), C.R.S.

Section 8-42-107(8)(b), C.R.S. provides that the initial determination of MMI is to made by an authorized treating physician. Pursuant to *Town of Ignacio*, the authorized treating physician's opinion is binding, and the parties may not litigate the issue of MMI, unless the party disputing the authorized treating physician's determination of MMI obtains a DIME. *See also Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Section 8-42-107(8)(b)(III), C.R.S. adds that in the absence of a DIME, ALJs lacks authority to hear a challenge to the treating physician's finding of MMI. *Story v. Industrial Claim Appeals Office*, 910 P.2d 80 (Colo. App. 1995); *see also Postlewait v. Midwest Barricade*, 905 P.2d 21 (Colo. App. 1995). Therefore, we previously have held that ALJs lack jurisdiction to make an independent determination of MMI where a DIME has been requested but not yet completed. *See Deyle v. Prowers Medical Center*, W.C. No. 4-185-255 (June 23, 1997).

[1] Prior to issuance of the ALJ's order, the parties submitted their Proposed Findings of Fact, Conclusions of law, and Orders. However, the respondents moved to strike the claimant's proposed order, arguing, in part, that the claimant addressed issues that were not before the ALJ, most notably whether the total knee replacement surgery was reasonable, necessary, and related. On January 23, 2017, the ALJ denied the respondents' motion. However, in her order, the ALJ clarified that the only issued tried in this matter was that of MMI.

However, it is now well established and we long have held that a DIME is not a prerequisite to the ALJ's resolution of whether an authorized treating physician has determined the claimant to be at MMI. *Town of Ignacio v. Industrial Claim Appeals Office*, *supra*; *cf. MGM Supply Co. v. Industrial Claim Appeals Office*, 62 P.3d 1001 (Colo. App. 2002)(ALJ may resolve ambiguities in DIME physician's report regarding whether claimant is at MMI); *Loyda v. Gregory G. Farthing, DDS,* W. C. No. 4-467-593 (Jan.21, 2005). This is true because the purpose of a DIME under §8-42-107(8)(b), C.R.S. is to make an independent determination of whether the claimant has reached MMI, not to determine whether the treating physician has rendered an opinion on MMI. *Town of Ignacio v. Industrial Claim Appeals Office, supra*.

Generally, the DIME process is not triggered until the authorized treating physician places the claimant at MMI. Thus, where the question is disputed, the ALJ's determination of whether the authorized treating physician has placed the claimant at MMI is a necessary prerequisite to the applicability of the DIME procedures. Indeed, the parties cannot determine whether to dispute the authorized treating physician's determination of MMI until the parties know the true nature of the treating physician's opinion.

Here, we perceive no error in the ALJ's determination that Dr. Williams did not place the claimant at MMI. The ALJ's determination in this regard is supported by a plausible interpretation of the evidence. As found by the ALJ, although Dr. Williams' physician's report states the claimant reached MMI on May 17, 2016, with permanent impairment and permanent restrictions, another report provides that Dr. Williams did "not think [the claimant] will have reasonable recovery until such time as she completes knee replacement surgery on the left." Ex. 2 at 60, 62. Dr. Williams further added that while he provided permanent work restrictions, "[t]hese could perhaps be rescinded after knee replacement surgery and subsequent rehabilitation." Indeed, permanent restrictions on lifting, carrying, pushing/pulling, walking, standing, and sitting are contained in Dr. William's physician's report. Ex. 2 at 60, 62. During the hearing, Dr. Williams testified that he was speaking about conservative treatment when he checked the MMI box on his physician's report. He explained that at the time, that was all that had been approved by the respondent insurer. Tr. at 40-41. Dr. Williams further testified that in his opinion, knee replacement surgery was reasonably expected to improve the claimant's condition. Tr. at 40-42; Ex. 2 at 62. He explained that at the time he wrote his report, he knew the insurance carrier had denied the surgery that was recommended by Dr. Patel. He testified that when this happens, his hands are somewhat tied, and the patient, or the claimant in this instance, is placed in limbo. Dr. Williams testified that he believed that if he said the claimant was at MMI for conservative treatments, which was all that had been allowed by

the insurer, then it would allow her case to close so that she could then move forward outside of the workers' compensation system to get her knee replaced because he felt that this "would most likely give her, her best chance of recovery." Tr. at 41-42. The respondents' arguments notwithstanding, it most certainly could be inferred from this evidence that there were ambiguities in Dr. Williams' opinions. As explained above, if the ATP issues ambiguous opinions concerning MMI, the ALJ may determine the ATP's true opinion without the necessity of a DIME. For these reasons, we reject the respondents' contention that the ALJ lacked jurisdiction to determine the ATP's true opinion without the necessity of a DIME. *See Town of Ignacio v. Industrial Claim Appeals Office, supra* (specialist's report was ambiguous with respect to MMI and that the matter must be remanded for a factual determination as to whether the specialist found claimant to be at MMI).

Under these circumstances, therefore, we have no basis to disturb the ALJ's order on these grounds.

II.

Next, the respondents contend the ALJ erred in ordering them liable for the claimant's knee replacement surgery. They argue that the issue was not properly before the ALJ as it previously had been held in abeyance pending resolution of the MMI issue, and the ALJ also ruled that it was not an issue presently before her. Consequently, they argue their right to due process was violated.

Conversely, the claimant argues that the respondents tried the issue of medical benefits by consent and, therefore, waived any right to object to the ALJ's award of knee replacement surgery. We set aside the ALJ's order on the issue of medical benefits.

A party has the right to procedural due process, which generally requires that the party be provided with notice and an opportunity to be heard. *See Hendricks v. Industrial Claim Appeals Office*, 809 P.2d 1076 (Colo. App. 1990). Thus, the essence of procedural due process is that the proceedings be fundamentally fair. Due process also requires that a party have advance notice of the issues to be adjudicated at the hearing. Due process contemplates that the parties will be apprised of the evidence to be considered, and afforded a reasonable opportunity to present evidence and argument in support of their positions. Inherent in these requirements is the rule that parties will receive adequate notice of both the factual and legal bases of the claims and defenses to be adjudicated. *Id.*

Moreover, matters relating to procedure and that are not of a jurisdictional character may be waived, either expressly or impliedly by conduct that manifests an intent to relinquish the right or that is inconsistent with its assertion. *See Johnson v. Industrial Commission*, 761 P.2d 1140 (Colo. 1988). We previously have held, for example, that notice that the claimant is claiming benefits based upon an occupational disease may be waived. *See Lopez v. Stresscon Corp.*, W.C. Nos. 4-198-942, 4-198-943 (Oct. 1995). In general, if a party does not object to consideration of an issue and litigates it through presentation of evidence and cross-examination of adverse witnesses, a waiver may be found. *Robbolino v. Fisher-White Contractors, Inc*., 738 P.2d 70 (Colo. App. 1987). However, the conclusion that an issue was tried by implied consent should be rejected where a reasonable doubt exists as to whether the issue was intentionally and actually tried. *See Bill Dreiling Motor Co. v. Schultz*, 168 Colo. 59, 450 P.2d 70 (1969)(applying principle under C.R.C.P. 15(b)). This is true because waiver must be the product of a voluntary, knowing and intelligent action. *Johnson v. Industrial Commission*, 761 P.2d 1140 (Colo. 1988).

Here, we initially conclude that the respondents had insufficient notice that entitlement to the total knee replacement surgery would be decided at the hearing. As detailed above, the claimant's amended application for hearing did not identify medical benefits as an issue to be heard at the hearing. It is true, as the ALJ found, that the respondents filed a response to the claimant's amended application for hearing and identified medical benefits as an issue to be heard. However, the respondents previously had filed an application for hearing identifying medical benefits as an issue, and they filed a motion to hold their hearing on medical benefits in abeyance pending resolution of the DIME. As explained above, pre-hearing ALJ Gallivan ultimately found that the ambiguity in Dr. Williams' medical report provided a basis for an objection to the FAL and a hearing regarding factual issues raised by the ambiguity. However, because the MMI issue had not been endorsed, he held the August 11, 2016, hearing in abeyance with regard to medical benefits. He found that the issue was not ripe unless and until there is a finding that the claimant is not at MMI. Moreover, the claimant did not raise the issue of medical benefits at the commencement of the hearing. Instead, at the commencement of the hearing, the claimant stated that the single issue before the ALJ was MMI. Tr. at 7-8. When the ALJ asked the respondents' counsel what the issue or issues were before the ALJ, he responded "MMI." Tr. at 8-9. Also, during the hearing on this matter, the ALJ orally ruled that the sole issue before her was MMI. Tr. at 11.

Additionally, we have a reasonable doubt that the respondents intentionally tried the issue of medical benefits or tried the issue of whether the knee replacement surgery was reasonable, necessary, and related. Admittedly, the respondents cross-examined Dr.

Williams on the issue of whether the knee replacement surgery was related to the claimant's work injury. Tr. 53-60. However, this testimony also was relevant to whether the claimant was at MMI for her admitted work injury or whether the claimant's need for surgery instead was related to her pre-existing but previously asymptomatic chondromalacia. Accordingly, we are not persuaded that this testimony amounts to a waiver of the respondents' right to now argue that the issue of medical benefits was not before the ALJ. Thus, the fact Dr. Williams' testimony is arguably relevant to the issues of medical benefits does not compel the conclusion the respondents agreed to litigate the issue. To the contrary, had the respondents known that the claimant was seeking an order awarding the total knee replacement surgery, they may have engaged in further cross-examination of Dr. Williams or presented other evidence to refute the claimant's need for such surgery. Thus, the respondents were not afforded a fair opportunity to decide what evidence and testimony to present because they received inadequate notice that the claimant sought an award of such medical benefits. Under these circumstances, we agree with the respondents that they were not afforded adequate notice that the ALJ would consider whether the claimant is entitled to total knee replacement surgery.

Consequently, under these circumstances, we must set aside the ALJ's award of medical benefits.

IT IS THEREFORE ORDERED that the ALJ's order dated April 10, 2017, is set aside to the extent it awarded the claimant medical benefits, and otherwise is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

11/17/17 by TT .

THE MCCARTHY LAW FIRM PC, Attn: JOHN D MCCARTHY, ESQ, 7884 RALSTON ROAD, ARVADA, CO, 80002 (For Claimant)
LEE & KINDER LLC, Attn: DANIEL MOWREY, ESQ, C/O: JOSEPH W GREN, ESQ, 3801 EAST FLORIDA AVENUE SUITE 210, DENVER, CO, 80210 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. Nos. 4-962-974-01 and
4-962-974-02

IN THE MATTER OF THE CLAIM OF:

JENNIFER M. MUNOZ BOTELLO,
and JOSE E. BALQUIER MUNOZ, JR.,

Claimants,

JOSE E. BALQUIER,

Decedent,

v.

FINAL ORDER

EVERGREEN CAISSONS, INC.,

Employer,

and

TRAVELERS INDEMNITY COMPANY,

Insurer,
Respondents.

The respondents seek review of an order from Administrative Law Judge (ALJ) Cain dated November 18, 2015, that determined Botello (claimant) is the dependent of Jose E. Balquier (decedent) for purposes of § 8-41-501(1)(a), C.R.S. The respondents and Jose Balquier Jr. (minor claimant) seek review of an order from ALJ Michelle Jones dated March 21, 2017, that apportioned death benefits between the dependents and ordered the respondents to pay for the reasonable fees and costs for the Guardian ad Litem (GAL). We affirm.

This matter was previously before us. In the November 18, 2015, order ALJ Cain entered factual findings that for purposes of review can be summarized as follows. The decedent died on April 16, 2014, as a result of injuries arising out of and in the course of his employment. The respondents filed a Fatal Final Admission admitting that the minor claimant is entitled to death benefits. In August 2014, the claimant filed a Dependent Notice and Claim for Compensation alleging that she was the common law spouse of the decedent and is entitled to death benefits. The claimant's date of birth was October 13,

1995, making her 18 at the time of the decedent's death. The claimant was born in Mexico and testified that she met her husband, the decedent, at a funeral in Mexico in January of 2011. After the funeral the decedent asked the claimant's mother for the claimant's hand in marriage and the claimant's mother agreed. The claimant testified that she has considered herself married to the decedent since January 2011.

After the January 2011 funeral, the decedent returned to the United States but the claimant remained in Mexico. The decedent began sending her money to support herself. The decedent was incarcerated from January 2012 through December 2012 for transporting marijuana. The claimant came to live with the decedent at the decedent's mother's home in Colorado when the decedent was released from jail in December 2012. The decedent's mother was charging rent and the decedent did not have enough money to support the claimant so she returned to Mexico on January 4, 2013.

The claimant returned to Colorado in March of 2013 and again lived with the decedent and his mother. In July of 2013, the decedent and the claimant left the mother's house and moved together to an apartment in Westminster, CO. The decedent was the only person identified on the lease as living in the apartment. The claimant testified that she was not listed on the lease because she was a minor at the time. The claimant provided documentation from Rent-A-Center, showing that she and the decedent rented a television together and that she resides at the apartment with the decedent. The claimant stated that she cooked and cleaned house and that she never had a job while residing in the United States.

The claimant turned 18 on October 13, 2013. The testimony established that there was a birthday celebration at the decedent's mother's house and that the decedent gave the claimant a heart shaped ring. The claimant was pregnant with the decedent's child at the time of the decedent's death. The minor claimant was born on July 23, 2014, after the decedent had passed away.

The decedent's death certificate lists the claimant as the decedent's spouse. The death certificate lists the "informant" as the decedent's mother. The decedent's obituary states that the decedent is survived by his wife, the claimant.

The claimant's father testified and corroborated the claimant's version of the events. The father also testified that after the decedent died the claimant had no means of support so he and his wife moved to Colorado to provide support to her. There was other testimony from a friend, Lilliana Arrellano, that she thought the decedent and the claimant were married and that the decedent would call the claimant "his lady." The

decedent's uncle, Savino Avilla, testified that he observed the decedent and the claimant at various family events and that the decedent treated the claimant as a wife and knew they lived together in an apartment. Savino testified that he told the decedent and the claimant that they should get married but that the decedent and claimant said they wanted to buy a house first. Savino later clarified his testimony that he thought the decedent and claimant were already "married" but that that he was referring to an official ceremony with a license.

The decedent's mother, Josefa Avila Soto, testified that the decedent did not tell him that he was in love with a girl, that he married the claimant or that he intended to marry a girl. She further testified that during the time that the claimant and the decedent lived with her, neither of them told her that they were married. The mother also testified that the decedent did not refer to the claimant as his wife but did refer to her has his "old lady." The mother also testified that she gave the claimant a ring with a heart on it and thinks that the decedent gave the ring to the claimant for her birthday. Although the mother denied telling the funeral home that the decedent was survived by his wife, she did not know who would have told the funeral home that. The mother speculated that it was the claimant's father but it was discovered that the funeral arrangements were completed by the time the claimant's father came to Colorado from Mexico.

Romero, a close friend of the decedent, testified that he knew the decedent went to a funeral and also stated that the decedent was always broke because he was sending money to Mexico to help out the claimant and her parents. Romero also testified that the decedent did not say he was married to the claimant but referred to her as "my lady."

Evidence was also introduced showing that the decedent claimed only one withholding allowance and indicated he was single on his W-4 forms he filled out in March of 2012. The decedent claimed a second withholding allowance by listing himself head of household. The W-4 contains printed instructions stated that the taxpayer may claim "head of household" status if the taxpayer is unmarried and pays "more that 50 % of the costs of keeping up a home for yourself and your dependent." The decedent completed another W-4 in August of 2013, again identifying himself as single and claiming one withholding allowance.

Although the claimant and decedent both had Facebook accounts that identified them as "married," the ALJ found that Facebook was not a reliable indicator of how the claimant and decedent represented their marital status to family, friends and community because it was subject to manipulation.

The ALJ found that the weight of credible evidence established that the claimant cohabitated with the decedent before and after she reached the age of 18 and that the cohabitation was well known to friends and family. The ALJ specifically pointed to the decedent's intention to be married as evidenced by the decedent declaring his intent to marry the claimant to her mother and father in January 2011, the decedent provided financial support for the claimant and the fact that the decedent and the claimant conceived a child. The ALJ determined that the decedent represented to his family and community that he was married to the claimant by referring to her has his "old lady," and "my lady," which the ALJ found to be colloquial synonyms for "wife." The ALJ was also persuaded by documentation for the rental agreement and the fact that the claimant was listed as the wife on the death certificate and in the obituary. The ALJ found that the claimant proved that she was the decedent's common law spouse after she turned 18 and before the decedent's death on April 16, 2014. The ALJ, therefore, concluded that the claimant was the decedent's dependent. The ALJ, however, reserved all other issues for future determination and then specifically instructed the parties to set a hearing to determine the allocation of death benefits between the dependents.

The respondents appealed. In an order dated June 2, 2016, the panel dismissed the respondents' petition to review without prejudice for lack of a final order. The respondents' appealed to the court of appeals which also dismissed the petition to review on February 16, 2017, for lack of a final order. A subsequent hearing was held on March 1, 2017, and an ordered entered on March 21, 2017, apportioning the death benefits between the spouse claimant and the minor claimant. Consequently, ALJ Cain's November 18, 2015, order is now subject to appeal.

I. ALJ Cain Order November 18, 2015

Section 8-42-114, C.R.S., provides for the payment of death benefits to dependents of a deceased worker. According to § 8-41-503, C.R.S., dependency shall be determined as of the date of the industrial injury and under § 8-41-501(1)(a), C.R.S. a widow is presumed to be wholly dependent unless it is shown that she was voluntarily separated and living apart from the spouse at the time of the injury or death or was not dependent in whole or in part on the deceased for support.

A common-law marriage is established by mutual consent or agreement of the parties, followed by mutual and open assumption of the marital relationship. *People v. Lucero*, 747 P.2d 660, 663 (Colo. 1987). This test contemplates the parties will exhibit conduct manifesting their agreement to become man and wife. *Id.* The two most important factors demonstrating the parties' agreement are cohabitation and reputation

among persons in the community that the parties hold themselves out as man and wife. *Id.* Numerous behaviors may be considered as evidence of the parties' intention such as maintenance of joint bank accounts, ownership of joint property, use of the man's surname by the woman and the filing of joint tax returns. The panel previously has held that evidence the decedent provided financial support to the claimant and her child was relevant in determining whether there was a common-law marriage. *Marquez v. LVI Environmental Services, Inc.*, W.C. No. 4-425-155 (April 5, 2001) *aff'd. LVI Environmental Services, Inc., v. Industrial Claim Appeals Office,* (Colo. App. No. 01CA0731, November 1, 2001) (not selected for publication). There is no determinative single form of evidence required. The ultimate determination "turns on issues of fact and credibility, which are properly within the trial court's discretion." *Id*. at 665.

Because the determination of whether a common law marriage existed is one of fact for determination by the ALJ, we must uphold the ALJ's determination if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. 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 credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). Further, we note the ALJ is not obliged to enter findings concerning all the evidence in the record, but only that evidence which he finds dispositive of the issues involved. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

The respondents' arguments notwithstanding, the record contains ample evidence that the claimant and decedent cohabited and held themselves out as married in the community where they resided. The ALJ credited the testimony of the claimant and her witnesses. The ALJ also made detailed findings of why he discredited the respondents' witnesses and found them unpersuasive. The ALJ also explained the basis for the plausible inferences he made from the evidence. The fact that some behaviors tending to prove the existence of a common law marriage were not present does not change the result. The *Lucero* case expressly provides that the evidence need not take any particular form so long as the agreement of the parties is evidenced by actual behavior. *Lucero*, 747 P.2d at 664-65. Here, the record supports the ALJ's findings and plausible inferences that a common law marriage was proven.

There was conflicting evidence in the record. However, the weight to be accorded this evidence in determining whether a common-law marriage existed was a matter for the ALJ and was to be balanced against all other facts in the case. *See Moffat Coal Co. v. Industrial Commission*, 108 Colo. 388, 118 P. 2d 769 (1941). We cannot say

the ALJ erred as a matter of law in concluding the evidence weighed in favor of finding a common law marriage. We reject the respondents' argument that the cases of *Zuzich v. Leyden Lignite Co.*, 120 Colo. 21, 206 P.2d 833 (1949) and *Employer's Mutual Liability Insurance v. Industrial Commission*, 124 Colo. 68, 234 P.2d 901 (1951) stand for the proposition that conflicting evidence concerning the elements of common law marriage compels a conclusion that no common law marriage existed. Both cases held the well-settled principle that where the evidence is conflicting, the inferences to be drawn and findings of facts were exclusively for the commission and had to be accepted by the court where there was substantial evidence to support them. Thus, the respondents' reliance on these cases is misplaced and does not compel a contrary conclusion.

Nor are we persuaded to disturb the order based on the respondents' argument that the ALJ erred as a matter of law in allowing testimony from the claimant and her father about oral statements allegedly made by the decedent in violation of the Colorado Dead Man's Statute.

Section 13-90-102, C.R.S. limits the admissibility of statements made by persons who are incapable of testifying and thereby seeks "to guard against perjury by living interested witnesses when deceased persons cannot refute the testimony, thus protecting estates against unjust claims." *In re Estate of Crenshaw*, 100 P.3d 568, 569 (Colo. App. 2004). We assume, for purposes of argument, that the Dead Man's Statute applies to a workers' compensation death benefit proceeding where there is no diminishment of the decedent's estate.[1] We agree with the ALJ's determination that the disputed testimony in this case was not barred by the Dead Man's Statute.

The respondents specifically contest four statements allegedly made by the decedent: (1) that he had talked to the claimant's parents about wanting to marry her, (2) asked her mother's permission to marry her, (3) told the claimant that he thought they were married and (4) told friends and family that they were married.

The ALJ here determined that the claimant's statements and the claimant father's statements were corroborated by material evidence and, therefore, properly admissible.

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[1] *See Clark v. Estate of Brookoff*, 2016 Colo. App. LEXIS 473 (Colo. Ct. App., Apr. 7, 2016)(*cert granted*)(Whether the court of appeals erred in holding that Colorado's Dead Man's Statute, section 13-90-102, C.R.S. (2016), which applies in "any civil action," in fact applies only in cases involving the potential diminishment of an estate and whether the court of appeals erred in holding that the Dead Man's Statute does not apply where insurance coverage may be available to satisfy a potential judgment).

Section 13-90-102(1)(c), permits testimony concerning an oral statement by decedent if the statement is corroborated by material evidence of an independent and trustworthy nature. Section 13-90-102(3) (a), C.R.S. provides:

> "Corroborated by material evidence" means corroborated by evidence that supports one or more of the material allegations or issues that are raised by the pleadings and to which the witness whose evidence must be corroborated will testify. Such evidence may come from any other competent witness or other admissible source, including trustworthy documentary evidence, and such evidence need not be sufficient standing alone to support the verdict but must tend to confirm and strengthen the testimony of the witness and show the probability of its truth.

We agree with the ALJ that the application of the Dead Man's Statute does not require that a party's testimony concerning a statement made by a deceased person be corroborated by testimony of a disinterested witness that personally heard the deceased person make the disputed statement. Rather, the Dead Man's Statute requires that the corroborating evidence be material to the underlying issue and tend to confirm, strengthen and show the probable truthfulness of the party's testimony. The ALJ found that this exception was met here finding corroborating testimony from witnesses, such as Romero, who could confirm that the claimant met a girl and was sending her money. The ALJ also pointed to the evidence on cohabitation, the fact that a child was conceived, the evidence about the ring given to the claimant on her 18th birthday and the evidence that the claimant was listed on the death certificate and that it appeared that this information came from the decedent's mother who was listed as the informant on the death certificate.

The respondents go on to assert that all of the disputed statements occurred before the claimant turned 18 and, therefore, none could serve as grounds to establish that the claimant had ratified her legally void relationship into a valid common marriage. The ALJ found, however, that the evidence demonstrating the required elements to establish a common law marriage prior to the claimant turning 18 were relevant to the parties' intent after the claimant turned 18. In any event, even if the statements disputed by the respondents were erroneously admitted, it is harmless error. Section 8-43-310, C.R.S. (harmless error to be disregarded). The ALJ stated in the order that even if the specific testimony that the respondents seek to exclude is considered inadmissible, the ALJ would still find the remaining evidence set forth in the findings of fact sufficient to establish that the claimant was the decedent's common law spouse after she turned 18 and before the decedent's death.

The respondents also argue that the ALJ erred in his determination that the claimant could ratify an otherwise void common law marriage. Section 14-2-109.5, C.R.S., provides, in pertinent part:

> A common law marriage entered into on or after September 1, 2006, shall not be recognized as a valid marriage in this state unless, at the time the common law marriage is entered into: (a) each party is eighteen years of age or older.

When the claimant here met the decedent in 2011, she was not 18 years old. However, as found by the ALJ, the plain language of this statute did not prohibit the claimant from consenting to a common law marriage after she turned 18. The ALJ declined to read such a non-existent provision into the statute, as do we. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d. 558 (Colo. App. 2000)(court may not read non-existent provisions into the statute).

It was plausible for the ALJ to infer from the evidence of the claimant's birthday celebration where the decedent gave the claimant a ring and the fact that the claimant was living with the decedent after she turned 18, was identified as his wife on the death certificate and in the obituary and had conceived a child, evidenced an intent by the parties for a common law marriage after the claimant turned 18. *See Rocky Mountain Fuel Co v. Reed*, 110 Colo. 88, 130 P.2d 1049 (Colo. 1942)(cohabitation after removal of an obstacle to marriage raises "presumption of marriage").

Even assuming that the parties were bound by the January 2011 as the date establishing the common law marriage, it is not clear that the marriage is necessarily "invalid" at this time. *See Ramos v. Colorado Hardscapes*, W.C. No. 4-439-791 (January 31, 2002) *aff'd Colorado Hardscapes v. Industrial Claim Appeals Office*, 02CA0381 (June 19, 2003) (not selected for publication). Section 14-10-111(1), C.R.S. divides marriages into two classifications. The first classification is *invalid* marriages, and the circumstances of such marriages are listed in § 14-10-111(1)(a) through (1)(f). The second classification is prohibited marriages, the circumstances of which are listed in § 14-10-111(1)(g)(I) through (g)(IV). *See Estate of Fuller*, 862 P.2d 1037 (Colo. App. 1993). Section 14-10-111(1)(c) provides the district court shall enter a decree declaring the invalidity of a marriage where "a party was under the age as provided by law and did not have the consent of his parents or guardian or judicial approval as provided by law." However, § 14-10-111(2) provides that a declaration of invalidity under subsection (1) "shall be commenced within the time specified *but in no event may a declaration of invalidity be sought after the death of either party to the marriage* except

as provided in subsection (3)." (Emphasis added). Further, § 14-10-111(2)(c) provides that a declaration of invalidity on the grounds set forth in "subsection (1)(c) of this section" may be sought by "the underaged party, his parent, or his guardian, if such action for declaration of invalidity of marriage is commenced within twenty-four months of the date the marriage was entered into." Finally, § 14-10-111(3) establishes certain circumstances under which a declaration of invalidity may be sought after the death of a party, but those circumstances apply only in cases of “prohibited" marriages.

We have considered the respondents' remaining arguments concerning the inferences to be drawn from the record. These arguments are factual in nature and we lack authority to interfere with the ALJ's findings concerning this evidence. Section 8-43-301(8). Thus, we decline to substitute our judgment for that of the ALJ concerning the conclusions to be drawn from this record. In our view the ALJ properly applied the law and the ALJ’s findings are supported by the evidence in the record. Consequently we have no basis to disturb the ALJ’s order. Section 8-43-301(8), C.R.S.

II. ALJ Jones Order March 21, 2017

The minor claimant appeals ALJ’s Jones decision in the March 21, 2017 order apportioning the death benefits 80 percent to the claimant and 20 percent to the minor claimant. The respondents appeal ALJ Jones award insofar as it requires them to pay the GAL fees and argue that these fees should be split equally between the respondents and the minor claimant. We are not persuaded the ALJ committed reversible error.

A hearing was held by ALJ Jones on March 1, 2017, on the allocation of death benefits between the minor claimant and the claimant. A GAL on behalf of the minor claimant submitted a stipulated agreement between the minor claimant and the respondents requesting that the dependent benefits be allocated 50 percent to the claimant and 50 percent to the minor child. The claimant was not a party to the stipulation. The stipulation also requested appointment of a conservator for the minor claimant to handle the proceeds of a lump sum request which the GAL would make on behalf of the minor claimant. According to the stipulation this money would then be deposited in an account of the conservator’s choosing, subject to withdrawal only upon good cause and with an order from the Director of the Division of Workers’ Compensation or his representatives until the minor claimant’s 18th birthday.

The claimant was *pro se* and requested that the death benefits be allocated 80 percent to her and 20 percent to the protected account for her son. The claimant

contended that she needed more than half of the benefits as requested by the GAL so that she could care for her son and herself and indicated her desire to purchase a home.

According to the stipulation of the minor claimant and of the respondents, at the time of the hearing the minor claimant was two years old and the claimant was 21. The stipulation asserts the claimant is a Mexican citizen and has an 8th grade Mexican education. The legal status as a citizen in the United States is unknown. The claimant is Spanish speaking and lives with her father, mother and brother. The claimant's father has a 3rd grade Mexican education. The stipulation maintains the claimant is dependent on her parents for support and has no checking account and has not filed tax returns.

Based on these facts, ALJ Jones found the claimant's request for 80 percent of the death benefits just and equitable. The ALJ determined that the claimant established that she would have significant costs in raising and caring for the minor claimant and that a split of benefits in this percentage will assist her in caring for and meeting the everyday basic needs of the minor claimant. The ALJ determined, based on the claimant's education and the fact that she was previously completely supported by the decedent, the 50 percent split of death benefits was not reasonable because the spouse also has to use her portion to meet the basic needs of the minor claimant for the next 16 years. The ALJ, therefore, ordered the respondents' to pay a lump sum of 20 percent of the death benefits to a conservator who will deposit the lump sum death benefits in an account of his choosing. The ALJ also ordered the respondents to pay the GAL in this case for her reasonable fees and costs at the rate of $150.00 per hour. The minor claimant appeals the apportionment of benefits.

On appeal, the minor claimant asserts the decision in *Spoo v. Spoo*, 145 Colo. 268, 358 P.2d 870 (1961), places the burden of proof on the claimant to justify any deviation from an equal, 50/50, split of the death benefits between the claimant and the minor claimant. The minor claimant also contends the claimant did not present any evidence to support the ALJ's distribution of the benefits between the two parties. We do not read the *Spoo* decision as placing such a burden of proof on the claimant. In *Spoo* the Court found: "No specific provision prescribes an equal apportionment among dependents such as is claimed here by counsel for the minor children." *Id*. At 871. The *Spoo* opinion referred to the express provisions of § 8-42-121 in support of its conclusion.

Section 8-42-121, C.R.S., which is applicable here, provides that:

> Death benefits shall be paid to such one or more of the dependents of the decedent, for the benefit of all the dependents entitled to such

> compensation, as may be determined by the director, who may apportion the benefits among such dependents in such manner as *the director may deem just and equitable.* (*Emphasis added*).

The standard for review of an ALJ's apportionment of death benefits is abuse of discretion. *Spoo v. Spoo, supra.* Consequently, we may not interfere with the ALJ's order unless it is beyond the bounds of reason, as where it is unsupported by the evidence or contrary to law. *Rosenberg v. Board of Education of School District No. 1*, 710 P.2d 1095 (Colo. 1985). Section 8-42-121, C.R.S. does not require that all dependents be treated on an equal basis. *Spoo v. Spoo, supra.* Rather, the *Spoo* Court held that the apportionment must be justified by the particular facts and circumstances presented to the ALJ and an ALJ may consider the "actual dependence" of the claimants as well as the relative incomes and circumstances of each in determining a just and equitable distribution. Once death benefits are awarded, a subsequent change in economic circumstances does not authorize an ALJ to reapportion death benefits. *See Ward v. Ward*, 928 P.2d 739 (Colo. App. 1996). Consequently, the ALJ's apportionment requires consideration of foreseeable changes affecting the dependents. *Id.*

While there was no testimony pertinent to the issue of the apportionment of benefits submitted at the March 1, 2017, hearing, the record does support the findings of the ALJ. Colorado Rule of Evidence 603, and § 8-43-207(b) require that competent testimony be taken under oath. *Lewis v. Pacific Fruit Produce*, W.C. No. 3-048-301 (November 15, 1995). The ALJ did not place the claimant under oath at the hearing. However, the stipulation submitted by the minor claimant and the respondents asserted several facts relevant to the apportionment issue. We construe this stipulation to be a judicial admission. *Wang v. August Moon Asian Grill*, W.C. No. 4-885-554-07 (January 17, 2017). A judicial admission is a formal, deliberate declaration which a party or his attorney makes in a judicial proceeding for the purpose of dispensing with proof of formal matters or of facts about which there is no real dispute. *Kempter v. Hurd*, 713 P.2d 1274 (Colo. 1986). The stipulation of the minor claimant asserts it is based on testimony presented in the June 19, 2015, hearing. The transcript of that hearing contains extensive testimony, under oath, by the claimant which describes the circumstances within which she and the minor claimant live. The claimant described her housing, the individuals also residing with her, Tr. at 46, their employment, the receipt of Social Security, Tr. at 47, and typical items she must buy to care for the minor claimant, Tr. at 49. Both the prior testimony of the claimant and the minor claimant’s stipulation represent substantial evidence to support the findings of the ALJ.

Although there are equitable arguments in favor of both dependents, the ALJ considered the relevant factors in making her findings and the findings are supported by the record. The ALJ relied on the facts as stipulated by the minor claimant and the respondents to conclude that the benefits should be split 80 percent to the claimant and 20 percent to the minor claimant that will be put into a conservatorship. The stipulation specifically indicates that money from the conservator account could only be withdrawn for circumstances involving the welfare of the child, such as medical or educational needs, and states that the general obligation of support would be borne by the claimant.[2] The claimant also represented that she was seeking 80 percent of the benefits because she had to provide for basic needs of herself and her child at least for the next 16 years. It was reasonable for the ALJ to infer that the claimant demonstrated a greater dependence on the decedent's income than was demonstrated by the minor child considering that the basic needs of the minor child will be taken care of by the claimant. Under these circumstances we cannot say that the ALJ's determination exceeded the bounds of reason or is unsupported by the applicable law.

The respondents appeal this order insofar as it ordered them to pay all of the fees and costs of the GAL, arguing that equity demands that the cost should be split between the minor claimant and the respondent. We see no basis to disturb the ALJ's order.

Section 8-43-207 (1)(l), C.R.S. states that an ALJ has the authority to appoint a guardian ad litem and to assess the reasonable fees and costs from one or more of the parties. Because the determination of the reasonable fees and costs are left to the discretion of the ALJ, the ALJ's determination cannot be set aside unless it is shown that there is an abuse of discretion. *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867 (Colo. App. 2001)

The stipulation submitted by the respondents and the minor claimant indicates that these parties agreed that $150 per hour was a reasonable fee. It is also noted in the stipulation that it is the customary practice of another insurer, Pinnacol Assurance, to pay the fees for a GAL in this situation. We also find no error in the ALJ's determination that equity does not demand that the costs of a GAL be assessed against the limited benefits owed to the minor claimant. We, therefore, cannot say that the ALJ abused her discretion is assigning the entire cost to the respondents.

[2] We note an ALJ does not have statutory authority to appoint conservators. That task is assigned to the District Court, § 15-14-402(a). *Nanez v. Mechanical & Piping Inc*., W.C. No. 4-922-618-04 (June 16, 2017). However, the stipulation negotiated by the GAL and the respondents may serve as an agreement between themselves by which they may administer the payment of the dependent's benefits. While the stipulation provides the lump sum payment of death benefits is to be deposited in an account "of conservator's choosing," the conservator is constrained by § 8-42-122 to limit the deposit to an account "insured by the federal deposit insurance corporation."

IT IS THEREFORE ORDERED the orders dated November 18, 2015, and March 21, 2017, are affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

CERTIFICATE OF MAILING

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

11/13/17 by TT .

JENNIFER M MUNOZ BOTELLO, 138 S SABLE BLVD APT F205, AURORA, CO, 80012 (Claimant)
RAY LEGO & ASSOCIATES, Attn: JONATHAN S ROBBINS ESQ, 6060 S WILLOW DR SUITE 100, GREENWOOD VILLAGE, CO, 80111 (For Respondents)
THE FRICKEY LAW FIRM PC, Attn: JANET FRICKEY ESQ, 940 WADSWORTH BLVD SUITE 400, LAKEWOOD, CO, 80214 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-997-086-02

IN THE MATTER OF THE CLAIM OF:

MARVIN MURRAY,

Claimant,

v.

REMAND ORDER

TRISTATE GENERATION AND TRANSMISSION ASSOCIATION,

Employer,

and

SELF-INSURED,

Insurer,
Respondent.

The respondent seeks review of an order of Administrative Law Judge Sidanycz (ALJ) dated August 16, 2017, insofar as it awarded penalties for failure to comply with Workers' Compensation Rule of Procedure 16-11 for prior authorization. We set aside the ALJ's award of penalties, remand that issue for further findings and otherwise affirm the ALJ's order.

This matter went to hearing on the claimant's request for right total knee arthroplasty and penalties for the respondent's violation of Rule 16 and alleged dictation of the claimant's care. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant had pre-existing non-work-related right knee problems which included a meniscus surgery in 2012. On July 30, 2015, the claimant sought medical treatment complaining of an aching pain in his right knee. X-rays showed a normal well maintained knee joint.

The claimant sustained an admitted work-related injury on September 18, 2015, when he fell off of a ladder and landed on his right leg. The claimant initially complained of pain in his low back and right hip. The claimant had surgery on November 4, 2015, to repair a tear in the right proximal hamstring. The surgery was performed by Dr. Borchard. The claimant was seen by physician's assistant, Thomas

Doty, at Dr. Borchard's office on December 23, 2015, complaining of right knee pain. Doty ordered x-rays of the claimant's right knee and administered a right knee injection. The x-rays showed moderate knee joint effusion with moderately severe degenerate arthropathy involving the medial joint compartment. The claimant continued to complain of right knee pain and underwent an MRI in September of 2016 which showed a high grade, near complete tearing of the ACL, extensive degeneration, tearing of the body and medial posterior horn of the medial meniscus, bone edema and mild degenerative arthrosis.

On September 23, 2016, the insurance adjuster, Sherri Boyle, noted that the claimant "did mention the knee throughout the claim so it needs to be included in the claim handling."

In November of 2016, the claimant returned to Dr. Borchard and again reported pain in his right knee. Dr. Borchard discussed treatment options including anti-inflammatory medications, injections, use of a knee brace and possible surgery. On December 5, 2016, the respondent requested an independent medical examination (IME) with Dr. Harrington. Prior to the claimant's evaluation, Dr. Borchard recommended that the claimant undergo a right total knee arthroplasty. A request for authorization for the recommended surgery was submitted to the insurer on January 16, 2017, and a second request was submitted to the insurer on January 20, 2017.

On January 16, Boyle sent a letter to Dr. Harrington asking him to opine whether the claimant's right knee issues were related to the September 18, 2015, work injury and what treatment options were warranted. Dr. Harrington reviewed the claimant's medical records, including medical records from the claimant's prior right knee treatment. Dr. Harrington concluded that the mechanism of injury described by the claimant was certainly plausible for an ACL tear and deferred to Dr. Borchard regarding whether it would be appropriate to pursue surgery or more conservative treatment.

On February 8, 2017, Boyle provided Dr. Borchard's office with a verbal authorization for the recommended knee replacement surgery. Based upon the verbal authorization from an insurer, Dr. Borchard's office scheduled the surgery for March 27, 2017.

On March 24, 2017, the counsel for respondent notified Dr. Borchard that the respondent was revoking authorization for the surgery. The basis given for the revocation was that the respondent was in receipt of new medical records that indicated the claimant had a pre-existing condition in his right knee.

The respondent requested another IME which was performed by Dr. O'Brien on May 30, 2017. Dr. O'Brien testified that although a knee replacement would be reasonable treatment for the claimant's condition, that need was related to the claimant's longstanding arthritis and not any acute injury.

The ALJ credited the opinions of Dr. Borchard and Dr. Harrington over Dr. O'Brien and found that the ACL tear in the claimant's right knee is related to the September 18, 2015, injury resulting in the need for a total knee replacement.

The ALJ also credited Boyle's testimony to find that the respondent failed to take action to contest the requested surgery, within seven business days of the request, in compliance with Rule 16-11. The ALJ concluded that the surgery was, therefore, automatically authorized. WCRP 16-11(E). The ALJ also found that the respondent "violated the plain language of Rule 16-11 when they took no steps to contest the requested surgery but instead, waited 23 days" before they authorized surgery and then later revoked that authorization. ALJ Order at 7. The ALJ determined that this was not objectively reasonable and penalties under §8-43-304 were warranted. The ALJ calculated 111 days between the respondent's revocation of their prior authorization for the surgery on March 24, 2017, to the date of hearing, July 13, 2017, and assessed $100.00 per day for each of the 111 days for a total of $11,100.00 in penalties. [1] The ALJ denied the claimant's request for penalties for the alleged violation of §8-43-503(3), C.R.S. (dictation of care).

The only issue on appeal is the ALJ's determination to award penalties for violation of Rule 16-11. The respondent argues that the ALJ erred as a matter of law because the respondent did not receive a "completed request" for prior authorization as defined by WCRP 16-10(F) and, therefore, they allege that the provisions in Rule 16-11 were not triggered. We agree that the ALJ's findings are insufficient to permit appellate review of the basis of her decision and, therefore set aside the award of penalties and remand the matter for further findings. §8-43-301(8), C.R.S.

Section 8-43-304(1), C.R.S., allows an ALJ to impose penalties of up to $1000 per day against any party "who violates any provision of articles 40 to 47 of [Title 8], or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the

[1] We note that the respondent does not contest the calculation of days for the penalty and we do not address it here.

director or panel or any judgment or decree made by any court." The failure to comply with a procedural rule has been determined to be a failure to obey an "order" and failure to perform a "duty lawfully enjoined" within the meaning of § 8-43-304(1), C.R.S.; *Pioneers Hospital v. Industrial Claim Appeals Office*, 114 P.3d 97, 98 (Colo. App. 2005); *Diversified Veterans Corporate Center v. Hewuse*, 942 P.2d 1312 (Colo. App. 1997).

The imposition of penalties under § 8-43-304(1), C.R.S., is a two-step process. The ALJ must first determine whether the disputed conduct constituted a violation of the Workers' Compensation Act, of a duty lawfully enjoined, or of an order. If the ALJ finds such a violation, she may impose penalties if she also finds that the actions were objectively unreasonable. *City Market, Inc. v. Industrial Claim Appeals Office*, 68 P.3d 601(Colo. App. 2003); *see also Jiminez v. Industrial Claim Appeals Office*, 107 P.3d 965, 967 (Colo. App. 2003) (reasonableness of conduct in defense of penalty claim is predicated on rational argument based in law or fact).

The ALJ here determined that the respondent violated Rule 16-11 by failing to contest the requests for surgery within seven business days of the requests and that the respondent's violation was objectively unreasonable. Rule 16-10(C), requires the respondent to respond a request for prior authorization within seven business days from the receipt of the provider's "completed request," as defined in Rule 16-10(F). In order to complete a prior authorization request, the provider must "concurrently explain the medical necessity of the services requested and provide relevant supporting medical documentation," which means "documents used in the provider's decision-making process to substantiate the need for the requested service or procedure." The issue of whether a provider has submitted a completed request for purposes of Rule 16-10(F) is a question of fact to be determined by the ALJ. *See Aguirre v. Nortrack*, W.C. No. 4-742-953 (October 5, 2011). Rule 16-10(F). It is the claimant's burden to demonstrate that there was a "completed request" for purposes of assessing a penalty for violation of Rule 16. *McDaniel v. Vail Associates. Inc.*, W.C. No. 3-111-363 (July 18, 2011). A respondent is not required to plead insufficiency of a request for authorization as an affirmative defense. *Id.*

The ALJ's order here does not address whether the documents faxed on January 16th and January 20th were "completed requests" pursuant to WCRP 16-10(F). Both of these faxed documents stated, "Please see the following and please let me know if the surgery will be authorized." Claimant Exhibit 4 at 15 and 17. It also appears that a form titled "Surgery Authorization Form," stated the name of the procedure/surgery requested was a "Right Total Knee Arthroplasty" and there was also Orthopedic Surgery Service

Pre-op Orders attached to the fax. Claimant's Exhibit 4 at 16. It is not apparent from the fax cover sheets what else may have been attached to the faxed documents. The ALJ's order does not make findings on whether the faxed requests for authorization contained an explanation of the reasonableness and medical necessity or contained the relevant supporting medical documentation as required under the Rule. Moreover, the ALJ stated, "[e]ven if the request for treatment submitted by Dr. Borchard was somehow 'defective,' that does not negate the requirements of Rule 16(11)." The ALJ's statement is contrary to prior panel decisions recognizing the critical requirement that medical documents accompany a Rule 16 request for preauthorization. *Lichtenberg v. J.C. Penney Corp*., W.C. No. 4-814-897 (July 19, 2012); *Aguirre v. Nortrak*, W.C. No. 4-742-953 (March 19, 2012); *McDaniel v. Vail Associates*, *supra*; *Skelly v. Wal-Mart*, W.C. No. 4-632-887 July 31, 2008); *Cross v. Microglide*, W.C. No. 4-355-764 (September 2, 2003) *aff'd*, *Cross v. ICAO*, 03CA1807 (Colo. App. 2004)(*not selected for publication*); *Wilkens v. First Lutheran Church*, W.C. No. 4-369-843 May 17, 2001).

Under these circumstances the matter must be remanded for the ALJ to make additional findings on whether the January 16th or January 20th requests for prior authorization were "completed requests" for purposes of Rule 16-10(F). *Wilkens v. First Lutheran Church, supra.* On remand the ALJ shall re-determine whether there was a completed request for preauthorization and shall make specific findings of fact which articulate the evidence she relied upon to resolve the issue. Based on this determination the ALJ shall enter a new order on the issue of penalties.

IT IS THEREFORE ORDERED that the ALJ's award of penalties in the August 16, 2017, order is set aside and remanded. The order is otherwise affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

CERTIFICATE OF MAILING

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

12/22/17 by TT .

BURG SIMPSON ELDREDGE HERSH & JARDINE PC, Attn: STEPHAN J MARSH, 40 INVERNESS DRIVE EAST, ENGLEWOOD, CO, 80112 (For Claimant)
LAW OFFICE OF STEVEN J PICARDI PC, Attn: STEVEN J PICARDI, 12900 STROH RANCH WAY SUITE 110, PARKER, CO, 80134-7401 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-028-767-01

IN THE MATTER OF THE CLAIM OF:

ALAN VOIT,

Claimant,

v.

FINAL ORDER

XCEL ENERGY,

Employer,

and

OLD REPUBLIC INSURANCE COMPANY,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Michelle Jones (ALJ) dated June 1, 2017, that determined the claimant's right eye cataract was caused by an accident at work and ordered the respondents liable for the surgery to treat the cataract. We affirm the decision of the ALJ.

The claimant worked for the employer as a fitter apprentice on February 25, 2016. While he and another employee were disassembling a fence to install a gas meter, one of the fence posts fell over and hit the claimant in the face. The claimant treated in the emergency room for a laceration above the right eyebrow and an abrasion on his nose. By March 10, 2016, the claimant reported to Dr. Rafferty that he was experiencing problems with visual acuity and blurring. The claimant visited an optometrist who diagnosed the presence of a cataract and referred the claimant to a second optometrist. That optometrist, Dr. Cruse, saw the claimant on April 14 and diagnosed the claimant with a posterior subcapsular cataract at 2+ in degree within the right eye. The doctor also noted the claimant exhibited a similar cataract in the left eye, characterized as only a trace by degree. Dr. Cruse indicated both were age-related cataracts. The doctor recommended surgery to remove the right eye cataract.

Following the diagnosis of Dr. Cruse, Dr. Rafferty, the authorized treating physician, restricted the claimant from driving commercial vehicles. This restriction prevented the claimant from performing his regular job and he was relegated to

alternative work for the employer. The claimant was not referred to an ophthalmologist for surgery by the respondents. The claimant elected to undergo the cataract surgery with Dr. Amiel on June 1 by using his personal health insurance. The claimant reported the surgery was successful. His vision problems cleared and he sustained no further disability. The claimant filed an application for a hearing to recover the costs of the cataract surgery.

The respondents arranged for an evaluation of the request for surgery by Dr. Kauvar. They also requested the claimant undergo an examination by Dr. Rowe. Dr. Kauvar issued a report following a review of the medical records. Dr. Kauvar wrote that it is typical of age related cataracts to be of less severity than those caused by trauma. A traumatic cataract is denser than an age related cataract. He stated a traumatic cataract is often accompanied by a corneal abrasion or laceration. The doctor commented that the history did not show the pole that hit the claimant also hit his right eye. Because the claimant's cataract was not as dense, there was no corneal laceration and no contact by the pole with the eye, Dr. Kauvar concluded the claimant's cataract was just as likely to not have been caused by the contact with the pole as it was to have been caused by that episode. Dr. Rowe also wrote a report, which indicated the pole did not hit the claimant's eye and the cataract, therefore, was probably not work related.

Following the claimant's cataract surgery, Dr. Rafferty wrote a report stating the cataract was caused by the claimant's February 2016, work injury. Dr. Rafferty reasoned that trauma can cause cataracts, the claimant did not previously have problems with his vision and the difficulties with vision occurred very closely following the date of the work injury. On June 30, 2016, Dr. Cruse also wrote a report concluding the claimant's right eye cataract was a result of the trauma represented by the pole hitting the claimant's face. Dr. Cruse noted the claimant's younger age of 55 made trauma the likely cause. The claimant obtained an opinion from Dr. Gunderson, a retired optometrist, who observed that he was familiar with many cases of cataracts, which were the product of trauma to the orbital area of the face. Dr. Gunderson pointed to the claimant's age and the absence of another apparent cause for the cataract to deem the claimant's cataract to be work related.

A hearing conducted on May 2, 2017 concerned the claimant's request for the cost of the cataract surgery. The claimant and Dr. Rowe testified. The claimant described the accident on February 25 as involving the round end of the fence pole hitting him above the eye and below the eye on his nose. He stated there was no wire attached to the pole that could have caused the abrasions on his nose. He indicated the abrasions were caused by the end of the pole itself. The claimant described how he developed vision problems

involving floating spots in his vision within two weeks of the fence pole episode. Dr. Rowe testified his review of the medical records revealed there was no trauma to the claimant's eye when the pole hit him. He explained the chances of developing a cataract by way of a trauma to the face above the eye was unlikely. Based primarily on the ALJ's resolution of the dispute that the fence pole did hit the claimant's eye, the ALJ surmised the claimant's work injury did include the development of a cataract in his right eye. The ALJ ruled the surgical treatment for that cataract was compensable.

The respondents are liable for medical treatment, which is reasonably necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S.; *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997); *Country Squire Kennels v. Tarshis,* 899 P.2d 362 (Colo. App. 1995). Where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove a causal relationship between a work-related injury and the condition for which benefits or compensation are sought. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997).

Pursuant to §8-41-301(1) (c), C.R.S., a disability is compensable if it is shown that it was "proximately caused by an injury . . . arising out of and in the course of the employee's employment." To establish that an injury arose out of an employee's employment, there must be 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. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999). In reaching a conclusion concerning causation, the ALJ may make reasonable inferences from the circumstantial evidence presented. *See Electric Mutual Liability Insurance Co. v. Industrial Commission*, 154 Colo. 491, 391 P.2d 677 (1964). Furthermore, it is the prerogative of the ALJ to resolve conflicts in the evidence and determine the credibility of witnesses and the probative value of the evidence. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). So long as such determination is supported by substantial evidence in the record, it is binding on review. *See May D & F v. Industrial Claim Appeals Office*, 752 P.2d 589 (Colo. App. 1988). Substantial evidence is probative evidence, which would warrant a reasonable belief in the existence of facts supporting a particular finding, without regard to the existence of contradictory or contrary inferences. *F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985); *Ackerman v. Hilton's Mech. Men*, 914 P.2d 524, 527-28 (Colo. App. 1996).

Under this standard, we must defer to the ALJ's assessment of the sufficiency and probative weight of the evidence. *Rockwell International v. Turnbull*, 802 P.2d 1182

(Colo. App. 1990). Further, we may not interfere with the ALJ's credibility determinations except in the extreme circumstance where the evidence credited is so overwhelmingly rebutted by hard, certain evidence that the ALJ would err as a matter of law in crediting it. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986); *Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997). The respondents' arguments notwithstanding, we perceive no extreme circumstances here.

The ALJ found compelling the testimony of the claimant explaining that he sustained not only a laceration above the right eye but also abrasions from the pole hitting him on the nose. The claimant felt these injuries indicated the pole did hit him right on the eye. The ALJ reasoned that if the pole did hit the claimant's eye, the opinions of Dr. Rafferty and of Dr. Cruse would become particularly persuasive. The ALJ found the opinions of Dr. Kauvar and Dr. Rowe were not as authoritative as those of Dr. Rafferty and Dr. Cruse. The former two physicians premised their opinions on the finding that the pole hitting the claimant hit him above the eye and not on the eye. The ALJ's finding that the claimant's eye did suffer a direct impact from the pole undermined the credibility of the causation determinations of doctors Kauvar and Rowe. The ALJ ruled the claimant met his burden of proof that the cataract surgery was reasonable and was related to an eye injury arising out of his work activities.

We have reviewed the order and the record provided and we do not perceive reversible error. To the extent the ALJ relied on the evidence provided by the testimony of the claimant and the medical opinions of Dr. Rafferty and of Dr. Cruse that the claimant's right eye cataract injury was caused by his February, 2016 collision with a falling fence pole, the ALJ's decision represents a reasonable inference for the ALJ to draw.

The credibility attributed to expert medical opinion on the issue of causation is within the ALJ's province as fact-finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). Here, the ALJ credited the claimant's experts and resolved the conflicts in the evidence in favor of the claimant and we perceive no basis on which to disturb her resolution. Section 8-43-301(8), C.R.S. We may not interfere with the ALJ's assessment of the probative value of the evidence. *See Eisnach v. Industrial Commission*, 633 P.2d 502 (Colo. App. 1981). Further, the respondents' argument notwithstanding, the ALJ need not address every piece of evidence if the basis of the order is clear from the findings, as they are here, and evidence not addressed was presumably rejected as not persuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Consequently, we perceive no error in the

ALJ's decision to find the claim for a right eye cataract compensable and to find the respondents liable for the surgery to repair that condition.

IT IS THEREFORE ORDERED that the ALJ's order issued June 1, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

11/14/17 by TT .

KEATING WAGNER POLIDORI FREE, Attn: LAURENCE J FREE ESQ, 1290 BROADWAY SUITE 600, DENVER, CO, 80203 (For Claimant)
RITSEMA & LYON PC, Attn: TAMA L LEVINE ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-968-907-04

IN THE MATTER OF THE CLAIM OF:

MARIA REYES,

Claimant,

v.

FINAL ORDER

JBS USA LLC,

Employer,

and

ZURICH AMERICAN INS. CO.,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Cayce (ALJ) dated May 22, 2017, that determined the claimant's claim was compensable and ordered the respondents liable for temporary total disability (TTD) benefits and medical benefits for the claimant's right shoulder injury. We affirm.

This matter went to hearing on whether the claimant suffered a compensable industrial injury, whether the claimant established that the medical treatment by Greeley Medical Clinic, University of Colorado Health – Longmont Clinic, and their referrals was reasonably necessary, related, and authorized, and whether the claimant's December 2014 slip and fall incident or her May 2015 motor vehicle accident were intervening events which severed the causal relationship between the work injury and the claimant's symptoms and need for treatment and TTD benefits, and whether the claimant was responsible for the termination of her employment.

After the hearing, the ALJ found that the claimant had worked for the respondent employer for 18 years as a short rib trimmer. The claimant's job duties involved grabbing meat product from the conveyor belt using a hook in her left hand, and trimming fat from pieces of short rib using a knife in her right hand. On September 30, 2014, the claimant was performing her regular job duties when she felt a pull or tear in her right shoulder. The claimant explained that the meat product was frozen that day and she was having difficulty maintaining a sharp knife. The claimant was unable to work

the remainder of her shift and reported the incident to her supervisor. The claimant testified that the employer did nothing that day and she subsequently returned to working her same job duties.

On October 6, 2014, the employer sent the claimant to see a nurse at the employer's health facilities. The claimant reported pain in her right shoulder.

The employer then provided the claimant a designated provider list with three medical providers. The claimant chose Banner Occupational Medicine, and subsequently was seen by Dr. Smith. The claimant reported that she had experienced a sudden onset of pain in her right shoulder while performing her work. Dr. Smith diagnosed right shoulder pain, muscle spasm, and right hand strain, and released the claimant to restricted duty.

Dr. Smith reevaluated the claimant on December 4, 2014. Dr. Smith and the claimant reviewed a video of a worker performing the claimant's job duties. Dr. Smith remarked that the video did not correlate with the claimant's current complaints. She noted that x-rays of the claimant's right shoulder revealed acromioclavicular joint degenerative changes. Dr. Smith recommended the claimant return to regular duty and opined that her right shoulder symptoms were not work-related. Dr. Smith discharged the claimant and advised her that further treatment for the right shoulder would need to be continued with her primary care physician.

Thereafter, the claimant sought treatment for her right shoulder with a primary care physician at Greeley Medical Clinic. The claimant was diagnosed with shoulder pain.

In December 2014, the claimant was involved in a slip and fall accident in her bathtub. She went to the hospital because she hit the left side of her head when she fell.

Additionally, on May 18, 2015, the claimant was involved in a low-speed motor vehicle accident. The report noted that the claimant was wearing a seatbelt and the airbags did not deploy. The ambulance report notes the claimant complained of midline neck pain, midline thoracic back pain, and right shoulder pain. The claimant eventually was diagnosed with a back sprain, cervical sprain, and contusion.

In connection with her motor vehicle accident, the claimant was evaluated by Dr. Denzel. The claimant reported pain in the right side of her collar bone and low back pain. Dr. Denzel assessed low back pain, thoracic strain, and injury of the shoulder region.

The claimant continued to treat with Greeley Medical Clinic. On October 13, 2015, the claimant was referred for a surgical consultation with Dr. Jani at the Longmont Clinic.

Dr. Jani noted that the claimant presented for right shoulder pain that had been occurring for one year in connection with a work incident in September 2014. She assessed biceps tendonitis on the right, acromioclavicular joint arthritis, and bursitis of the right shoulder.

A subsequent MRI revealed partial tearing and tendinosis of supraspinatus, AC arthritis, and biceps tendinitis. Dr. Jani assessed an incomplete tear of the right rotator cuff, biceps tendonitis on the right, and arthritis of right acromioclavicular joint. Dr. Jani recommended the claimant undergo surgery. On November 11, 2015, Dr. Jani performed an arthroscopic right shoulder extensive debridement, subacromial decompression, and a distal clavicle excision with open biceps tenodesis.

Dr. Hughes conducted an independent medical examination (IME) at the request of the claimant. The claimant reported having very little pre-existing problems with her right shoulder, and Dr. Hughes noted that this was consistent with the medical record documentation he reviewed. Dr. Hughes assessed work-related right shoulder sprain/strain with development of partial rotator cuff tears and tendinopathy, as well as tendinopathy of the biceps long head tendon, partial labral tearing, and development of right shoulder impingement syndrome. Dr. Hughes opined that there were no alternate explanations for the claimant's right shoulder issues.

At the request of the respondents, Dr. Wunder conducted an IME. Dr. Wunder formerly served as the Medical Director at the respondent employer's beef plant. Dr. Wunder opined that the claimant did not have a work-related shoulder condition. He explained that the claimant's job required minimal use of her right shoulder, and did not require significant abduction or internal rotation, overhead activities, or use of her arm at a prolonged extended or overhead position. He noted that the claimant's x-rays demonstrated degenerative osteoarthritis, and opined that the claimant's job activities observed in the video could not cause, exacerbate, or result in the advanced degenerative change in the claimant's right shoulder. Dr. Wunder agreed with Dr. Smith that it was unlikely that the claimant's job duties contributed to her symptoms. Dr. Wunder also noted that the protocols for cumulative trauma disorder for the right upper extremity contained in the Medical Treatment Guidelines (Guidelines) emphasize force and position as primary risk factors, and such risk factors were not present in the claimant's

case. He concluded that the claimant's only reasonable pain generator would have been the degenerative disease in her AC joint and glenohumeral joint.

Dr. Smith opined that the claimant's mechanism of injury and review of the video of work activities did not fall within the Guidelines for causality of AC joint sprain or strain, impingement, rotator cuff tears or labral tears. During her deposition, Dr. Smith testified that the claimant's right shoulder symptoms are not work-related. She agreed with Dr. Wunder's analysis regarding causation and his assessment of the cumulative trauma disorders under the Guidelines. Dr. Smith explained that the claimant's job did not involve work above chest level, any repetitive reaching, or any heavy lifting over her head or above chest level. Dr. Smith further testified that the sharpness of the knife did not cause any tears or damage to the claimant's shoulder. Dr. Smith also testified that the claimant's May 18, 2015, motor vehicle accident could have caused her right shoulder pain. She explained that the seatbelt, airbags, or an attempt by the claimant to steady herself on the dashboard could have caused injury to her right shoulder. She also acknowledged, however, that there was nothing in the medical records indicating the claimant was hit with an airbag during the accident.

The claimant subsequently treated with Dr. Mason. While Dr. Mason acknowledged that the claimant had some underlying AC arthropathy and impingement, she opined that the specific work activities exacerbated the claimant's condition leading to the need for surgery.

Crediting the opinions of Dr. Mason and Dr. Hughes over those of Dr. Wunder and Dr. Smith, the ALJ ultimately determined that the claimant suffered an acute industrial injury to her shoulder on September 30, 2014. She also found the claimant had established that the medical treatment at Greeley Medical Clinic, and the Longmont Clinic, and their referrals were reasonably necessary, related, and authorized. The ALJ concluded that the claimant's December 2014 bathtub incident and her May 2015 motor vehicle accident were not sufficient intervening events that severed the causal relationship between the work injury and the claimant's ongoing symptoms and need for treatment. The ALJ further concluded that the respondents failed to establish the claimant was responsible for her termination. The ALJ credited the claimant's testimony, over that of the employer's witness, that she provided a letter to Human Resources from Dr. Jani regarding her work restrictions. The ALJ found that the claimant was informed by the employer that she could not return to work with her restrictions. The ALJ therefore ordered the respondents liable for TTD benefits, and medical benefits for the care the claimant received from Greeley medical Clinic, Longmont Clinic, and any other referrals made by these providers.

I.

On appeal, the respondents argue that the ALJ erred in finding the claimant sustained a compensable industrial injury on September 30, 2014. They reason that Dr. Hughes' report indicates he was not aware of the claimant's car accident and the subsequent right shoulder injury and treatment arising from the accident. Further, they argue that Dr. Hughes did not review the video of the claimant performing her job and did not apply the causation risk factors outlined in the Guidelines. Consequently, they contend that Dr. Hughes' opinions cannot be considered substantial evidence for a proximate cause determination. Similarly, the respondents argue that although Dr. Mason did have knowledge of the claimant's car accident at the time of her records review, she did not review the job performance video and disregarded the primary causation risk factor in the Guidelines. Again, therefore, the respondents argue that Dr. Mason's opinions cannot be considered substantial evidence for a proximate cause determination. Additionally, the respondents contend the ALJ erred in crediting the testimony of the claimant despite "clear contradiction of her testimony" regarding her May 18, 2015, car accident. We are not persuaded the ALJ erred.

It is the claimant's burden to prove a compensable injury. To sustain her burden of proof, the claimant is required to establish that the condition for which she sought benefits was proximately caused by an injury arising out of and in the course of employment. *Loofbourrow v. Industrial Claim Appeals Office*, 321 P.3d 548 (Colo. App. 2011), *aff'd Harman-Bergstedt, Inc. v. Loofbourrow*, 320 P.3d 327 (Colo. 2014); §8-41-301(1), C.R.S. The question of whether the claimant has met her burden to prove compensability is factual in nature. Thus, we are bound by the ALJ's determinations in this regard if they are supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires us to consider the evidence in the light most favorable to the prevailing party and defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Panera Bread, LLC v. Industrial Claims Appeals Office*, 141 P.3d 970 (Colo. App. 2006).

Additionally, the relative weight and credibility to be assigned expert opinions is the ALJ's province as fact-finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). As such, we may not substitute our judgment by reweighing the evidence in an attempt to reach a result that is different from that of the ALJ. *See Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31, 32-33 (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); *see also Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). Further, we have no authority to interfere with the ALJ's credibility determinations unless the testimony she

credited is rebutted by such hard, certain evidence that it would be an error as a matter of law to believe the testimony. *See Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986).

Here, to the extent the respondents complain that Dr. Hughes did not know of the claimant's car accident and subsequent treatment, and that neither Dr. Hughes nor Dr. Wunder reviewed the video of the claimant performing her job duties, this simply goes to the probative weight of their opinions. As noted above, 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. *Rockwell International v. Turnbull*, *supra* (ALJ, as fact-finder, is charged with resolving conflicts in expert testimony); *Sullivan v. Industrial Claim Appeals Office*, *supra*. Regardless, both Dr. Hughes and Dr. Mason opined that the claimant sustained an acute work-related injury to her right shoulder on September 30, 2014. Dr. Hughes explained that the claimant "did not have a significant past medical history of right shoulder problems preceding her work-related right shoulder injury of September 30, 2014." Further, Dr. Mason explained that while the claimant did have "underlying AC arthropathy and impingement, it [did] appear that specific work activities caused an exacerbation which ultimately led to surgery." Ex. 7 at 66; Ex. 8 at 90. Additionally, the claimant testified that when she was starting to cut the meat at her job on September 30, 2014, she felt a pull in her shoulder. She explained that the meat was frozen and her knife was not sharp. Tr. at 18. We are unable to say that the opinions and testimony the ALJ credited is rebutted by such hard, certain evidence that it would be an error as a matter of law to believe the testimony. *See Halliburton Services v. Miller*, *supra*. Further, while the respondents cite to evidence which, if credited, could have supported the contrary result, this does not afford a basis for relief on appeal. *See Cordova v. Industrial Claims Appeals Office*, *supra*. Thus, we conclude that the ALJ relied on substantial evidence to find that the claimant sustained a compensable industrial injury on September 30, 2014. Section 8-43-301(8), C.R.S.

To the extent the respondents also argue that Dr. Hughes' and Dr. Mason's causation opinions are not consistent with the Guidelines, we again perceive no reversible error. The Guidelines are regarded as accepted professional standards for care under the Workers' Compensation Act. *Rook v. Industrial Claim Appeals Office*, 111 P.3d 549 (Colo. App. 2005). However, the compensable nature of the claimant's industrial injury is not definitively controlled by application of the Guidelines. In determining the compensability of a claim, an ALJ is not bound by any medical opinion, even if it is unrefuted. *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004); *Industrial Commission v. Riley*, 165 Colo. 586, 591, 441 P.2d 3, 5 (1968). Rather, the determination of the compensable nature of an injury remains controlled by the Workers'

Compensation Act and by relevant case law. The claimant sustains a compensable injury when, at the time of the injury, she is performing a service arising out of and in the course of her employment. Section 8-43-301, C.R.S. Consequently, while it is appropriate for the ALJ to consider the Guidelines on the question of diagnosis and cause of the claimant's condition, even assuming there might have been some deviation from the Guidelines here, it does not compel the fact finder to disregard the opinion of that medical expert on the issue of the causal connection between a work related injury and a particular medical condition. *See Eldi v. Montgomery Ward*, W. C. No. 3-757-021 (October 30, 1998); *see also Jones v. T.T.C. Illinois, Inc.*, W.C. No. 4-503-150 (May 5, 2006)(the Guidelines are not definitive); *cf.* §8-43-201(3), C.R.S. ("[t]he director or administrative law judge is not required to utilize the medical treatment guidelines as the sole basis" for determining whether certain medical treatment is reasonable, necessary, and related."). We further note that Dr. Hughes' proximate cause opinion is not contrary to the Guidelines' description as to how rotator cuff tears commonly occur. WC Rule 17, Exhibit 4, Shoulder Injury, part (E)(12)(b) (effective Feb. 1, 2015), provides that tears are commonly thought to occur under five certain circumstances, but it does not exclude other causes. Thus, we disagree with the respondents' argument that the ALJ erred in crediting the proximate cause opinions of Dr. Hughes and Dr. Mason, even assuming their opinions may deviate from the Guidelines. Similarly, the ALJ's award of medical benefits is not in error even assuming that approval may represent a departure from the Guidelines.

II.

Next, the respondents argue the ALJ erred in finding that the claimant was not responsible for the termination of her employment. They contend that the employer's file demonstrates the claimant failed to produce any letter from Dr. Jani with medical restrictions. We are not persuaded the ALJ erred.

Sections 8-42-105(4), C.R.S. and 8-42-103(1)(g), C.R.S. (termination statutes) contain identical language stating that in cases "where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury." *See Colorado Springs Disposal v. Industrial Claim Appeals Office*, 58 P.3d 1061 (Colo. App. 2002). "Fault" requires that the claimant must have performed some volitional act or exercised a degree of control over the circumstances resulting in the termination. *See Gonzales v. Industrial Commission*, 740 P.2d 999 (Colo. 1987). An employee is not responsible for a termination from employment if the physical effects of the industrial injury preclude the performance of assigned duties and cause the termination. *See Colorado Springs Disposal v. Industrial Claim Appeals Office, supra*.

The employer bears the burden of establishing evidence that a workers' compensation claimant was terminated for cause or was responsible for the separation from employment. *Gilmore v. Industrial Claim Appeals Office*, 187 P.3d 1129 (Colo. App. 2008). The question whether the claimant acted volitionally or exercised a degree of control over the circumstances of the termination is ordinarily one of fact for the ALJ and we must uphold the ALJ's findings if supported by substantial evidence in the record. *Id*.; Section 8-43-301(8), C.R.S. This is a narrow standard of review which requires us to view the evidence in a light most favorable to the prevailing party, and to defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

The respondents' argument notwithstanding, substantial evidence supports the ALJ's determination that the claimant was not responsible for her termination. Initially, we note that the respondents again cite to evidence which, if credited, could have supported the contrary result. As noted above, however, this does not afford a basis for relief on appeal. *See Cordova v. Industrial Claims Appeals Office*, *supra*. The ALJ simply was not persuaded by the respondents' contention that the claimant was in violation of its no-call, no-show policy or that she failed to provide the employer with documentation supporting her medical restrictions. Instead, the ALJ was persuaded by the claimant's testimony that she provided to the respondent employer her restrictions from Dr. Jani. The claimant explained that the employer could not provide her with work because of her restrictions. Tr. at 86-87. It was the ALJ's sole prerogative as the fact finder to resolve the conflicts in the evidence. *See Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997)(ALJ's prerogative to evaluate evidence "extends to resolving the inconsistencies in a particular witness' testimony"); *Sullivan v. Industrial Claim Appeals Office*, *supra*; *Rockwell International v. Turnbull*, *supra*. The ALJ weighed the evidence and determined its respective probative value against the respondents. The ALJ could, and did, reasonably infer from the evidence that the claimant provided the employer with the required medical documentation supporting her restrictions, and the employer was unable to offer the claimant work because of such restrictions. Under these circumstances, the claimant is not responsible for the termination of employment. *See Colorado Springs Disposal v. Industrial Claim Appeals Office*, *supra*. The ALJ's findings are supported by substantial evidence and we have 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 May 22, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

December 4, 2017 by KG .

THE FRICKEY LAW FIRM, Attn: JORDAN FRAKES ESQ, 940 WADSWORTH BLVD 4TH FLOOR, LAKEWOOD, CO, 80214 (For Claimant)
RITSEMA & LYON PC, Attn: KIM D STARR ESQ, 2629 REDWING ROAD SUITE 330, FORT COLLINS, CO, 80526 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-030-925-01

IN THE MATTER OF THE CLAIM OF:

PETER WRIGHT,

Claimant,

v.

FINAL ORDER

HSS INC. - CO HARTFORD,

Employer,

and

CO HARTFORD,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Margot Jones (ALJ) dated July 5, 2017, that found that the claimant willfully violated the employer's safety rule and imposed a 50 percent penalty on compensation benefits pursuant to §8-43-112(1)(b), C.R.S. We affirm the ALJ's order.

This matter went to hearing on the issues of safety rule violation and average weekly wage. After hearing the ALJ made factual findings that for purposes of review can be summarized as follows. The claimant is employed at Denver International Airport (DIA) for the employer. As part of his job the claimant is required to operate vehicles at DIA and to ride as a passenger in the employer's vehicles. On November 3, 2016, the claimant was riding as a passenger in an employer owned vehicle when he was involved in a rollover accident. The ALJ found that the claimant was not wearing a seat belt.

The employer's "Vehicle Driving and Usage Policy" requires that the "Driver shall always wear seat belts and require the same of passengers." The ALJ found that this policy requires that drivers and passengers should "always" wear seat belts while operating employer-owned vehicles during work hours. The claimant testified that he was aware of the employer's seat belt policy and understood the policy to require that the driver ensure he is restrained and all passengers in the vehicle are restrained also. Although the claimant testified that he understood the employer's policy to place the

responsibility on the driver to ensure that all riders in the vehicle were belted, the ALJ rejected this portion of the claimant's testimony.

The claimant was provided with safe driving training which included seat belt usage. The claimant took a test as part of this training. One of the test questions asked whether seat belt use was a safe driving habit for the employer. The claimant answered the test question affirmatively. The employer also provided occasional safety presentations and bulletins to its employees. Some of these bulletins included information regarding seat belt use and oral presentations emphasized the importance of seat belt usage. The claimant answered affirmatively to a question in a quiz that stated, "You can maintain safe driving habits by driving the speed limit, fastening your seat belt…." The claimant also credibly testified that he is responsible for presenting the safety rules to new employees, including seat belt usage.

At hearing the claimant maintained that he was wearing his seat belt at the time of the accident. He testified that he distinctly recalled hearing the seat belt reminder bell ringing in the car and remembered thinking that it was ringing because he was without his seat belt. He then recalled fastening his seating belt. The ALJ did not find the claimant's testimony credible in this regard. Photographs taken immediately after the accident showed that the seat belt had not been used. This was corroborated by witness testimony and the testimony of an expert accident reconstructionist. The medical records also established that the claimant had no injury or bruising to his right shoulder or chest which is the area most often injured on a restrained passenger in an accident.

The claimant also alleged that the employer never enforced the seat belt policy and that there was a debate among the employees about the necessity of using seat belts in view of the fact that the duties often required employees to stop and exit their vehicle every 200 feet. The claimant contended that using a seat belt when performing these duties was unreasonable.

The ALJ determined that the claimant's injuries were caused by his willful failure to obey an employer's reasonable safety rule resulting in a 50 percent reduction in the claimant's workers' compensation benefits. The ALJ also increased the claimant's average weekly wage.

On appeal the claimant contends that there is no evidence that the rule was enforced. The claimant specifically relies on the fact that the driver of the vehicle was not reprimanded for the claimant's failure to wear a seat belt, despite the language in the employer's policy placing the responsibility on the driver to require the passengers to

wear a seat belt. Based on this language in the policy, the claimant also argues that there is no employer specific safety rule that requires *passengers* to wear a belt. We are not persuaded the ALJ committed reversible error.

Section 8-42-112(1)(b), C.R.S., permits imposition of a 50 percent reduction in compensation in cases of "willful failure to obey any reasonable rule" adopted by the employer for the claimant's safety. The question of whether the respondents carried the burden of proof to show that the employer had a reasonable safety rule in place was one of fact for determination by the ALJ. *City of Las Animas v. Maupin*, 804 P.2d 285 (Colo. App. 1990). We are required to uphold the ALJ's order if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. In applying this standard, we must defer to the ALJ's resolution of conflicts in the evidence, her credibility determinations, and the plausible inferences she drew from the evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

The ALJ's determinations are supported by substantial evidence here. The claimant testified that his understanding of the employer's written policy was that the "driver shall ensure that they are restrained and that all passengers in the vehicle are restrained also." Tr. at 9. He also conceded that the employer instilled the habit of seat belt use in its employees. Tr. at 13 and 29. The employer witnesses also testified that the employer has a policy requiring passengers to wear a seat belt. Tr. at 38, 50. The claimant further stated that he customarily wore his seat belt. Tr. at 13. Under these circumstances it was plausible for the ALJ to conclude that the respondents produced credible evidence to show that the employer had adopted a safety rule requiring all employees to wear a seat belt.

Moreover, we are not persuaded by the claimant's contention that the employer failed to enforce the seat belt policy. Although an employer's failure to enforce a safety rule may provide grounds for rejecting the imposition of a penalty, the determination of whether such grounds exist is a factual matter. The determination of whether the employer acknowledged and acquiesced in employee misconduct by failing to enforce its own rules is one of fact for determination by the ALJ. *Lori's Family Dining Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995). Relevant facts include whether or not the employer was aware of violations, the frequency of such violations and the extent of employer discipline in responding to violations.

Here, the ALJ credited the evidence that the employer regularly conducted training and provided material to its employees on seat belt use. It was also part of the claimant's job to instruct other employees on the requirement for seat belt usage. Therefore there is

sufficient, albeit conflicting, evidence to support the ALJ's order. The claimant's argument that the driver of the accident was not reprimanded for the claimant's failure to wear a seat belt does not compel a contrary conclusion. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002) (existence of evidence which, if credited, might permit a contrary result also affords no basis for relief on appeal). We see no basis to disturb the ALJ's order. §8-43-308(1), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated July 5, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

ERTIFICATE OF MAILING

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

12/12/17 by TT .

BELL & POLLOCK PC, Attn: ROBERT A BROVEGE JR ESQ, 5660 GREENWOOD PLAZA BLVD SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Claimant)
POLLART MILLER LLC, Attn: ERIC J POLLART ESQ, C/O: JESSICA L GRIMES ESQ, 5700 S QUEBEC STREET SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-025-741-01

IN THE MATTER OF THE CLAIM OF:

JAMES R. SCHAEFER,

Claimant,

v.

ARVADA FIRE PROTECTION DISTRICT,

Employer,

and

SELF-INSURED,

Insurer,
Respondent.

REMAND ORDER

The respondent seeks review of an order of Administrative Law Judge Felter (ALJ) dated June 28, 2017, that determined the claimant sustained a compensable occupational disease of pancreatic cancer under the firefighter cancer presumption statute, §8-41-209, C.R.S., and ordered the respondent to pay all costs of medical care and treatment for the claimant's pancreatic cancer, subject to the Division of Workers' Compensation Medical Fee Schedule. We set aside the ALJ's compensability determination and remand the matter for further proceedings.

This matter went to hearing on whether the respondent overcame the presumption of compensability in the firefighter statute by a preponderance of the medical evidence. Prior to hearing the parties stipulated that the claimant qualifies for the presumption of compensability as outlined in §8-41-209, C.R.S., in that the claimant had completed in excess of five or more years of employment as a firefighter and has been diagnosed with pancreatic cancer. Pancreatic cancer is a cancer of the digestive system. The parties further stipulated that if the claim was determined to be compensable "the treatment directed by the authorized treating physician (ATP) Tom VanderHorst, M.D. is causally related and reasonably necessary to cure and relieve the effects of the pancreatic cancer."

The claimant has been a firefighter for approximately 20 years with the Arvada Fire Protection District. The claimant was first diagnosed with pancreatic cancer in September of 2016. After his diagnosis the claimant began treating with Dr.

VanderHorst. In a report dated September 16, 2016, Dr. VanderHorst confirmed the claimant's pancreatic cancer diagnosis and stated that the condition was work-related within a reasonable degree of medical probability. Dr. VanderHorst noted that the claimant had no history or risk exposures consistent with an alternative explanation for his cancer. The claimant is a non-smoker.

At the respondent's request, Dr. Allems performed an independent medical examination (IME) by telephone with the claimant. Dr. Allems testified at hearing, consistent with the conclusion in his report that the claimant's pancreatic cancer was not caused by occupational exposure sustained during his employment and was more likely due to non-industrial factors. According to Dr. Allems the claimant's cancer is more probably related to non-industrial factors. In his report, Dr. Allems provided a review and discussion of multiple epidemiological studies regarding pancreatic cancer in general and pancreatic cancer in firefighters. Dr. Allems states in his report that "despite what are reasonably presumed to be exposures to various carcinogenic substances on the job, none of them are recognized to cause pancreatic cancer." Dr. Allems noted that the epidemiological data on firefighters fails to find that pancreatic cancer rates are higher in firefighters despite their exposure potential and specifically concluded that the evidence demonstrates that the claimant's known or typical occupational exposures are not capable of causing pancreatic cancer. Dr. Allems also pointed to the fact that the claimant's records refer to the claimant eating a lot of red meat and that red meat consumption is an identified risk factor for pancreatic cancer.

At the close of the respondent's case, the claimant moved for a directed verdict which the ALJ granted. The ALJ determined that the respondent failed to overcome the presumption that the claimant sustained a compensable occupational disease of pancreatic cancer under §8-41-209. The ALJ found Dr. VanderHorst's opinions highly persuasive and credible because he has the greatest familiarity with the claimant's medical case, his opinions are based on first-hand treatment and his opinions are clearly and cogently articulated**.**

The ALJ rejected Dr. Allems' opinions and provided a detailed explanation of his reasons. The ALJ found that,

> Dr. Allems' opinions and conclusions are based, almost entirely, on his interpretation of the articles he attached to his report. His expertise in Oncology and Epidemiology is dubious yet his opinions are heavily laden with his interpretation of epidemiological articles. The ALJ finds Dr. Allems' opinions are based, substantially, on hearsay medical articles with

> few, if any, identifiable opinions of his own. His opinions are neither credible nor persuasive. Dr. Allems bases his conclusions on general assumptions, and sometimes unsupported assumptions, regarding what exposures the claimant may or may not have encountered over the course of his 20 year career. Dr. Allems further bases his opinions substantially, as found herein above, on generalized studies as opposed to evaluating the Claimant's individualized exposure and causation. Dr. Allems' opinions fail to overcome the presumption as outlined in §8-41-209, C.R.S., as it pertains to the claimant diagnosed pancreatic cancer.

ALJ Order, Finding of Fact 22 at 6.

The ALJ also ordered that "medical benefits as stipulated and all other medical benefits are reasonable necessary and related." The respondent now appeals.

On appeal the respondent argues that the ALJ misapplied the firefighter presumption statute contained in § 8-41-209, C.R.S. The respondent specifically disputes the ALJ's credibility analysis of Dr. Allems' opinions claiming that the ALJ failed to properly consider the epidemiological evidence and in discrediting Dr. Allems' opinions and testimony. We agree that the ALJ erred.

The firefighter presumption statute contained in § 8-41-209, C.R.S. provides as follows:

> (1) Death, disability, or impairment of health of a firefighter of any political subdivision who has completed five or more years of employment as a firefighter, caused by cancer of the brain, skin, digestive system, hematological system, or genitourinary system and resulting from his or her employment as a firefighter, shall be considered an occupational disease.
>
> (2) Any condition or impairment of health described in subsection (1) of this section:
>
> (a) Shall be presumed to result from a firefighter's employment if, at the time of becoming a firefighter or thereafter, the firefighter underwent a physical examination that failed to reveal substantial evidence of such condition or impairment of health that preexisted his or her employment as a firefighter; and

> (b) Shall not be deemed to result from the firefighter's employment if the firefighter's employer or insurer shows by a preponderance of the medical evidence that such condition or impairment did not occur on the job.

In *City of Littleton v. Industrial Claim Appeals Office*, 370 P.3d 157 (Colo. 2016), the Supreme Court held that the firefighter presumption relieves a qualifying firefighter of the burden to prove that his cancer "result[ed] from his employment as a firefighter" for purposes of establishing his claim to workers' compensation benefits. The Court noted, however, that this statute does not establish a conclusive presumption that firefighting duties cause cancers relating to the brain, skin, digestive system, hematological system, or genitourinary system, or that a firefighter's employment caused a particular firefighter's condition. Rather, the statute shifts the burden of persuasion regarding the job-relatedness of the firefighter's condition to the employer. The employer's burden is to show, by a preponderance of the medical evidence that the firefighter's cancer "did not occur on the job." *Id.* The Court explained that the employer can satisfy this burden by establishing the absence of ***either general or specific causation.*** *Id. (Emphasis added).* Specifically, an employer can show, by a preponderance of the medical evidence, either:

> (1) that a firefighter's known or typical occupational exposures are not capable of causing the type of cancer at issue; ***or***
> (2) that the firefighter's employment did not cause the firefighter's particular cancer where, for example, the claimant firefighter was not exposed to the cancer-causing agent, or where the medical evidence renders it more probable that the cause of the claimant's cancer was not job-related. (*Emphasis added).*

See also Industrial Claim Appeals Office v. Town of Castle Rock, 370 P.3d 151 (Colo. 2016)(to satisfy burden of proof, employer is not required to prove specific alternate cause of firefighter's cancer).

In *City of Littleton*, the employer presented the testimony of three expert witnesses: Dr. Denise M. Damek (neuro-oncology); Dr. Patricia A. Buffler (epidemiology); and Dr. Javier C. Waksman (toxicology). The ALJ concluded that, collectively, employer's expert witnesses established that the substances to which the claimant's expert opined he was likely exposed as a firefighter do not target the brain and do not cause brain cancer. The Supreme Court held that employers may rely on epidemiological evidence to show the lack of an association or general causal relationship between known or typical substances to which the firefighter is likely to be exposed on

the job and the firefighter's particular condition or impairment. The ALJ may then determine whether that medical evidence shows, by a preponderance, that the claimant firefighter's cancer "did not occur on the job." The Court stated that if a firefighter's exposure to a substance is speculative, remote, or illogical, then it is not typical of the occupation. *Id.*

The respondent here presented Dr. Allems' opinions and testimony on the first prong of the *City of Littleton* test concerning the lack of an association or general causal relationship between a known or typical substance to which the claimant was likely to be exposed to and pancreatic cancer. The ALJ summarily dismissed this evidence on the basis of the second prong of the *City of Littleton* test that Dr. Allems' opinions did not go to the claimant's individualized exposures and causation. The ALJ analysis ignores the holding in *City of Littleton* that an employer may prove a lack of general causation.[1]

The ALJ also erroneously precluded Dr. Allems from testifying on epidemiological studies insofar as they related to general causation. Tr. at 24-26, 26-27, 40-45. It is not readily apparent from the transcripts why the ALJ sustained the claimant's general objections to the form and clarity of the respondent's questions concerning the epidemiological evidence. At one point the ALJ states that Dr. Allems' testimony goes to the weight of the epidemiological evidence but, nonetheless, sustains the objection. Tr. at 44, ll. 2-15. We recognize that §8-43-207(1), C.R.S., gives the ALJ wide discretion in the conduct of evidentiary proceedings. *Ortega v. Industrial Claim Appeals Office*, 207 P.3d 895, 897 (Colo. App. 2009). Here, however, the ALJ's basis for precluding Dr. Allems' testimony is contrary to law and, therefore, is an abuse of discretion. *see Eller v. Indus. Claim Appeals Office*, 224 P.3d 397 (Colo. App. 2009) (applying an abuse of discretion standard to evidentiary rulings); *Heinicke v. Industrial Claim Appeals Office*, 197 P.3d 220, 222 (Colo. App. 2008) ("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.")

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[1] The ALJ also stated the credibility of Dr. Allem's opinions were undermined by the "undisputed" testimony of the claimant and by the opinions of Dr. VanderHorst. However, the record contains no testimony by the claimant. The only opinion offered by Dr. VanderHorst concerning the relation of the claimant's cancer to work exposure is his reference to the statement in § 8-41-209(1) providing an evidentiary presumption that the listed cancers are work related. That reliance notwithstanding, the Court in *City of Littleton, supra*, found: "… section 8-41-209 contains no legislative declaration or express finding that cancers of the brain, skin, digestive system, hematological system, or genitourinary system result from occupational exposures associated with firefighting." *Id*. at 170. The credibility determinations of the ALJ remain unsupported by the record.

The ALJ's preclusion of the respondent's evidence and failure to consider whether the evidence rebutted the general causation of the claimant pancreatic cancer is inconsistent with applicable law. We, therefore, must set the ALJ's order aside. Section 8-43-301(8), C.R.S. On remand the ALJ must consider whether the respondent established, by a preponderance of the medical evidence, that the respondent overcame the presumption of general causation to show that a firefighter's known or typical occupational exposures are not capable of causing the type of cancer at issue in view of the epidemiological evidence presented. We express no opinion as to the credibility and persuasiveness of the evidence presented and merely remand the matter for the ALJ to properly consider it in the context of general causation.

In view of our disposition of the compensability issue we do not reach respondent's issue of medical benefits on appeal. We note, however, that the ALJ's order for the respondent to "pay all costs of medical care and treatment for the Claimant's pancreatic cancer…" is not consistent with the stipulated agreement that all medical care and treatment provided by Dr. VanderHorst was reasonably necessary, causally related and authorized. Tr. at 11.

IT IS THEREFORE ORDERED that the ALJ's order dated June 28, 2017, is set aside and remanded for further proceedings.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

CERTIFICATE OF MAILING

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

11/14/17 by TT .

BURG SIMPSON ELDREDGE HERSH & JARDINE PC, Attn: NICK FOGEL, ESQ, 40 INVERNESS DRIVE EAST, ENGLEWOOD, CO, 80112 (For Claimant)
DWORKIN CHAMBERS WILLIAMS YORK BENSON & EVANS PC, Attn: C SANDRA PYUN ESQ, 3900 E MEXICO AVE SUITE 1300, DENVER, CO, 80210 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-011-916-03

IN THE MATTER OF THE CLAIM OF:

CHRIS BACA,

Claimant,

v.

FINAL ORDER

DEPARTMENT OF HUMAN SERVICES,

Employer,

and

SELF-INSURED,

Insurer,
Respondent.

The respondent seeks review of an order of Administrative Law Judge Cannici (ALJ) dated August 8, 2017, that determined the claim to be compensable and ordered the payment of temporary total disability benefits. We affirm the order of the ALJ.

The claimant worked for the employer as a certified nursing assistant at a facility for developmentally disabled adults. On April 1, 2016, the claimant asserted he tore the meniscus ligament in his right knee while assisting residents to exit a van upon their return to the facility from a movie night. The claimant had started his shift that day at 7:30 p.m. He estimated his knee accident occurred at 10:30 p.m. The claimant reported the injury to the employer that evening. He was referred to the Lutheran Medical Center Emergency room and then to Dr. Vanderhorst at SCL occupational medicine. On April 2, the doctor noted in his exam record the claimant's description or the mechanism of injury: "He was planted on his right foot and turning to the right when he 'felt a pop' in his right knee which buckled and he fell down …." Dr. Vanderhorst requested an MRI study of the claimant's right knee. The doctor read the MRI on April 12. He noted an oblique undersurface tear of the body of the medial meniscus. Dr. Vanderhorst recommended physical therapy and felt surgery would not be necessary.

The respondents filed a Notice of Contest form asserting the claimant's injury was not work related.

At the request of the respondent, the claimant was evaluated by Dr. Wallace Larson on January 17, 2017. The claimant reported to Dr. Larson he used his personal medical insurance to undergo a knee arthroscopy and partial meniscectomy in August 2016 (assumed to be on the right knee). No further treatment was recommended. Dr. Larson reviewed a record from the Lakewood Kaiser Permanente clinic dated April 1, 2016, at 5:25 p.m. The record noted the claimant had called to request the appointment at 3:06 p.m. and complained of a right knee injury occurring two days previously. He stated he twisted the knee while walking. The physician conducting the April 1 exam recorded a history stating: "… 25 year old male who complains of right knee pain for 2 days. Patient was standing at work, right foot planted, twisted medially, heard pop and had immediate pain of the medial knee … Over the past 24-48 hours, pain has increased and has had increased swelling in the knee." The Kaiser doctor suspected a medial meniscal injury and ordered an X-ray and an MRI.

Dr. Larson surmised the claimant did not sustain a work related knee injury. He referenced the Kaiser record which indicated the claimant already was suffering from a meniscus injury or tear in his right knee prior to reporting for work on April 1. Dr. Larson suggested the claimant either was afflicted with a degenerative tear (acknowledged to be uncommon for a 25 year old) or encountered a traumatic event not recorded in the medical record. Due to the visit to the Kaiser clinic immediately prior to the claimant's report of a subsequent work injury, Dr. Larson concluded the right knee injury would not have occurred at work as claimed by the claimant.

At the July 20, 2017, hearing, the claimant testified he did not visit the Kaiser clinic until April 2, the day following his work injury. He described the circumstances of his fall in the employer's van the evening of April 1. The claimant's coworker, and girl-friend, was with the claimant in the van and verified his fall and complaints of immediate pain on April 1. She testified she then drove him to the emergency room at that time. The claimant testified he was unable to work for the employer at his job after April 1 until December 2016, when the claimant secured another job as a CNA with a different employer.

In his order of August 8, 2017, the ALJ found the claimant's version of the events leading to his right knee injury to be credible. The ALJ concluded the claimant actually had occasion to be evaluated at the Kaiser clinic "sometime after April 1, 2016 …." The ALJ resolved that the Kaiser medical records were incorrectly dated. The ALJ pointed out that the description of the incident causing the injury included in the Kaiser record was consistent with the claimant's description of his injury provided to Dr. Vanderhorst and with his testimony at the hearing. The description featured the planting of the

claimant's right foot and a twisting turn to the right. The incident was said in all three versions to have occurred at work and the claimant's coworker verified his account of the injury. The ALJ deemed the claimant's injury to have occurred at work on April 1. Accordingly, the ALJ ordered the respondents to pay temporary benefits beginning April 1 through December 1, 2016, and to provide reasonable medical treatment for the claimant's right meniscus tear.

On appeal, the respondent complains the ALJ was in error by drawing the inference from the evidence in the record the claimant was injured at work on April 1. The respondent asserts the ALJ's finding the Kaiser record was misdated and that the claimant actually was seen at the Kaiser clinic "sometime after" April 1 is not supported by substantial evidence in the record. The respondent points to the testimony of the claimant's coworker that she did not testify she ever took the claimant to Kaiser on April 2. The respondent observes the claimant testified he went to the Kaiser appointment on April 2, the day following his alleged injury, while the Kaiser report states he was complaining of pain which began two days previously and had worsened over the previous 24-48 hours. Finally, the respondent argues the ALJ's Finding of Fact ¶ 5 relies on the coworker's testimony she took the claimant to the Lutheran emergency room on April 1 while Finding of Fact 10 references the Lutheran medical records and concludes the claimant did not report to the emergency room until April 2. The respondent explains the inference the ALJ draws from this record that the claimant was injured on April 1 is an impossible and illogical deduction, which is not supported by substantial evidence.

Pursuant to §8-41-301(1) (c), C.R.S., a disability is compensable if it is shown that it was "proximately caused by an injury . . . arising out of and in the course of the employee's employment." To establish that an injury arose out of an employee's employment, there must be 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. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999). In reaching a conclusion concerning causation, the ALJ may make reasonable inferences from the circumstantial evidence presented. *See Electric Mutual Liability Insurance Co. v. Industrial Commission*, 154 Colo. 491, 391 P.2d 677 (1964). Furthermore, it is the prerogative of the ALJ to resolve conflicts in the evidence and determine the credibility of witnesses and the probative value of the evidence. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). So long as such determination is supported by substantial evidence in the record, it is binding on review. *See May D & F v. Industrial Claim Appeals Office*, 752 P.2d 589 (Colo. App. 1988). Substantial evidence is probative evidence, which would warrant a reasonable belief in the existence of facts supporting a

particular finding, without regard to the existence of contradictory or contrary inferences. *Ackerman v. Hilton's Mech. Men*, 914 P.2d 524, 527-28 (Colo. App. 1996); *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

Under this standard, we must defer to the ALJ's assessment of the sufficiency and probative weight of the evidence. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). Further, we may not interfere with the ALJ's credibility determinations except in the extreme circumstance where the evidence credited is so overwhelmingly rebutted by hard, certain evidence that the ALJ would err as a matter of law in crediting it. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986); *Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997). The respondent's arguments notwithstanding, we perceive no extreme circumstances here.

In his reading of the evidence, the ALJ made several factual findings. However, it is clear he attached varying significance to the various findings. Utmost significance was ascribed to the consistency involved in the three descriptions of the mechanism of the claimant's injury. The claimant testified that while at work assisting the residents on the employer's van he "turned right to exit the bus with my residents, my knee popped and gave way." Tr. at 13. Compared to the versions provided to Vanderhorst ("He was planted on his right foot and turning to the right when he 'felt a pop' in his right knee which buckled …") and to the Kaiser doctor ("…was standing at work, right foot planted, twisted medially, heard pop and had immediate pain of the medial knee…") these versions appear interchangeable. The employer's records verified the claimant clocked in to work a shift the evening of April 1 and he never worked for the employer again. Independent confirmation the injury occurred on April 1 was supplied by the personal observation of the coworker present on that shift. The ALJ did not assign the same degree of credibility to the dates accompanying the Kaiser record or the claimant's testimony pertinent to the Kaiser visit. Were he to do so, the ALJ would necessarily have been required to disregard the dating of Dr. Vanderhorst's records, the testimony of the coworker and the employer's attendance records. In addition, the respondent seeks to ignore the attribution by the Kaiser record to work as the source of the injury. When faced with inconsistencies in the evidentiary record, the ALJ is charged with resolving the conflict. The ALJ did so in this matter and we cannot say his method was arbitrary or without sufficient support from the record.

We may not interfere with the ALJ's assessment of the probative value of the evidence. *See Eisnach v. Industrial Commission*, 633 P.2d 502 (Colo. App. 1981). Further, the respondents' argument notwithstanding, the ALJ need not address every piece of evidence if the basis of the order is clear from the findings, as they are here, and evidence not addressed was presumably rejected as not persuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Consequently, we perceive no error in the ALJ's decision to find the claim for a meniscus injury to the claimant's right knee occurred on April 1, 2016, while the claimant was at work for the employer. Accordingly, the ALJ's direction that the respondents pay temporary benefits from that date until December 1 and provide necessary medical treatment shall remain undisturbed.

IT IS THEREFORE ORDERED that the ALJ's order issued August 8, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

12/13/17 by TT .

THE MINTZ LAW FIRM, Attn: HUNTER HOLLEY ESQ, 605 PARFET STREET SUITE 102, LAKEWOOD, CO, 80215 (For Claimant)
WORKERS COMPENSATION UNIT, Attn: SYKE K MEYERS ESQ, C/O: ASSISTANT ATTORNEY GENERAL, 1300 BROADWAY 10TH FLOOR, DENVER, CO, 80203 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-007-733-03

IN THE MATTER OF THE CLAIM OF:

BARTOLOMEU MONOPOLI,

Claimant,

v.

FINAL ORDER

HOBBY LOBBY STORES, INC.,

Employer,

and

INDEMNITY INSURANCE COMPANY OF NORTH AMERICA,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Cannici (ALJ) dated July 27, 2017, that dismissed his claim for benefits. We affirm the decision of the ALJ.

The claimant asserts he sustained an injury to his left leg at work on December 10, 2015. The claimant worked in the employer's stock room unloading inventory from truck deliveries. The claimant did not request a copy of the transcript of the July 5, 2017, hearing to assist in his appeal. The ALJ summarized the claimant's testimony to state that the claimant was working early on the morning of December 10 when a cart was pushed into him from behind. The claimant was noted to explain that the cart hit him at knee height. He said he experienced pain in his knee and yelled. As the day progressed, the claimant related that his feet began to hurt and it became difficult for him to walk. The claimant eventually complained to his supervisor on December 17 that his feet were swollen and he needed to take three days off from work. The supervisor approved his leave request. The claimant however, never returned to work. On January 15, 2016, the claimant wrote a letter to his supervisor advising that the claimant had injured his left foot at work between November 13 and December 4, 2015.

The claimant went to an Urgent Care clinic for treatment on December 29, 2015. The record from that visit describes a condition of bilateral leg pain accompanied by

swelling and itching. The claimant specifically complained of pain in his left ankle. The cause was said to be standing and walking. The claimant described an incident four weeks previously where he was moving boxes from one area to another. The Urgent Care report diagnosed only edema (swelling) of the left lower extremity.

The claimant later treated on his own at a Kaiser Permanente clinic on January 15, 2016. The Kaiser report of that date indicated the claimant complained of bilateral foot pain and left ankle pain. An X-ray was obtained and the claimant was diagnosed with plantar fasciitis, an inflammation of the ligaments in the sole of the foot. The claimant returned to the clinic on April 6, 2016. A second X-ray on that date revealed a healing posterior malleolar fracture in the left ankle which was determined to not have been present on the January 15 X-ray. An MRI study completed at the Kaiser clinic on June 24, 2016, was read to show either a diffuse case of osseous necrosis or a diffuse impaction injury but it ruled out a fracture.

The claimant filed an application for a hearing requesting medical benefits and temporary total disability benefits. He proceeded to hearing on July 5, 2017, without the benefit of counsel.[1]

The respondents presented the testimony of Dr. Roth. The ALJ noted that Dr. Roth had reviewed the claimant's medical records. The doctor was found by the ALJ to have testified that the records showed the claimant did not sustain an acute injury to his legs and that his symptoms are not related to his work activities. Dr. Roth pointed out that a collision with a cart at knee level was unlikely to cause foot and heel pain. He explained that the June 24 MRI did not find any fracture. Instead, Dr. Roth expressed the opinion that the symptoms afflicting the claimant were most likely a disease process or vascular impairment of his lower extremity function.

The ALJ ruled the claimant had not established a connection between the disability in his legs and any circumstances of his work for the employer. The ALJ credited the testimony of the claimant's supervisor that the claimant had not reported an injury in December and had not mentioned it to anyone else at work. The ALJ pointed to the medical records, which indicated no evidence of an acute injury. Those records also

[1] On October 26, 2017, we remanded the matter to the ALJ noting that the claimant's exhibits entered into the record at the hearing were not present in the record submitted for review. The respondents supplied a copy of the absent exhibits to the ALJ. On November 16, 2017, the ALJ directed the staff of the Office of Administrative Courts to return the case to us after including the exhibits supplied. The claimant has responded to our order of remand by stating there was tampering with the exhibits or a deliberate deletion of exhibits. However, the claimant does not express any objection to the exhibits presented by the respondents on remand.

contained no reference to any incidents at work, which the claimant identified as a cause of his symptoms. The ALJ found persuasive the testimony of Dr. Roth which expressed the view that the medical records not only did not reveal an acute injury to the claimant's legs but that they verified the claimant suffered from swelling in both feet which persisted long after the alleged date of injury. Dr. Roth explained the medical evidence supported a conclusion that the claimant suffered from a vascular compromise of his legs, which was not related to his work for the employer. The ALJ denied and dismissed his claim for medical and temporary total disability benefits.

On appeal, the claimant disputes the ALJ's factual findings related to his description of the mechanism of the injury and the details of his reporting of the injury. The claimant contends the medical testimony of Dr. Roth was poor and could have been presented by any medical school graduate. The claimant complains that, despite being subpoenaed, an individual identified as Jake Johnson did not attend the hearing.

The claimant, as the party seeking review, is responsible for presenting a record sufficient to demonstrate error, and assertions contained in his brief may not substitute for that which must appear of record. *Fleet v. Zwick,* 994 P.2d 480, 483 (Colo. App. 1999); *Subsequent Injury Fund v. Gallegos,* 746 P.2d 71 (Colo. App. 1987). Consequently, in the absence of a transcript we must presume that the ALJ's factual determinations are supported by substantial evidence in the record. *Nova v Industrial Clam Appeals Office*, 754 P.2d 800 (Colo. App. 1988).

There is no indication in the record as to who Jake Johnson is or what his testimony may have been. Similarly, there is no evidence the claimant brought to the ALJ's attention the absence of Mr. Johnson or that he sought any postponement, post-hearing deposition or other relief from the ALJ. The party offering rebuttal evidence "must demonstrate that the evidence is relevant to rebut a specific claim, theory, witness or other evidence of the adverse party." *Larsen v. Archdiocese of Denver*, 631 P.2d 1163 (Colo. App. 1981) (where no formal offer of proof, reviewing court cannot determine without such offer whether claimed error is prejudicial), *People v. Welsh*, 80 P.3d 296, 304 (Colo.2003). Without a record containing these items, we are unable to entertain any review of the claimant's contentions of procedural error. Thus, the claimant has not established a basis for reversing the ALJ's order on this ground.

Where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove a causal relationship between a work-related injury and the condition for which benefits or compensation are sought. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997).

Pursuant to §8-41-301(1) (c), C.R.S., a disability is compensable if it is shown that it was "proximately caused by an injury . . . arising out of and in the course of the employee's employment." To establish that an injury arose out of an employee's employment, there must be 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. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999). In reaching a conclusion concerning causation, the ALJ may make reasonable inferences from the circumstantial evidence presented. See *Electric Mutual Liability Insurance Co. v. Industrial Commission*, 154 Colo. 491, 391 P.2d 677 (1964). Furthermore, it is the prerogative of the ALJ to resolve conflicts in the evidence and determine the credibility of witnesses and the probative value of the evidence. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). So long as such determination is supported by substantial evidence in the record, it is binding on review. *See May D & F v. Industrial Claim Appeals Office*, 752 P.2d 589 (Colo. App. 1988). Substantial evidence is probative evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding, without regard to the existence of contradictory or contrary inferences. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). *Ackerman v. Hilton's Mech. Men*, 914 P.2d 524, 527-28 (Colo. App. 1996).

Under this standard, we must defer to the ALJ's assessment of the sufficiency and probative weight of the evidence. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). Further, we may not interfere with the ALJ's credibility determinations except in the extreme circumstance where the evidence credited is so overwhelmingly rebutted by hard, certain evidence that the ALJ would err as a matter of law in crediting it. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986); *Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997). Claimant's arguments notwithstanding, we perceive no extreme circumstances here.

The ALJ found compelling the testimony of the claimant's supervisor that the claimant did not report an injury occurring at work until many weeks after he last worked for the employer. The ALJ also credited the supervisor's description of his interviews with the claimant's coworkers. These discussions included no mention of previous complaints by the claimant describing an injury at work. The ALJ reviewed the medical records submitted by both parties. The ALJ observed those records did not correspond to the claimant's account of a cart colliding with his legs at knee level. The ALJ found compelling the testimony of Dr. Roth. That testimony indicated the medical records did not lend credibility to the claimant's account of his injury. Dr. Roth stated that, in the

alternative, the records verified that the claimant was beset by an age related vascular dysfunction in his lower extremities. This last malady led Dr. Roth to conclude the source of the claimant's symptoms was not work related. Relying on these records and this testimony, the ALJ ruled the claimant failed to meet his burden of proof that his left leg condition was related to a December, 2015 work incident.

We have reviewed the order and the record provided and we do not perceive reversible error. To the extent the ALJ relied on the evidence provided by the testimony of Dr.Roth that the claimant's leg injury was not caused by the conditions of his employment, the ALJ's decision is a reasonable conclusion for the ALJ to draw.

The credibility attributed to expert medical opinion on the issue of causation is within the ALJ's province as fact-finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). Here, the ALJ credited the respondents' expert and resolved the conflicts in the evidence in favor of the respondents and we perceive no basis on which to disturb his resolution. Section 8-43-301(8), C.R.S. We may not interfere with the ALJ's assessment of the probative value of the evidence. *See Eisnach v. Industrial Commission*, 633 P.2d 502 (Colo. App. 1981). Further, the claimant's argument notwithstanding, the ALJ need not address every piece of evidence if the basis of the order is clear from the findings, as they are here, and evidence not addressed was presumably rejected as not persuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Consequently, we perceive no error in the ALJ's decision to find the claim for a left leg or foot injury not compensable and to deny the request for benefits.

IT IS THEREFORE ORDERED that the ALJ's order issued July 27, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

12/1/17 by TT .

BARTOLOMEU MONOPOLI, 3720 W 68TH AVE #325, WESTMINSTER, CO, 80030 (Claimant)
POLLART MILLER LLC, Attn: R JAKE JOHNSON ESQ, 5700 S QUEBEC ST SUITE 200, GREENWOOD, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-006-922-03

IN THE MATTER OF THE CLAIM OF:

HOLLY R. OUELLETTE,

Claimant,

v.

FINAL ORDER

UPS,

Employer,

and

LIBERTY MUTUAL,

Insurer,
Respondents.

The claimant seeks review of a supplemental order of Administrative Law Judge Edie (ALJ) dated September 19, 2017, that denied the claimant's request for temporary total disability and medical benefits. We affirm the order of the ALJ.

The claimant, a 20 year old package handler for the employer, slipped on ice in the employer's parking lot on February 3, 2016. The claimant fell onto her low back, rear and tail bone. The fall occurred at the conclusion of the claimant's shift at approximately 8:45 a.m. The claimant then proceeded to attend school classes. By the end of the day the claimant testified she experienced pain in her tailbone. The claimant reported the injury to the employer the next day and elected to treat with SCL Physicians.

The medical records from SCL indicate the claimant treated primarily with Dr. Ogrodnick. X-rays and MRIs of the claimant's low back did not reveal any signs of injury. The claimant's original complaints were recorded as pertaining to soreness in the sacrum. The claimant was returned to work with a lifting restriction of 30 pounds. The employer accommodated this limitation by providing a largely seated job. Over the next several weeks the claimant's complaints escalated and became widely disbursed. She described numbness in her arms and right leg. The claimant noted urinary incontinence, right hip and knee pain. She reported fatigue, blurred vision, joint pain, dizziness, headaches and memory loss. Subsequent X-rays did not explain these symptoms. The claimant was provided physical therapy but the therapy did not result in improvement of

these subjective symptoms. Dr. Ogrodnick raised her work restriction to no lifting over 50 pounds and then it was reduced again to 35 pounds. The claimant left work with the employer on March 23, 2016, when she was informed she would need to be approved for full duty work before her employment could resume.

The respondents filed a Notice of Contest in April, 2016. As a consequence, the SCL clinic ceased to schedule any further appointments for the claimant. Dr. Ogrodnick acknowledged at the time his treatment ceased there were no objective findings to substantiate the claimant's symptoms. However, he maintained the work restrictions, had pending treatment recommendations and had not made a decision the claimant was at maximum medical improvement (MMI).

The respondents arranged for the claimant to be evaluated by Dr. D'Angelo in August, 2016. Dr. D'Angelo reviewed an extensive list of prior medical records beginning when the claimant was 14 years old. The records indicated the claimant was treated between 2009 and 2014 for feet pain, cervical subluxations, right trapezius pain, headaches, low back pain radiating down her leg, thoracic pain, lumbar pain, bilateral shoulder soreness, left knee swelling, ankle pain, bunions, left wrist pain, left hip and low back pain, depression and suicide ideation. Pertinent to her February, 2015 injury, Dr. D'Angelo examined the various histories the claimant provided her treaters. These suggested the claimant provided inconsistent explanations of the timing, location and nature of her symptoms. Dr. D'Angelo surmised the versions provided by the claimant were not only internally inconsistent, but also at odds with objective medical tests and physiological observations. Dr. D'Angelo concluded the claimant was legitimately at MMI for her fall on the ice at work. The only diagnosis attributed to that fall was a contusion of the coccyx and myofascial pain in the lumbar and sacral regions. Otherwise, Dr. D'Angelo characterized the claimant's symptoms to be the result of a somatic symptom disorder. Neither further medical treatment nor work restrictions were deemed justified by the work injury.

Dr. D'Angelo also reviewed records associated with a motor vehicle accident experienced by the claimant. On March 30, 2016, the claimant was rear ended in a low speed collision. Subsequent to the accident the claimant reported symptoms similar to those she described after her fall at work. She complained of low back pain down to the tailbone and radiating into her right leg. In addition, Dr. D'Angelo consulted records created by a Licensed Professional Counselor (LPC) who had treated the claimant for post traumatic stress disorder in 2014-15. The diagnosis of PTSD was reported to be caused by traumatic abuse and neglect inflicted by the claimant's parents.

The claimant sought a review of her condition by Dr. Mechanic. Dr. Mechanic acknowledged he was not provided an extensive amount of the claimant's prior records to review. The doctor determined the claimant's fall at work led to her pain complaints relative to her low back as well as to her right arm and leg numbness. He recommended an electromyogram and nerve conduction studies of the arm and leg to allow development of further therapy.

Seeking an award of temporary disability benefits and medical benefits, the claimant requested a hearing which occurred on February 14, 2017. The claimant testified as did Dr. Mechanic and Dr. D'Angelo. Subsequent to the hearing the ALJ ruled the claimant did sustain an injury at work on February 3, 2016, in the form of a contusion to her coccyx with some myofascial irritation. However, the ALJ found particularly persuasive the testimony of Dr. D'Angelo that characterized this February 3 injury as very limited in its significance and one that resolved without medical treatment within a few weeks. The ALJ adopted the view of Dr. D'Angelo that following the results of several medical diagnostic studies which showed no particular injury due to the claimant's fall in February, the claimant's work injury had resolved and no further medical treatment was necessary. Prior to the claimant's departure from work on March 23, the ALJ deemed the claimant's February 3 injury to have resolved. The claimant's absence from work after that date was reasoned by the ALJ to be unrelated to her fall of February 3. The ALJ considered evidence and testimony pertinent to the claimant's March 30, 2016, motor vehicle accident, as well as a similar rear end collision the claimant encountered on October 11, 2016. The ALJ concluded it was probable those accidents represented the cause of many of the claimant's symptoms. The ALJ also observed the claimant suffered from a somatoform disorder which caused the claimant to express chronic physical complaints that are derived from psychological stressors. The somatoform disorder was noted to be unaffected by the claimant's fall at work. Accordingly, the ALJ denied the claimant's request for additional medical treatment and for temporary disability benefits.

On appeal, the claimant contends the ALJ disregarded substantial evidence to arrive at his findings. Dr. Ogrodnick's letter of October 9, 2016, letter stating he had outstanding recommendations is asserted to have been ignored by the ALJ. The ALJ is claimed to be mistaken in holding that the claimant's motor vehicle accidents severed the causal relationship between the claimant's fall at work and her symptoms of disability. The claimant maintains the ALJ did not rely on evidence that contradicted the claimant's testimony she missed work as a consequence of her work injury. We are not persuaded.

The respondents are liable for medical treatment, which is reasonably necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S.; *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997); *Country Squire Kennels v. Tarshis*, 899 P.2d 362 (Colo. App. 1995). Where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove a causal relationship between a work-related injury and the condition for which benefits or compensation are sought. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997).

Pursuant to §8-41-301(1) (c), C.R.S., a disability is compensable if it is shown that it was "proximately caused by an injury . . . arising out of and in the course of the employee's employment." To establish that an injury arose out of an employee's employment, there must be 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. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999). In reaching a conclusion concerning causation, the ALJ may make reasonable inferences from the circumstantial evidence presented. *See Electric Mutual Liability Insurance Co. v. Industrial Commission*, 154 Colo. 491, 391 P.2d 677 (1964). Furthermore, it is the prerogative of the ALJ to resolve conflicts in the evidence and determine the credibility of witnesses and the probative value of the evidence. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). So long as such determination is supported by substantial evidence in the record, it is binding on review. *See May D & F v. Industrial Claim Appeals Office*, 752 P.2d 589 (Colo. App. 1988). Substantial evidence is probative evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding, without regard to the existence of contradictory or contrary inferences. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). *Ackerman v. Hilton's Mech. Men*, 914 P.2d 524, 527-28 (Colo. App. 1996).

Under this standard, we must defer to the ALJ's assessment of the sufficiency and probative weight of the evidence. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). Further, we may not interfere with the ALJ's credibility determinations except in the extreme circumstance where the evidence credited is so overwhelmingly rebutted by hard, certain evidence that the ALJ would err as a matter of law in crediting it. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986); *Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997). Claimant's arguments notwithstanding, we perceive no extreme circumstances here.

The ALJ did not make a specific finding pertinent to the October 9, 2016, letter of Dr. Ogrodnick. However, that letter does not serve to disagree with the findings of the ALJ. The doctor observes that "Given her atypical complaints with no objective substantiation, her prognosis was for delayed recovery." The doctor continued by explaining "Nevertheless further treatment was being recommended back in April, in part, to provide the standard of care." The referenced treatments were neurology and physiatry consults. In summary, the further treatment consisted of additional diagnostic inquiries. The doctor concludes by noting "These do not correspond to objective findings as there are no objective findings." In his letter, Dr. Ogrodnick confirmed there is no support for any particular therapy to alleviate the claimant's condition. After three months, the doctor was still unable to specify a diagnosis which corresponded to both the mechanism of the claimant's fall at work and her multifaceted symptoms. Whereas the doctor is hopeful further evaluations may somehow resolve the discrepancy between the two, the ALJ concluded, instead, that they were irreconcilable. The October 9 letter however, offers no reason for the ALJ to conclude otherwise.

The ALJ ruled no further medical treatment was justified due to the resolution of the claimant's injury within a few weeks. This finding could be seen as a functional finding of MMI. If that were the finding of the ALJ, it would be in error. As noted in *Lissauer v. Arapahoe House*, W.C. No. 4-208-121 (November 26, 1997), the ALJ is without authority to end entitlement to medical benefits prior to a determination by an authorized treating physician that the claimant has reached MMI. We have also determined in *Garret v. MeNelly Construction Co*., W.C. No 4-734-158 (May 17, 2011), that a finding by an ALJ that a compensable injury was limited to only certain body parts is not an adjudication which easily lends itself as issue preclusion defense to a later determination in the same case that other body parts are involved and require medical treatment. This is due to the absence of an 'identical' issue or similarity between the previously determined issues and a subsequent development in the claimant's condition which involves other body parts or a worsening of the claimant's condition. *Goff v. Schwan's Home Services, Inc*., W.C. No. 4-97-447-921-03 (August 9, 2017). We imply instead, that the ALJ in this matter was ruling that "at this time," the claimant's work related injury did not require further medical treatment and does not necessarily mean any future recommendations for treatment are barred.

The claimant has misread the ALJ's discussion pertinent to her motor vehicle accidents on March 30 and October 11, 2016. The ALJ did rule that the claimant's symptoms for which she complained at the hearing were most likely due to these accidents. However, he also ruled that the claimant's work injury had resolved prior to March 23. Therefore, when the claimant began missing work on that date the ALJ

reasoned it was not on account of her fall at work. Accordingly, when the claimant encountered her car accident a week later, there was no causal relationship to sever.

The claimant's assertion the ALJ made insufficient findings to explain his rejection of the claimant's testimony concerning her relation of her fall at work to her inability to perform her job is difficult to understand. The ALJ devoted numerous paragraphs in both his Findings of Fact and in his Conclusions of Law setting forth the evidence he found credible pertinent to the cause of the claimant's symptoms. The ALJ found the testimony of Dr. D'Angelo authoritative, in contrast to that of the claimant or of Dr. Mechanic, which he did not find persuasive. Dr. D'Angelo explained that injuries to the spine result in immediate symptoms. Therefore, the delayed manifestation by the claimant of subjective symptoms were noted as unlikely to be related to the fall at work. The claimant underwent an X-ray of the spine, two MRIs of that area, an X-ray of the hips and a CT scan of the spine. Dr. D'Angelo described how none of these revealed any acute injuries to those areas. F of F 42, C of Law I. The inconsistency of the claimant's complaints, such as an unreliable limp, or pain symptoms belied by full range of motion measurements, similarly indicated disconnection between the claimant's fall and her perceived symptoms. Dr. D'Angelo indicated the claimant's prior medical records revealed a lifelong pattern of multiple physical complaints without accompanying objective diagnosis. C. of Law J. This signaled to the doctor the claimant persisted in a somatoform pain disorder not caused or related to her work episode. F of fact 33, C. of Law J. By February 21 and 22, 2016, Dr. D'Angelo believed the claimant should have been discharged from care because by that date the MRI studies verified the absence of any acute injury to the claimant's spine. C. of Law 44. The ALJ relied on these conclusions as justification for his determination the claimant's work injury had resolved at least by March 23 when the claimant left work, if not earlier. C. of Law I, L, O, and U.

The credibility attributed to expert medical opinion on the issue of causation is within the ALJ's province as fact-finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). Here, the ALJ credited the respondents' experts and resolved the conflicts in the evidence in favor of the respondents and we perceive no basis on which to disturb his resolution. Section 8-43-301(8), C.R.S. We may not interfere with the ALJ's assessment of the probative value of the evidence. *See Eisnach v. Industrial Commission*, 633 P.2d 502 (Colo. App. 1981). Further, the claimant's argument notwithstanding, the ALJ need not address every piece of evidence if the basis of the order is clear from the findings, as they are here, and evidence not addressed was presumably rejected as not persuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Consequently, we perceive no error in the

ALJ's decision to find the claim for temporary disability benefits and further medical benefits unjustified.

We have reviewed the order and the record provided and we do not perceive reversible error. To the extent the ALJ relied on the evidence provided by the testimony of Dr. D'Angelo that the claimant's injury was of very limited duration and had resolved before the claimant missed time from work or underwent more than a few weeks of medical treatment, the ALJ's decision is a reasonable judgment for the ALJ to reach.

IT IS THEREFORE ORDERED that the ALJ's order issued September 19, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

12/22/17 by TT .

THE MCDIVITT LAW FIRM, Attn: NICOLE B SMITH ESQ, 19 EAST CIMARRON, COLORADO SPRINGS, CO, 80903 (For Claimant)
LEE & KINDER LLC, Attn: MATT B BOATWRIGHT ESQ, C/O: KATHERINE MARKHEIM LEE ESQ, 3801 EAST FLORIDA AVENUE SUITE 210, DENVER, CO, 80210 (For Respondents)

DATE FILED: November 16, 2017
CASE NUMBER: 2017CA294

SUMMARY
November 16, 2017

2017COA145

No. 17CA0294, *Berthold v. ICAO* — Workers' Compensation — Authorized Treating Physician — Change of Physician

In this workers' compensation action, a division of the court of appeals considers the effect of the claimant's approved request to begin treatment with a new physician. Specifically, did her treatment with her newly approved physician automatically terminate her first physician's status as an authorized treating physician? The division answers "no." In reaching this conclusion, the division holds that the automatic termination provision of section 8-43-404(5)(a)(VI)(B), C.R.S. 2017, applies only to a request to change a treating physician made after the effective date of that provision. The division furthers hold that section 8-43-404(5)(a)(IV) applies only to changes of physician obtained under section 8-43-404(5)(a)(III).

Because the claimant's request to change her physician predated section 8-43-404(5)(a)(VI)(B), and because the request was not granted under section 8-43-404(5)(a)(III), her treatment with her new physician did not automatically terminate her first physician's status as an authorized treating physician. Therefore, the division affirms the order of the Industrial Claim Appeals Office

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Court of Appeals No. 17CA0294
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-956-601

Judy Berthold,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, Eberl's Claim Service, and Liberty Mutual Insurance,

Respondents.

ORDER AFFIRMED

Division V
Opinion by JUDGE NAVARRO
Román and Ashby, JJ., concur

Announced November 16, 2017

Burg Simpson Eldredge Hersh & Jardine, P.C., Nickolas D. Fogel, Nelson Boyle, Stephan J. Marsh, Englewood, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Ruegsegger Simmons Smith & Stern, LLC, Michele Stark Carey, Denver, Colorado, for Respondents Eberl's Claim Service and Liberty Mutual Insurance

¶ 1 In this workers' compensation action, Judy Berthold (claimant) challenges an order of the Industrial Claim Appeals Office (Panel). To resolve claimant's challenge, we must consider the effect of her approved request to begin treatment with a new physician. Specifically, did her treatment with her newly approved physician automatically terminate her first physician's status as an authorized treating physician (ATP)? The answer matters because her first physician opined that claimant had reached maximum medical improvement (MMI) *after* claimant had begun treating with her new physician. If her first physician was no longer an ATP at the time of this MMI finding, claimant's employer could not properly rely on that finding.

¶ 2 To answer the broader query, we must address two subsidiary questions of first impression. First, does newly enacted section 8-43-404(5)(a)(VI)(B), C.R.S. 2017 — which automatically terminates the relationship between an ATP and an injured worker upon treatment with a new ATP — apply retroactively to a request to change physicians made *before* the statutory provision took effect? Second, if it does not apply retroactively, does the termination provision contained in section 8-43-404(5)(a)(IV) apply

to all changes of physician or is it limited to changes made under section 8-43-404(5)(a)(III) "within ninety days after the date of the injury"?

¶ 3 We hold that the termination provision of section 8-43-404(5)(a)(VI)(B) applies only to a request to change a treating physician made after the effective date of that provision. We further hold that section 8-43-404(5)(a)(IV) applies only to changes of physician obtained under section 8-43-404(5)(a)(III). Because claimant's request to change her physician predated section 8-43-404(5)(a)(VI)(B), and because the request was not granted under section 8-43-404(5)(a)(III), her treatment with her new physician did not automatically terminate her first physician's status as an ATP. We therefore affirm the Panel's order.

I. Factual and Procedural History

¶ 4 Claimant worked as a property damage adjuster for Eberl's Claim Service (employer). In June 2014, she sustained injuries from falling off a roof she was inspecting for employer.

¶ 5 After the accident, claimant received medical care from Dr. Anjmun Sharma, an ATP. Several months later, claimant requested and received permission to begin treatment with

Dr. William Miller. Dr. Miller evaluated her for the first time in February 2015. Yet, even after the agreed-upon change of claimant's physician, employer periodically sent her to Dr. Sharma for "demand appointments."

¶ 6 In January 2016, Dr. Sharma saw claimant and reported that she "was noncompliant in presenting for functional capacity evaluation and noncompliant in her completion of this task. I have, therefore, assigned maximum medical improvement [MMI] date as of 01/22/2016 with this report serving as the final dictated report for this claim." Dr. Miller, however, disagreed with Dr. Sharma's MMI determination, criticizing it for lacking "medicolegal sense." Despite this disagreement between medical practitioners, employer filed a final admission of liability (FAL) based on Dr. Sharma's MMI conclusion.

¶ 7 Claimant challenged the FAL's validity on the ground that, under section 8-43-404(5)(a)(IV)(C), Dr. Miller's assumption of her care in February 2015 automatically terminated Dr. Sharma's status as her ATP, rendering him unqualified to issue an MMI finding. As a result, she argued, the FAL was invalid and she was entitled to continuing temporary total disability benefits. Employer

countered that section 8-43-404(5)(a)(IV)(C)'s automatic termination provision applied only to so-called "one-time" changes of physician permitted by section 8-43-404(5)(a)(III). And claimant's change of physician did not satisfy section 8-43-404(5)(a)(III).

¶ 8 The administrative law judge agreed with claimant, finding that Dr. Sharma's status as claimant's ATP terminated when she began treating with Dr. Miller, per section 8-43-404(5)(a)(IV)(C). The Panel reached the opposite conclusion, however, and agreed with employer that section 8-43-404(5)(a)(IV)(C) applied only if the worker sought a change of physician under section 8-43-404(5)(a)(III). The Panel further held that the termination provision in section 8-43-404(5)(a)(VI)(B), enacted in 2016, did not apply either because that provision was not in effect when claimant changed physicians.

II. Claimant's Contentions

¶ 9 Claimant contends that employer erred in relying on Dr. Sharma's MMI finding when issuing the FAL because Dr. Sharma was no longer an ATP at the time of his MMI determination. She presents two theories in support: (1) her treating relationship with Dr. Sharma was automatically terminated

by section 8-43-404(5)(a)(IV) because it applies to all changes of physician; and (2) even if section 8-43-404(5)(a)(IV) does not apply to her change of physician, her relationship with Dr. Sharma was nonetheless terminated by recently amended section 8-43-404(5)(a)(VI).

¶ 10 Because claimant concedes that her physician change occurred under section 8-43-404(5)(a)(VI), we begin by assessing whether the new termination provision of sub-subparagraph (VI)(B) applies to claimant's change.

III. Does the Termination Provision Added to Section 8-43-404(5)(a)(VI) in 2016 Apply to Claimant's Change of Physician?

¶ 11 In 2016, the General Assembly amended section 8-43-404(5)(a)(VI) to add, among other things, a provision automatically terminating an injured worker's relationship with an ATP once the worker begins treating with a new ATP. Claimant argues that the legislative declaration accompanying this amendment requires it to apply to all workers' compensation claims and, thus, it should apply to all changes of physician regardless of the date of the change. Claimant is mistaken. Even where an amendment to the workers' compensation law applies to a claim

regardless of the date of injury, the amendment does not necessarily apply to all transactions within that claim. Instead, the amendment applies only to transactions occurring *after* the amendment's effective date unless the legislature clearly directs otherwise, which the legislature did not do in the amendment at issue.

A. Relevant Statutory Provisions

¶ 12 In 2014, when claimant sustained her work-related injury, the Workers' Compensation Act (Act) provided a means of changing physicians under section 8-43-404(5)(a)(VI):

> In addition to the one-time change of physician allowed in subparagraph (III) of this paragraph (a), upon written request to the insurance carrier or to the employer's authorized representative if self-insured, an injured employee may procure written permission to have a personal physician or chiropractor treat the employee. If permission is neither granted nor refused within twenty days, the employer or insurance carrier shall be deemed to have waived any objection to the employee's request. Objection shall be in writing and shall be deposited in the United States mail or hand-delivered to the employee within twenty days.

§ 8-43-404(5)(a)(VI), C.R.S. 2014. Notably, this version of subparagraph (VI), the mechanics of which had not changed since

the Act's 1990 reenactment, did not contain a provision terminating a claimant's relationship with a prior ATP upon a claimant's examination with a new ATP. Consequently, the Panel had held that the mere selection or designation of a new ATP under subparagraph (VI) did not have the effect of "deauthorizing" the previously authorized ATP. *Jeppsen v. Huerfano Med. Ctr.*, W.C. No. 4-440-444, 2003 WL 22997979 (Colo. I.C.A.O. Dec. 17, 2003); *Granger v. Penrose Hosp.*, W.C. No. 4-351-885, 1999 WL 603156 (Colo. I.C.A.O. July 20, 1999).

¶ 13 In 2016, the legislature amended subparagraph (VI) to include automatic termination language as well as other criteria and consequences of a physician change under this subparagraph:

> (VI)(A) In addition to the one-time change of physician allowed in subparagraph (III) of this paragraph (a), upon written request to the insurance carrier or to the employer's authorized representative if self-insured, an injured employee may procure written permission to have a personal physician or chiropractor treat the employee. The written request must be completed on a form that is prescribed by the director. If permission is neither granted nor refused within twenty days after the date of the certificate of service of the request form, the employer or insurance carrier shall be deemed to have waived any objection to the employee's request. Objection

shall be in writing on a form prescribed by the director and shall be served on the employee or, if represented, the employee's authorized representative within twenty days after the date of the certificate of service of the request form. . . .

(B) If an injured employee is permitted to change physicians under sub-subparagraph (A) of this subparagraph (VI) resulting in a new authorized treating physician who will provide primary care for the injury, *then the previously authorized treating physician providing primary care shall continue as the authorized treating physician providing primary care for the injured employee until the injured employee's initial visit with the newly authorized treating physician, at which time the treatment relationship with the previously authorized treating physician providing primary care is terminated.*

(C) Nothing in this subparagraph (VI) precludes any former authorized treating physician from performing an examination under subsection (1) of this section.

(D) If an injured employee is permitted to change physicians pursuant to sub-subparagraph (A) of this subparagraph (VI) resulting in a new authorized treating physician who will provide primary care for the injury, then the opinion of the previously authorized treating physician providing primary care regarding work restrictions and return to work controls unless that opinion is expressly modified by the newly authorized treating physician.

Ch. 272, sec. 4, § 8-43-404(5)(a)(VI), 2016 Colo. Sess. Laws 1129 (emphasis added). The amended statute went into effect July 1, 2016. *See* Ch. 272, sec. 5, 2016 Colo. Sess. Laws 1129.

B. The 2016 Amendment Does Not Apply to Claimant's Change

¶ 14 Claimant first saw Dr. Miller in February 2015, nearly a year and a half before the 2016 amendment went into effect. *See id.* Yet, claimant argues that the termination provision in section 8-43-404(5)(a)(VI)(B) should apply to her claim because the legislature declared that the 2016 amendment applies to all claims. Claimant rightly observes that the legislature prefaced the amendment with the declaration "that this act contains changes to existing law that are procedural and *apply to all workers' compensation claims, regardless of the date the claim was filed*." Ch. 272, sec. 1, 2016 Colo. Sess. Laws 1127 (emphasis added). But, is this declaration sufficient to apply the amendment to completed transactions that occurred before the amendment took effect? We conclude that it is not.

¶ 15 "A statute is applied prospectively if it operates on transactions that occur after its effective date; it is applied retroactively if it operates on transactions that have already

occurred or on rights and obligations that existed before its effective date." *Specialty Rests. Corp. v. Nelson*, 231 P.3d 393, 399 (Colo. 2010). "Absent legislative intent to the contrary, a statute is presumed to be prospective in its operation." *Id.* at 402. "In workers' compensation cases, the substantive rights and liabilities of the parties are determined by the statute in effect at the time of a claimant's injury, while procedural changes in the statute become effective during the pendency of a claim." *Am. Comp. Ins. Co. v. McBride*, 107 P.3d 973, 977 (Colo. App. 2004). Hence, absent language expressing a contrary intent, a substantive amendment to the Act applies prospectively only to injuries sustained after the amendment's effective date. *See Rosa v. Indus. Claim Appeals Office*, 885 P.2d 331, 334 (Colo. App. 1994) ("[T]he general rule [is] that the rights and liabilities of the parties are determined by the statute in effect at the time of injury, except that procedural changes may be immediately applied to ongoing claims for benefits.").

¶ 16 "Statutes cannot be construed in such a way as to defeat obvious legislative intent, and the best guide to intent is the declaration of policy which forms the initial part of an enactment."

Walgreen Co. v. Charnes, 819 P.2d 1039, 1044 (Colo. 1991) (citation omitted). Contrary to claimant's contention, however, we do not view the legislative declaration here as clearly and unambiguously applying the amendment to completed transactions. The declaration states only that it applies to all workers' compensation claims. We must decide, then, if the legislature intended the amendment to apply not only to all claims but also to completed transactions within those claims.

¶ 17 This question is governed by the principles discussed in *Specialty Restaurants*, as the Panel and the parties have recognized. In that case, the supreme court analyzed a 2007 amendment to section 8-43-406, C.R.S. 2017, governing lump sum payments. The amendment "increased the maximum aggregate lump sum an employee may receive." *Specialty Rests.*, 231 P.3d at 395. The increased maximum lump sum went into effect just months after the claimant, Stephanie Nelson, had received a lump sum payment for her claim. After the amendment's effective date, she requested the difference between the lump sum she received and the newly adopted maximum aggregate payment. *Id.* at 396.

¶ 18 The legislation analyzed in *Specialty Restaurants* did not include a legislative declaration specifying whether the increase to the statutory maximum aggregate lump sum payment applied prospectively or retroactively, nor did it include an effective date for the amendment's adoption. The legislation merely stated that the amendment was approved May 30, 2007. *See* Ch. 341, 2007 Colo. Sess. Laws 1475. Nelson's employer argued that permitting her to receive the increased aggregate lump sum violated the legislature's intent to apply the amendment only to injuries occurring after the amendment's adoption. The supreme court disagreed. The court concluded that the amendment was merely "procedural in nature" because it did not create, eliminate, or modify vested rights or liabilities. *Specialty Rests.*, 231 P.3d at 399-400. As a result, the legislature intended the amendment to apply to all claims irrespective of the date of an employee's injury. *Id.* at 402.

¶ 19 But the supreme court clarified that, while the procedural amendment applied to all claims, the legislature did not express a clear intent to apply the amendment retroactively — i.e., to completed transactions. *Id.* So, the amendment applied only to transactions that occurred after its effective date. *Id.* In Nelson's

case, her injury and claim predated the amendment's enactment, but the transaction in question (her request for an additional lump sum payment under the new cap) occurred after the amendment's effective date. Because her request came after the amendment's effective date, the request could be considered under the newly increased aggregate cap:

> Because the lump sum provision only functions where an employee has affirmatively chosen to elect a lump sum payment, the operative transaction is the employee's request for such payment. . . . [T]he new $60,000 maximum aggregate operates on Nelson's request for the additional lump sum payment — a transaction occurring after the amendment's enactment. Accordingly, the 2007 amendment is prospective in its operation and applies to all requests for lump sum payments made after the amendment's date of enactment, irrespective of the date of injury.

Id. at 402-03 (citation omitted).

¶ 20 The same is true here. As in *Specialty Restaurants*, the 2016 amendment to section 8-43-404(5)(a)(VI) is procedural in nature because it does not create, eliminate, or modify vested rights or liabilities. And the legislature clearly intended this procedural amendment to apply to all claims. But, as in *Specialty Restaurants*,

the legislature did not clearly express the intent to apply the amendment to completed transactions within those claims. So, the amendment applies only prospectively to transactions taking place after the amendment's effective date.

¶ 21 The 2016 amendment went into effect well after claimant began treating with her physician, Dr. Miller. She requested the change of physician — the "operative transaction" in the parlance of *Specialty Restaurants* — in late 2014. Likewise, Dr. Sharma's MMI finding and employer's FAL preceded the amendment by months. In other words, all the transactions pertinent to claimant's change from Dr. Sharma to Dr. Miller occurred *before* the 2016 amendment to section 8-43-404(5)(a)(VI)(B).

¶ 22 Hence, when employer granted claimant permission to treat with a new ATP under section 8-43-404(5)(a)(VI)(A) and employer later issued the FAL, employer could reasonably presume that Dr. Sharma continued as one of claimant's ATPs, based on prior Panel decisions. As noted, the Panel had long held that the authorization of a new ATP in such circumstances did not terminate a claimant's relationship with a previously authorized ATP. *See*

Jeppsen, 2003 WL 22997979; *Granger*, 1999 WL 603156.[1] To alter the effect of employer's authorizing a new ATP — years after the fact — could upset the parties' reasonable expectations.

¶ 23 In sum, the Panel correctly concluded that the amendment applies to all pending claims but should be applied only to requests for changes of physician made after the amendment's effective date. *See also Zerba v. Dillon Cos.*, 2012 COA 78, ¶ 37 ("[W]e give deference to the Panel's reasonable interpretations of the statute it administers."). Therefore, new section 8-43-404(5)(a)(VI)(B) does not terminate claimant's relationship with Dr. Sharma or invalidate employer's FAL.

IV. Does Section 8-43-404(5)(a)(IV) Apply to Claimant's Change of Physician?

¶ 24 As discussed, claimant was granted a change of physician under section 8-43-404(5)(a)(VI)(A). We have determined that the

---

[1] Although most Panel decisions addressing this issue predate the 2007 amendment adding section 8-43-404(5)(a)(III)-(IV), *see* discussion *infra* Part IV, the Panel has not repudiated its position since that amendment. On the contrary, the Panel recently reiterated that the addition of a new ATP does not automatically terminate a prior physician's status as an ATP, at least outside the context of a change permitted by subparagraph (III). *See Mohammed v. Cargill Meat Sols.*, W.C. No. 4-951-860-03, 2016 WL 439788 (Colo. I.C.A.O. Jan. 27, 2016).

automatic physician termination provision of newly amended section 8-43-404(5)(a)(VI)(B) does not apply retroactively to this change. An amendment is presumed to change the law. *See City of Colorado Springs v. Powell*, 156 P.3d 461, 465 (Colo. 2007). So, we presume that, before the enactment of section 8-43-404(5)(a)(VI)(B), a change of physician granted under section 8-43-404(5)(a)(VI)(A) did not automatically terminate an injured worker's treating relationship with her prior physician.

¶ 25 Notwithstanding this presumption, claimant contends that her change of physician under section 8-43-404(5)(a)(VI)(A) automatically terminated her relationship with her prior ATP because of the physician termination provision of section 8-43-404(5)(a)(IV). The Panel disagreed and held that section 8-43-404(5)(a)(IV) applies only to changes of physician obtained under section 8-43-404(5)(a)(III). Under section 8-43-404(5)(a)(III), a claimant, within the first ninety days after sustaining an injury, may request a "one-time" change of physician to another on the employer's physician list. Claimant argues that the Panel erred because subparagraph (IV) should be read independently of subparagraph (III) and, thus, should apply to *all* changes of

physician. We disagree because subparagraphs (III) and (IV) are intertwined and claimant has not rebutted the presumption that the 2016 amendment to subparagraph (VI) changed the law.

A. Relevant Statutory Provisions

¶ 26 In pertinent part, section 8-43-404(5)(a) provides:

> (III) An employee may obtain a one-time change in the designated authorized treating physician under this section by providing notice that meets the following requirements:
>
> (A) The notice is provided within ninety days after the date of the injury, but before the injured worker reaches maximum medical improvement;
>
> (B) The notice is in writing and submitted on a form designated by the director. The notice provided in this subparagraph (III) shall also simultaneously serve as a request and authorization to the initially authorized treating physician to release all relevant medical records to the newly authorized treating physician.
>
> (C) The notice is directed to the insurance carrier or to the employer's authorized representative, if self-insured, and to the initially authorized treating physician and is deposited in the United States mail or hand-delivered to the employer, who shall notify the insurance carrier, if necessary, and the initially authorized treating physician;
>
> (D) The new physician is on the employer's designated list or provides medical services for

> a designated corporate medical provider on the list;
>
> (E) The transfer of medical care does not pose a threat to the health or safety of the injured employee;
>
> . . . .
>
> (IV)(A) When an injured employee changes his or her designated authorized treating physician, the newly authorized treating physician shall make a reasonable effort to avoid any unnecessary duplication of medical services.
>
> . . . .
>
> (C) The originally authorized treating physician shall continue as the authorized treating physician for the injured employee until the injured employee's initial visit with the newly authorized treating physician, *at which time the treatment relationship with the initially authorized treating physician shall terminate*.
>
> (D) The opinion of the originally authorized treating physician regarding work restrictions and return to work shall control unless and until such opinion is expressly modified by the newly authorized treating physician.

(Emphasis added.) The provision at issue — the physician termination provision — is italicized. Subparagraphs (III) and (IV) were enacted together via a 2007 amendment. *See* Ch. 204, sec. 1, § 8-43-404(5)(a), 2007 Colo. Sess. Laws 763-66.

B. Because Subparagraphs (III) and (IV) Work Together, Subparagraph (IV) Does Not Apply to Claimant's Change

¶ 27 Section 8-43-404(5)(a)(IV) does not expressly state that it applies only when an injured employee makes a change of physician under section 8-43-404(5)(a)(III). Claimant maintains, therefore, that section 8-43-404(5)(a)(IV)(C) terminates the relationship between an "initially authorized treating physician" and an injured employee whenever the claimant begins treating with a new ATP. Although we appreciate claimant's position, we cannot accept it.

¶ 28 We review statutes de novo. *Ray v. Indus. Claim Appeals Office*, 124 P.3d 891, 893 (Colo. App. 2005), *aff'd*, 145 P.3d 661 (Colo. 2006). When analyzing a provision of the Act, "we interpret the statute according to its plain and ordinary meaning" if the language is clear. *Davison v. Indus. Claim Appeals Office*, 84 P.3d 1023, 1029 (Colo. 2004). And "we give effect to every word and render none superfluous because we 'do not presume that the legislature used language idly and with no intent that meaning should be given to its language.'" *Lombard v. Colo. Outdoor Educ. Ctr., Inc.*, 187 P.3d 565, 571 (Colo. 2008) (quoting *Colo. Water*

Conservation Bd. v. Upper Gunnison River Water Conservancy Dist., 109 P.3d 585, 597 (Colo. 2005)).

¶ 29 We also give deference to the Panel's reasonable interpretations of the Act. *Sanco Indus. v. Stefanski*, 147 P.3d 5, 8 (Colo. 2006); *Dillard v. Indus. Claim Appeals Office*, 121 P.3d 301, 304 (Colo. App. 2005), *aff'd*, 134 P.3d 407 (Colo. 2006). Although we are not bound by the Panel's interpretation or its earlier decisions, *Olivas-Soto v. Indus. Claim Appeals Office*, 143 P.3d 1178, 1180 (Colo. App. 2006), we follow the Panel's interpretation unless "it is inconsistent with the clear language of the statute or with the legislative intent." *Support, Inc. v. Indus. Claim Appeals Office*, 968 P.2d 174, 175 (Colo. App. 1998).

¶ 30 If we were to consider section 8-43-404(5)(a)(IV) in isolation, we might agree with claimant because that provision seems to apply to all changes of physician. But "we cannot read statutory language in isolation from its context." *Berges v. Cty. Court*, 2016 COA 146, ¶ 10. Rather, we must view the Act as a whole and strive to harmonize its provisions because "[a] comprehensive statutory scheme should be construed in a manner which gives consistent, harmonious, and sensible effect to all parts of the statute." *Salazar*

v. Indus. Claim Appeals Office, 10 P.3d 666, 667 (Colo. App. 2000). Claimant's proposed interpretation does not harmonize all provisions of the statute.

¶ 31 As employer notes, the termination provision added to section 8-43-404(5)(a)(VI) in 2016 mirrors that in subparagraph (IV). Employer maintains that it would not have been necessary for the legislature to add parallel termination language to sub-subparagraph (VI)(B) if the termination language in sub-subparagraph (IV)(C) already applied to all changes of physician.

¶ 32 We agree with employer. To harmonize the statute, we must read it as interpreted by employer and the Panel. Claimant's interpretation would render superfluous the termination provision of subparagraph (VI). And if the legislature in 2016 had intended merely to clarify that subparagraph (IV) also applied to changes of physician granted under subparagraph (VI), the legislature could have simply said so. Instead, the legislature enacted a new set of provisions applicable to changes of physician granted under subparagraph (VI). This legislative labor would have been entirely unnecessary if subparagraph (IV) already applied to changes of physician granted under subparagraph (VI). We cannot adopt a

reading of the statute that "would render parts of it meaningless and without effect." *Keel v. Indus. Claim Appeals Office*, 2016 COA 8, ¶ 43.

¶ 33 Employer also points to particular language in section 8-43-404(5)(a) that confirms that subparagraphs (III) and (IV) work in tandem. Specifically, employer underscores the repetition of words and phrases found only in subparagraphs (III) and (IV) that indicates the legislature intended to limit the termination provision of subparagraph (IV) to "one-time" changes of physician under subparagraph (III). For instance, "designated authorized treating physician" is used in subparagraphs (III) and (IV) but nowhere else in the statute. Repeating "designated authorized treating physician" in subparagraph (IV) after using the term for the first time in subparagraph (III) strongly suggests that the legislature intended subparagraphs (III) and (IV) to work together.

¶ 34 Similarly, the legislature used the adverbs "initially" and "originally" in subparagraphs (III) and (IV) to distinguish a claimant's first authorized treating physician from the "newly authorized treating physician." As with "designated authorized treating physician," the phrases "originally authorized treating

physician" and "initially authorized treating physician" appear nowhere else in the statute. In contrast, sub-subparagraph (VI)(B) addresses the termination of a claimant's treating relationship with her "previously authorized treating physician."

¶ 35 The repetition of identical phrases in subparagraphs (III) and (IV) indicates that the legislature intended that the phrases should be applied uniformly in both subsections. *See People v. Rediger*, 2015 COA 26, ¶ 31 ("[W]e must ascribe the same meaning to the same words occurring in different parts of the same statute, unless it clearly appears therefrom that a different meaning was intended[.]" (quoting *Everhart v. People*, 54 Colo. 272, 276, 130 P. 1076, 1078 (1913))) (*cert. granted* Feb. 16, 2016). Conversely, "the use of different terms signals an intent on the part of the General Assembly to afford those terms different meanings." *Carlson v. Ferris*, 85 P.3d 504, 509 (Colo. 2003).

¶ 36 Consequently, we cannot ignore the legislature's use of "designated authorized treating physician" and "initially" or "originally authorized treating physician" in section 8-43-404(5)(a)(III) and (IV), as compared to its use of "previously authorized treating physician" in section 8-43-404(5)(a)(VI). By

drawing these distinctions, the legislature signaled that subparagraphs (III) and (IV) apply early in the claim process — when a claimant may still be treating with the "initially" or "originally" designated treating physician — while subparagraph (VI) covers other situations in which a claimant may seek to change physicians.

¶ 37 Although the plain language of the provisions, when read in context, is sufficient to resolve this appeal, we also note that the legislative history of this amendment confirms our interpretation. *See Specialty Rests.*, 231 P.3d at 400-01 ("Our plain language interpretation of the 2007 amendment as procedural in nature is supported . . . by the legislative history of the amendment."). Representative Morgan Carroll, the sponsor of the 2007 amendment that added subparagraphs (III) and (IV), explained that the purpose of subparagraph (IV) was to include the "criteria for transfer of care" occasioned by the change of physician permitted under subparagraph (III). Hearings on H.B. 07-1176 before the H. Business Comm., 66th Gen. Assemb., 1st Sess. (Mar. 5, 2007). Representative Carroll's statement corroborates our analysis that subparagraphs (III) and (IV) were intended to work in tandem, and

supports our conclusion that subparagraph (IV) does not operate to terminate any physician-patient relationships except those ended by a change of physician under subparagraph (III).

¶ 38 Because claimant's change of physician from Dr. Sharma to Dr. Miller was not granted under section 8-43-404(5)(a)(III), section 8-43-404(5)(a)(IV) did not automatically terminate her relationship with Dr. Sharma when she began treating with Dr. Miller. Therefore, employer's FAL was not invalid simply because it was based on Dr. Sharma's MMI determination.[2]

V. Conclusion

¶ 39 The Panel correctly interpreted section 8-43-404(5)(a). Neither the termination provision of sub-subparagraph (IV)(C) nor the termination provision of sub-subparagraph (VI)(B) applies to claimant's request to change physicians. We agree with the Panel that section 8-43-404(5)(a)(IV)(C) applies only to one-time changes of physician permitted under subparagraph (III) and that section 8-43-404(5)(a)(VI)(B)'s termination provision applies prospectively to requests for changes of physician made after the amendment's

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[2] We express no opinion on whether claimant may still challenge Dr. Sharma's MMI determination by requesting a division-sponsored independent medical examination.

effective date. As a result, employer's FAL was not invalid on the ground raised by claimant. The Panel's decision is affirmed.

JUDGE ROMÁN and JUDGE ASHBY concur.

COLORADO COURT OF APPEALS

DATE FILED: November 22, 2017
CASE NUMBER: 2016CA2236

Court of Appeals No. 16CA2236
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-991-171

Denise Heinz,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, State Farm Mutual Automobile Insurance Company, and Indemnity Insurance Company of North America,

Respondents.

ORDER AFFIRMED

Division VII
Opinion by JUDGE FREYRE
J. Jones and Fox, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced November 22, 2017

Richard K. Blundell, Greeley, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Pollart Miller LLC, Brad J. Miller, Greenwood Village, Colorado, for Respondents State Farm Mutual Automobile Insurance Company and Indemnity Insurance Company of North America

¶ 1 Claimant, Denise Heinz, challenges the statutory process for selecting a physician to perform a division-sponsored independent medical examination (DIME). She contends that the process unfairly harms injured workers by failing to ensure the selection of specialists to perform DIMEs. She further contends that she should have been awarded penalties because State Farm Mutual Automobile Insurance Company (employer) did not have a "good faith" basis to dispute the medical conclusions of her authorized treating physician (ATP). We affirm the final order of the Industrial Claim Appeals Office (Panel) dismissing Heinz's statutory challenge for lack of finality and rejecting her claim to penalties.

I. Background

¶ 2 In 2014, Heinz sustained an admitted work-related injury to her lower back when she tripped over an uneven door jam. She did not fall, but in catching herself, injured her left lower back.

¶ 3 Dr. John Charbonneau served as Heinz's ATP and evaluated her injury. Dr. Charbonneau referred Heinz to a rehabilitation specialist, Dr. Gregory Reichhardt. Dr. Reichhardt concluded that her work-related injuries resulted in a fifteen percent whole person impairment. He also opined that Heinz reached maximum medical

improvement (MMI) on July 13, 2015. Dr. Charbonneau issued a report on July 30, 2015, agreeing with Dr. Reichhardt's MMI and impairment conclusions and adopting them.

¶ 4 One week later, on August 7, 2015, employer filed a notice and proposal to select a DIME to evaluate Dr. Charbonneau's findings. Because the parties could not agree on a physician to perform the proposed DIME, employer filed an application for a DIME with the division of workers' compensation on October 9, 2015.

¶ 5 Heinz filed at least five applications for hearing between October 2015 and February 2016 challenging employer's DIME request. As pertinent here, Heinz challenged the "propriety of DIME panel selection and physician specialties, contrary to [her] DIME rights as expressed in *[Colo.] AFL-CIO v. Donlon*[, 914 P.2d 396 (Colo. App. 1995),] and *Whiteside v. Smith*, [67 P.3d 1240 (Colo. 2003),] contrary to [her] true treatment and diagnostic needs and extent of his (sic) occupational impairments and to hold the DIME process in abeyance per *Jesus Munoz v. [Indus. Claim Appeals Office]*, 271 P.3d 547 (Colo. App. 2011)." Additionally, Heinz listed "other issues to be heard," including the question "[t]o determine propriety and

effect of Respondents' preemptive and belated bogus DIME application." She also requested penalties against employer.

¶ 6 After conducting a hearing, an administrative law judge (ALJ) found that Heinz failed to establish an entitlement to penalties against employer. The ALJ further ruled that Heinz had not shown that, by requesting the DIME, employer had "acted in bad faith or that it failed to follow statutorily prescribed procedure to preserve the right to a Division IME in this case." The Panel agreed and affirmed the ALJ's decision. Heinz now appeals.

II. Analysis

¶ 7 As we understand Heinz's arguments, she makes two related contentions on appeal: (1) employer acted improperly by requesting a "preemptive DIME" without demonstrating a good faith basis to challenge the ATP's impairment rating or MMI date; and (2) employer acted in bad faith by requesting the DIME in violation of the implied duty of good faith and fair dealing incorporated into its workers' compensation insurance and, hence, into all its actions, including requesting a DIME. Heinz essentially challenges the propriety of the DIME selection process. She argues that failing to include a "competent and qualified" health care provider in a DIME

panel "precludes . . . claimants from obtaining an objective, unbiased determination of . . . [their] diagnostic and treatment needs."[1] These arguments do not persuade us to set aside the Panel's decision.

A. Propriety of the DIME Selection Process Not Final

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[1] In her opening brief, Heinz also alleges that the selection process is "contrary to . . . [her] due process, equal protection and property rights." However, she clarifies in her response brief that she is not "raising a constitutional challenge to the DIME process." We will not address the constitutionality of the DIME selection process because she has withdrawn any such challenge. *See In re Marriage of Morton*, 2016 COA 1, ¶ 37 (declining to address request for attorney fees raised in briefs that was later withdrawn at oral argument). In any event, even if she had not withdrawn it, her argument is conclusory and underdeveloped. *See Mauldin v. Lowery*, 127 Colo. 234, 236, 255 P.2d 976, 977 (1953) ("Our Court will not search through briefs to discover what errors are relied on, and then search through the record for supporting evidence. It is the task of counsel to inform us, as required by our rules, both as to the specific errors relied on and the grounds and supporting facts and authorities therefor."); *Meza v. Indus. Claim Appeals Office*, 2013 COA 71, ¶ 38 ("Given the dearth of legal grounds offered to set aside the ALJ's denial of maintenance benefits beyond the arguments already discussed, we decline to address maintenance benefits further."); *Antolovich v. Brown Grp. Retail, Inc.*, 183 P.3d 582, 604 (Colo. App. 2007) (declining to address "underdeveloped arguments"). Moreover, Heinz faults employer for not calling its endorsed witnesses at the hearing. However, she cites no authority requiring employer to do so, and the record shows that the fact that the witnesses were not at the hearing was due to her failure to subpoena them.

¶ 8 Heinz first challenges the DIME selection process, suggesting that the failure to ensure the inclusion of specialists on DIME panels harms claimants. Employer counters that this argument lacks the requisite finality for appellate review. Employer points out that "the portion of the ALJ's order regarding the propriety of the DIME panel selection process does not award or deny a benefit" and therefore is not a final, appealable order. Indeed, the ALJ dismissed the contention because no relief could be granted in conjunction with it:

> The Claimant has failed to prove the Respondents failed to follow the statutorily prescribed procedure to preserve the right to a Division IME in this case. The Claimant also failed to prove that the DIME unit failed to comply with its procedures or that Dr. Thurston is not qualified to perform the DIME. Therefore, the Claimant failed to raise an issue upon which an administrative law judge could grant relief and the Claimant's issues of propriety of the DIME Application and propriety of the DIME selection and physician specialties are dismissed.

As the Panel noted, orders resolving a dispute concerning the make-up of a DIME panel "are in the nature of evidentiary rulings and are therefore, interlocutory." The Panel accordingly declined to address this issue on review.

¶ 9 "To be final, an order must grant or deny benefits or penalties. Where an order neither awards nor denies benefits, it is merely interlocutory and is 'not ripe for appellate review.'" *Flint Energy Servs., Inc. v. Indus. Claim Appeals Office*, 194 P.3d 448, 449-50 (Colo. App. 2008) (citation omitted) (quoting *U.S. Fid. & Guar., Inc. v. Kourlis*, 868 P.2d 1158, 1163 (Colo. App. 1994)). We agree with the ALJ's and the Panel's assessment: until the DIME is completed and an order denying or awarding benefits associated with that DIME is issued, Heinz's contention that the DIME panel selection process harmed her is not final and appealable. Thus, to the extent she challenges the DIME selection process in general, we agree with the Panel that that portion of the order is not reviewable.

B. Penalties for Employer's Alleged Failure to Act in Good Faith When Requesting DIME

¶ 10 Heinz next asserts that employer failed to act in good faith in commencing the DIME procedure. Although it is not entirely clear that this contention is associated with her request for penalties, the Panel treated it as such. To the extent Heinz contends that she was wrongly denied penalties on this basis, we will address the issue. *See Flint Energy*, 194 P.3d at 449-50.

1. Standard of Review

¶ 11 When reviewing an ALJ's grant or denial of penalties, we are bound by the ALJ's factual determinations if supported by substantial evidence in the record. § 8-43-308, C.R.S. 2017; *Christie v. Coors Transp. Co.*, 919 P.2d 857, 860 (Colo. App. 1995), *aff'd*, 933 P.2d 1330 (Colo. 1997). Consequently, "[w]e review the determination of the amount of the penalty for an abuse of discretion." *Crowell v. Indus. Claim Appeals Office*, 2012 COA 30, ¶ 19.

¶ 12 To the extent Heinz contends that the ALJ's and the Panel's determination that employer did not violate a provision of the Act misinterprets it, she raises a question of law which we review de novo. *See Pena v. Indus. Claim Appeals Office*, 117 P.3d 84, 86 (Colo. App. 2004).

2. ALJ Did Not Abuse Discretion by Denying Claimant Penalties

¶ 13 The selection of a physician to perform a DIME is governed by the applicable workers' compensation rules of procedure. In general, if the parties cannot agree on a physician to perform the DIME, the Division of Workers' Compensation will provide the parties with the names of three potential DIME physicians who can

evaluate the injured worker. Dep't of Labor & Emp't Rule 11-3(C), 7 Code Colo. Regs. 1101-3. Each party in turn strikes one candidate; the remaining physician then performs the DIME. Dep't of Labor & Emp't Rule 11-3(G), 7 Code Colo. Regs. 1101-3. "Additionally, if a physician is removed from the three-physician panel for any reason other than having been struck by one of the parties, the Division will issue one replacement name using the same criteria and process set forth in section 11-3(C), above." *Id.*

¶ 14 Any party wishing to challenge a DIME physician's qualifications, or to raise any objections to the DIME, may file a motion seeking relief. Filing a motion concerning a pending DIME holds the DIME "in abeyance until the Division IME Unit is notified of the disposition as provided in this rule." Dep't of Labor & Emp't Rule 11-3(O), 7 Code Colo. Regs. 1101-3. Any disputes concerning the DIME process that the parties are unable to resolve "may be taken to an administrative law judge for resolution." Dep't of Labor & Emp't Rule 11-10, 7 Code Colo. Regs. 1101-3.

¶ 15 Heinz applied for a hearing under these rules to contest employer's DIME request. She argued that employer was required to act in good faith and with fair dealing when it requested a DIME.

Specifically, she alleged that employer did not have a good faith basis for requesting a DIME and therefore should have accepted Dr. Charbonneau's MMI and impairment finding.

¶ 16 The governing statute provides that "[i]f any party disputes a finding or determination of the authorized treating physician, such party shall request the selection of an IME." § 8-42-107.2(2)(b), C.R.S. 2017. Employers must request a DIME within thirty days of "the date of mailing or delivery of the disputed finding or determination." *Id.*

¶ 17 Here, Heinz does not dispute that employer complied with these statutory requirements. Indeed, she does not point to any statute or rule employer allegedly violated in asking for the DIME.

¶ 18 To successfully seek penalties under the Workers' Compensation Act (Act), Heinz had to show that employer (1) violated a provision of the Act; (2) committed an act prohibited by the Act; "(3) faile[d] or refuse[d] to perform any duty lawfully mandated within the time prescribed by the director or the Panel; or (4) fail[ed], neglect[ed], or refuse[ed] to obey any lawful order of the director or the Panel." *Pena*, 117 P.3d at 87; *see also* § 8-43-304(1), C.R.S. 2017.

¶ 19 Moreover, Heinz's burden of proof in establishing entitlement to penalties required her to show that, in seeking a DIME without an alleged "good faith" belief that her injuries were less severe than determined by the ATP, employer failed to take an action that a reasonable insurer would have taken in similar circumstances. *See Paint Connection Plus v. Indus. Claim Appeals Office*, 240 P.3d 429, 435 (Colo. App. 2010) (employer violated the Act by submitting a final admission of liability that did not comply with section 8-43-203(2)(b)(II), C.R.S. 2017). The claimed wrongdoing by employer is "measured by an objective standard of reasonableness." *Jiminez v. Indus. Claim Appeals Office*, 107 P.3d 965, 967 (Colo. App. 2003). And, employer's actions were reasonable if they were predicated on a rational argument based in law or fact. *Id.* Whether employer's conduct was reasonable is a question of fact for determination by the ALJ. *Pioneers Hosp. v. Indus. Claim Appeals Office*, 114 P.3d 97, 99 (Colo. App. 2005).

¶ 20 The ALJ found that Heinz had not met this burden. Employer complied with the applicable law when it requested a DIME. Moreover, there is no evidence in the record suggesting that a reasonable insurer or employer would have acted differently. We

therefore perceive no basis to set aside the ALJ's factual determination that employer did not violate a statute, rule, or order.

¶ 21 Nevertheless, Heinz contends that employer should have been required to demonstrate a "good faith" basis for requesting a DIME. She concedes that neither the Act nor the rules impose such a requirement, and that no precedential case has ever read such a requirement into the Act. Instead, she asks us to turn to the area of insurance law as the basis for reading a "good faith" requirement into the DIME request process.

¶ 22 Heinz correctly observes that insurers are required to deal in good faith with their insureds and beneficiaries. As our supreme court noted, "the duty of good faith and fair dealing . . . is not limited . . . merely to the claims or cancellation contexts. Instead, the duty, as formulated by the General Assembly, is a broad and wide-ranging one, extending to 'everything pertaining' to the provision of insurance services to the public." *Ballow v. PHICO Ins. Co.*, 875 P.2d 1354, 1363 (Colo. 1993). But, we perceive two hurdles Heinz cannot overcome to imposing this burden on employers requesting a DIME.

¶ 23 First, we are prohibited from reading any provision into the Act. The appellate courts of this state have "uniformly held that a court should not read nonexistent provisions into the . . . Act." *Kraus v. Artcraft Sign Co.*, 710 P.2d 480, 482 (Colo. 1985); *see also Kieckhafer v. Indus. Claim Appeals Office*, 2012 COA 124, ¶ 16. In addition, "[i]n respecting the legislature's phrasing, we do not add words to a statute that simply are not there." *Montez v. People*, 2012 CO 6, ¶ 19. Reading a "good faith" requirement into the DIME process would do just that: read words into the statute that "simply are not there." *Id.*

¶ 24 As the Panel noted, a dispute leading to a DIME request "may be based on tactical motivations as well as on evidentiary, compensatory, or medical disagreements with the ATP. A party need not provide any explanation for the reasoning behind their request for a DIME review."

> Since the Panel is charged with interpreting the statutes and regulations governing the Division of Workers' Compensation, we defer to the Panel's "reasonable interpretations" of its own regulations, and only set aside the Panel's interpretation "if it is inconsistent with the clear language of the statute or with the legislative intent."

Kilpatrick v. Indus. Claim Appeals Office, 2015 COA 30, ¶ 31 (quoting *Zerba v. Dillon Cos.*, 2012 COA 78, ¶ 37). Here, the Panel's interpretation is consistent with the Act, which does not include a requirement that a party have a good faith belief that an ATP's MMI or impairment rating is inaccurate before requesting a DIME. Given the absence of contrary language in the Act or the regulations implementing it, we perceive no reason to stray from the Panel's interpretation.

¶ 25 Second, even if we were inclined to read such a provision into the Act, we cannot say that employer violated it here. As with proving a violation of the Act or rules warranting imposition of penalties, to prove that an insurer acted in bad faith in the workers' compensation context, an insured or beneficiary "must establish that the insurer acted unreasonably and with knowledge of or reckless disregard for the fact that no reasonable basis existed for" acting as it did. *Travelers Ins. Co. v. Savio*, 706 P.2d 1258, 1274 (Colo. 1985). Put another way, "[i]n *Savio*, the supreme court concluded that, in the first-party context, an insured must prove that (1) the insurer's conduct was unreasonable, and (2) the insurer either had knowledge of or reckless disregard for the fact that its

conduct was unreasonable." *Kisselman v. Am. Family Mut. Ins. Co.*, 292 P.3d 964, 970 (Colo. App. 2011).

¶ 26 Here, employer and its insurer adhered to all the statutory and regulatory requirements for requesting a DIME. Nothing in the Act or interpreting regulations requires an employer or an insurer to limit its DIME requests to those situations in which it has a "good faith" belief that the ATP has misstated or overstated a claimant's injury. To the contrary, the Act imposes no limitations on the circumstances under which either party may seek a DIME. Accordingly, given the absence of any such requirement, we cannot say that employer here acted in bad faith, as Heinz implies.

¶ 27 Because the ALJ did not abuse her discretion in denying claimant's request for penalties, we conclude that the Panel did not err in affirming the ALJ's decision.

III. Employer's Request for Attorney Fees

¶ 28 Last, we address employer's request for attorney fees. Employer argues that attorney fees are justified here because the ALJ's and Panel's "orders are plainly correct and the legal authority is clearly contrary to Claimant's position such that there are no appealable issues in this case." Heinz responds that she has

asserted her arguments in a good faith effort to present "genuine legal theories . . . that have not been decided by Colorado courts of record."

¶ 29 We note that, even when a contention is rejected, an appeal is not automatically frivolous and sanctions may be denied. *See Price v. Conoco, Inc.*, 748 P.2d 349, 351 (Colo. App. 1987).

> A claim or defense is frivolous if the proponent can present no rational argument based on the evidence or law in support of that claim or defense. This test . . . does not apply to meritorious actions that prove unsuccessful, *legitimate attempts to establish a new theory of law, or good-faith efforts to extend, modify, or reverse existing law.*

W. United Realty, Inc. v. Isaacs, 679 P.2d 1063, 1069 (Colo. 1984) (emphasis added). Because we cannot conclude that Heinz's contentions presented "no rational argument based on the evidence or the law to support" them or that the claims were "not supported by any credible evidence," and because we are persuaded that her arguments constitute a good faith attempt to change existing law, we decline to award any attorney fees. *Double Oak Constr., L.L.C. v. Cornerstone Dev. Int'l, L.L.C.*, 97 P.3d 140, 151 (Colo. App. 2003); *see also Adams v. Land Servs., Inc.*, 194 P.3d 429, 434 (Colo. App.

2008) (rejecting request for attorney fees because claims were not frivolous).

IV. Conclusion

¶ 30 The Panel's order is affirmed.

JUDGE J. JONES and JUDGE FOX concur.