

# **BROWN BAG SEMINAR**

**Thursday, July 21, 2016**

(third Thursday of each month)

Noon - 1 p.m.

633 17<sup>th</sup> Street

**2nd Floor Conference Room (use elevator near Starbucks)**

1 CLE (including .4 ethics)

Presented by Craig Eley

Prehearing Administrative Law Judge

Colorado Division of Workers' Compensation

Sponsored by the Division of Workers' Compensation

**Free**

This outline covers ICAP and appellate decisions issued through July 15, 2016

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**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-954-271-04

IN THE MATTER OF THE CLAIM OF

BRIAN JOSUE,

Claimant,

v.

FINAL ORDER

ANHEUSER-BUSCH, INC.,

Employer,

and

ACE AMERICAN INSURANCE  
COMPANY,

Insurer,  
Respondents.

The claimant seeks review of an order of Administrative Law Judge Michelle Jones (ALJ) dated January 26, 2016, that granted the respondents' motion for summary judgment and ordered the claimant to repay the overpayment of \$16,222.32. We affirm.

This matter was scheduled to go to hearing on February 9, 2016, on the respondents' application for hearing on the issue of overpayment. Prior to hearing the respondents filed a motion for summary judgement contending that they were entitled to recoup an overpayment of benefits. The claimant objected. The ALJ entered the following facts. The claimant sustained an admitted injury on March 24, 2014, to his right knee. The respondents filed a general admission of liability admitting for temporary partial disability benefits from March 24, 2014 to August 11, 2014 and from October 2, 2014, an ongoing based on the claimant's work restrictions. On February 18, 2015, the claimant underwent a platelet rich plasma (PRP) injection. The respondents then filed a general admission of liability admitting for temporary total disability benefits starting February 18, 2015, based on the recommendation of the doctor who performed the injection.

On March 10, 2015, the respondents filed a petition to terminate temporary disability benefits arguing that the injection was not authorized, reasonable or necessary. The respondents asserted that the claimant was only off work because of the PRP injections and not because of the injury. The matter went to hearing on July 2, 2015, in

front of ALJ Margot Jones on the issues of whether the injection was authorized, reasonable or necessary medical treatment and the respondents' petition to terminate temporary disability benefits as of February 18, 2015.

ALJ Margot Jones issued a summary order finding that the PRP injection was not authorized, reasonable or necessary treatment. The ALJ also found that the claimant was able to work modified duty prior to the injection and that the claimant's wage loss after the injection was solely due to the injection. ALJ Margot Jones consequently found that the claimant was not entitled to temporary total disability benefits beginning February 18, 2015. ALJ Margot Jones granted the respondents' petition to terminate temporary total disability benefits as of February 18, 2015, and to reinstate temporary partial disability benefits from the date of the injection. Neither party appealed the ALJ's order.

The respondents filed an amended final admission consistent with ALJ Margot Jones' opinion and also admitted for a 10 percent scheduled impairment rating. The respondents' listed an overpayment of \$17,676.47, for the temporary total disability they paid to the claimant from February 18, 2015, through July 20, 2015.

In the present order on appeal ALJ Michelle Jones determined that the respondents established that there were no disputed issues of material fact and, therefore, granted the respondents' motion for summary judgement to determine that there was an overpayment of \$16,222.32, based on payment logs, due to the fact that the claimant was not entitled to receive temporary total disability benefits as of February 18, 2015, pursuant to ALJ Margot Jones's order. The ALJ ordered the claimant to repay the overpayment.

On appeal the claimant does not dispute the amount of the overpayment but contends that the claimant was statutorily entitled to receive temporary total disability at the time he received the benefits pursuant to the general admissions filed by the respondents and, the respondents, therefore, may not recover a mistaken payment retroactively. The claimant also contends that the ALJ's order violates the beneficent purpose of the Act by giving retroactive ex post facto effect to an order which did not find an overpayment of benefits. We are not persuaded the ALJ committed reversible error.

Office of Administrative Courts Rule of Procedure Rule (OACRP) 17, allows an ALJ to enter summary judgment where there are no disputed issues of material fact. See OARCP 17, 1 Code Colo. Reg. 104-3 at 7. Moreover, to the extent that it does not conflict with OACRP 17, C.R.C.P 56 also applies in workers' compensation proceedings. *Fera v. Industrial Claim Appeals Office*, 169 P.3d 231 (Colo. App. 2007); *Nova v.*

BRIAN JOSUE

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*Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988) (the Colorado rules of civil procedure apply insofar as they are not inconsistent with the procedural or statutory provisions of the Act).

Summary judgment is a drastic remedy and is not warranted unless the moving party demonstrates that it is entitled to judgment as a matter of law. *Van Alstyne v. Housing Authority of Pueblo*, 985 P.2d 97 (Colo. App. 1999). All doubts as to the existence of disputed facts must be resolved against the moving party, and the party against whom judgment is to be entered is entitled to all favorable inferences that may be drawn from the facts. *Kaiser Foundation Health Plan v. Sharp*, 741 P.2d 714 (Colo. App. 1987). We review the ALJ's legal conclusions de novo in the context of summary judgment. See *A.C. Excavating v. Yacht Club II Homeowners Association*, 114 P.3d 862 (Colo. 2005). Pursuant to § 8-43-301(8), C.R.S., we have authority to set aside an ALJ's order where the findings of fact are not sufficient to permit appellate review, conflicts in the evidence are not resolved, the findings of fact are not supported by the evidence, the findings of fact do not support the order, or the award or denial of benefits is not supported by applicable law. We are not persuaded that the ALJ erred in determining that an overpayment existed.

The claimant argues there is no "overpayment" because the payment of temporary disability was made pursuant to a general admission of liability, the claimant was entitled to receive those payments when they were received and cannot be characterized as an overpayment as described by § 8-40-201(15). We reject the claimant's contention the ALJ erroneously granted retroactive relief from the general admission.

The claimant asserts the court of appeals has never held that benefits paid pursuant to an admission can constitute an "overpayment," nor has the court ever applied retroactive application of an order denying benefits. However, both circumstances existed in the case of *Simpson v. Industrial Claim Appeals Office*, 219 P.3d 354 (Colo. App. 2009), *rev'd in part on unrelated grounds*, 232 P.3d 777 (Colo. 2010). In *Simpson* the Court pointed to the 1997 statutory amendments and to the definition of "overpayment" in § 8-40-201(15.5). The term "overpayment" is defined in § 8-40-201(15.5):

(15.5) "Overpayment" means money received by a claimant that exceeds the amount that should have been paid, or which the claimant was not entitled to receive, or which results in duplicate benefits because of offsets that reduce disability or death benefits payable under said articles. For an

overpayment to result, it is not necessary that the overpayment exist at the time the claimant received disability or death benefits under said articles.

The definition provision was held to refer to three distinct types of overpayments connected as they were by the disjunctive use of the word "or." One of those categories was that an "overpayment" could be found even when there would not have been an overpayment "at the time the claimant received ... benefits." The respondents in *Simpson* were ultimately allowed to recover a past overpayment which had occurred through payments made pursuant to a previous admission by the respondents, by reducing the payment to the claimant of a lump sum award.

Relying on the analysis in *Simpson*, the panel's decision in *Haney v. Shaw, Stone & Webster*, W.C. No. 4-790-763 (July 28, 2011), determined that the overpayment of temporary benefits was subject to recovery from the claimant as an overpayment. The present case is similar to *Haney*. In *Haney*, the claimant was terminated from work by the employer based on his failure to pass a drug test. The respondents had previously filed an admission for ongoing temporary benefits. After a hearing conducted several months after the claimant's termination from work, an ALJ found the claimant was responsible for the loss of his job pursuant to § 8-42-105(4)(a). The order by the ALJ requiring the claimant to repay to the respondents the temporary benefits paid between the date of the termination and the date of his order was affirmed. *See also Mattorano v. United Airlines*, W.C. No. 4-861-370 (July 25, 2013); *Franco v. Denver Public Schools*, W.C. No. 4-818-570 (November 13, 2014).

As support for his contention that the temporary disability paid to the claimant does not constitute an overpayment pursuant to the overpayment statute, the claimant cites to *Rocky Mountain Cardiology v. Industrial Claim Appeals Office*, 94 P.3d 1182 (Colo. App. 2004), *Cooper v. Industrial Claim Appeals Office*, 109 P.3d 1056 (Colo. App. 2005) and *United Airlines v. Industrial Claim Appeals Office*, 312 P.3d 235, (Colo. App. 2013). These cases, however, are distinguishable and do not support the claimant's contention.

In *Rocky Mountain Cardiology* the employer had suspended benefits after the employee failed to attend a medical appointment, but had failed to reinstate benefits once the employee attended a rescheduled appointment. The employer also sought to withdraw a previously filed admission of liability, contending that the claimant did not suffer a work-related injury. A division of the court determined that the employer was bound by a previous admission of liability to pay benefits and was not entitled to withhold payment once the employee kept the rescheduled appointment. However, the employer sought

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relief only as of the date of the hearing and did not seek retroactive relief. The court expressly acknowledged that "... the record here shows that employer sought relief only as of the date of hearing and did not seek retroactive relief." The ALJ and the Court were not asked in *Rocky Mountain Cardiology* to determine if any of the previously admitted and paid temporary benefits would constitute an 'overpayment' pursuant to § 8-40-201(15), C.R.S. In contrast, that is the issue presented to the ALJ here. In *Simpson*, the Court of Appeals explicitly stated that *Rocky Mountain Cardiology* should not be read to prohibit the recovery of benefits incorrectly paid in the past "under an admission of liability..." The court expressly limited that aspect of *Rocky Mountain Cardiology* because in that case "the employer sought only prospective relief." *Simpson v. Industrial Claim Appeals Office*, 219 P.3d at 361.

The claimant also cites to *Cooper v. Industrial Claim Appeals Office, supra.*, which held that a lump sum payment made pursuant to § 8-72-107(8)(d) need not be paid back even in the event the claimant dies shortly after the lump sum payment. The situation in *Cooper* is distinct from that in this case because, as the court noted, there was, in *Cooper*, a specific statutory provision setting forth the requirement to pay a lump sum in a specified amount without reference to the result of subsequent developments in the claim, resulting in the permanent partial disability award vesting. Here, however, the issue concerned whether the claimant was entitled to temporary disability benefits and not whether such benefits had vested.

Finally, the claimant relies on the decision in *United Airlines v. Industrial Claim Appeals Office, supra.* *United Airlines* also dealt with circumstances distinct from those featured here. In *United Airlines*, the Court was asked to determine if temporary benefits received in excess of the \$ 75,000 cap for combined temporary and permanent partial benefits referenced in § 8-42-107.5, could be seen as an overpayment subject to recovery by the respondents. The Court ruled that temporary benefits in that category were not an overpayment. This was based on the conclusion that the benefits cap is generally a limitation on permanent partial disability benefits and not on temporary benefits. The Court pointed out that § 8-42-105(3) is written to insist that temporary benefits "shall" be paid until one of the conditions to stop benefits is present (i.e. attainment of MMI, a return to work, an offer of employment or a release to regular employment). The terms of the cap, however, only applied to combined temporary and permanent partial disability benefits. It applied only to the eligibility for benefits, of either kind, after MMI is attained. In *United Airlines* the claimant's receipt of temporary benefits prior to the date of MMI was never affected by the benefits cap. Those benefits therefore, were not an "overpayment" when received, and would never be an overpayment at any point. This

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result however, was due to a construction of § 8-42-107.5, and not because of any analysis of § 8-40-201(15.5).

The claimant's argument would render useless the amendments made to the statute by H.B. 97-1128. As noted in *Simpson*, these amendments allow for the reopening of an award, regardless of whether the award is through an admission or an order, and provides that money "already paid" through such an award may be affected if that payment qualifies as an "overpayment." The legislation defined 'overpayment' in § 8-40-201(15.5) by using terms indicating the past tense. The term was applied to money "received" by a claimant in excess of what "should have been paid" or "was not" entitled to receive. The amendment did not limit itself to money the claimant "will" receive or "will not" be entitled. The statute also added "overpayment" as a basis for a reopening in § 8-43-303(1) and (2), C.R.S. The change to the reopening statute specifically provides that such a reopening in the case of an overpayment may affect "the earlier award as to money's already paid." The legislation also amended § 8-43-306(1), C.R.S., to provide a collection procedure in regard to overpayments. This section references the collection methods included in the rules of civil procedure for use in collecting District Court judgments. If there was no retroactive application of an overpayment finding, this amendment to § 8-43-306(1), C.R.S., would be unnecessary.

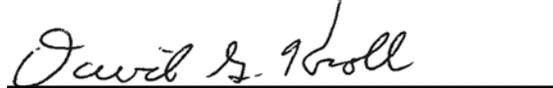
We also are not persuaded by the claimant's argument that imposing an overpayment violates the Act's beneficent purpose. The claimant suggests that the beneficent purpose of the statute requires that the claimant be shown to have knowingly participated in the effort to receive undeserved payments as a prerequisite for an overpayment to be ordered repaid. Nowhere in the statute is such a standard required. The claimant also overlooks advantages provided the claimant to discourage reckless payments by respondents which claimants will later be required to repay. Initially, the allowance of the respondents' ability to correct erroneous payments through reopening does encourage the efficient delivery for the payment of benefits. The respondents will not have the incentive to question every possible payment of indemnity benefits initially. They may instead, agree to pay badly needed temporary benefits because there is provided a correction mechanism through reopening for an overpayment should a mistake later be discovered. However, the claimant attains the advantage of seeing the burden of proof to prove his ineligibility for the benefits placed upon the respondents rather than on himself. §8-43-201(1), C.R.S. The beneficent purpose of the statute is not degraded through the requirement that overpayments be repaid by the claimant. Consequently, we perceive no error in the ALJ's order determining that the claimant received an overpayment in the amount of \$16,222.32 and was required to repay that sum.

BRIAN JOSUE  
W. C. No. 4-954-271-04  
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**IT IS THEREFORE ORDERED** that the ALJ's order dated January 26, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

  
\_\_\_\_\_  
Brandee DeFalco-Galvin

  
\_\_\_\_\_  
David G. Kroll

BRIAN JOSUE  
W. C. No. 4-954-271-04  
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CERTIFICATE OF MAILING

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

\_\_\_\_\_ 6/17/2016 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

LAW OFFICE OF O'TOOLE & SBARBARO, P.C., Attn: NEIL D. O'TOOLE, ESQ., 226  
WEST TWELFTH AVENUE, DENVER, CO, 80204-3625 (For Claimant)

LEE & KINDER, LLC, Attn: TIFFANY SCULLY KINDER, ESQ./KELSEY BOWERS, ESQ.,  
3801 E. FLORIDA AVENUE, SUITE 2100, DENVER, CO, 80210 (For Respondents)

## INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-830-409-07

IN THE MATTER OF THE CLAIM OF

ANTHONY MARCHESI,

Claimant,

v.

CITY AND COUNTY OF DENVER,

Employer,

and

SELF INSURED,

Insurer,  
Respondent.

FINAL ORDER

The respondent seeks review of an order of Administrative Law Judge Felter (ALJ) dated February 16, 2016, that ordered the respondent liable for the cost of a physician's treatment to provide and monitor the claimant's prescription for Cymbalta. We reverse the order of the ALJ.

The claimant sustained a work injury to his back on June 17, 2010. Surgery on the claimant's low back was proposed by a Division Independent Medical Examiner. The respondent disputed the relatedness and necessity of the surgery. In lieu of a hearing, the parties entered into a settlement stipulation on November 12, 2012. The agreement called for the respondent to pay for the surgery as well as temporary disability benefits and for permanent disability benefits related to the back injury. The respondent agreed to pay for medical benefits necessary for the claimant to reach maximum medical improvement (MMI). The stipulation was approved by an ALJ on November 16, 2012. In regard to medical benefits subsequent to MMI, the stipulation contained paragraph 4 (e):

e. In return, claimant agrees to waive post-MMI medical benefits connected with the work injury and back surgery described in paragraph 1 except Cymbalta, (or its generic equivalent) for neuropathic pain so long as this medication is reasonable, necessary, and related to the relief of neuropathic pain caused by the work injury. Claimant will

sign authorizations to release medical information directed to the physician who prescribes the medications for neuropathic pain.

The claimant later moved to Arizona and requested the respondent pay for his visits and treatment with his personal doctor in that state in connection with a prescription for Cymbalta. The respondent declined to do so pointing to paragraph 4 (e) which limited its liability to the cost of the Cymbalta medication and did not include the costs of a doctor's treatment.

A hearing was conducted on the issue on January 26, 2016. The hearing consisted entirely of the submission of written exhibits and oral argument. At the conclusion of the hearing, and later in a written order, the ALJ found that the claimant unambiguously waved his right to his entitlement to post-MMI medical benefits except for Cymbalta. However, the ALJ ruled the respondents were liable pursuant to paragraph 4 (e) for all payments associated with physical or mental health examinations conducted either in-person or via telemedicine for the prescribing, monitoring, and refilling of Cymbalta, or its generic equivalent, to the claimant. The ALJ reasoned any other interpretation of the statutory provision would be contrary to law or public policy because prescribing Cymbalta requires the claimant to establish a physician-patient relationship to avoid unprofessional conduct in violation of Arizona law. Because Cymbalta was a drug only available through a doctor's prescription, the failure of the respondent to pay for a doctor to examine and monitor the claimant's medical condition, so as to allow the doctor to prescribe Cymbalta, would frustrate the claimant's ability to secure Cymbalta and would make paragraph 4 (e) meaningless and incapable of performance.

On appeal, the respondent contends paragraph 4 (e) was specifically negotiated to limit the respondent's liability for post MMI medical treatment to the cost of the Cymbalta drug and not for any attendant medical costs. The respondent points to the language as not being ambiguous and as calling for the waiver of all post MMI medical costs "except Cymbalta." The respondent notes it was aware of the need for physician prescription and monitoring of Cymbalta and it is not seeking to preclude that medical treatment. The respondent maintains that paragraph 4 (e) was negotiated so as to relieve it from liability for that cost.

The claimant argues that the paragraph implies that physician oversight is required and will be part of the cost of providing Cymbalta. The reference to obtaining releases from a prescribing physician is said to imply physician involvement. The claimant asserts the respondent continued to pay for physician's visits after the stipulation was

approved. That course of conduct is argued to require the respondent to continue to pay for physician's services through to the present. The claimant notes any ambiguity should be construed against the party that drafted the contract, which is claimed to be the respondent.

We observe there is no evidence in the record that the respondent continued to pay for physician's costs after the stipulation was approved. The respondent admits one initial doctor visit was paid by mistake after the stipulation because the adjuster was not familiar with the terms of the settlement. Tr. at 20. The claimant did not testify as to any payments and there are no doctors' reports dated after the point of MMI. There is also no evidence as to who drafted paragraph 4 (e). At the hearing, the respondent claimed it was suggested and drafted by the claimant's counsel. Tr. at 19-20. Accordingly, there is no evidence and no agreement to support those two contentions. The ALJ does not indicate he relied on them.

This matter turns upon the interpretation of the settlement agreement between the parties to the claim, a copy of which is contained in the record. The agreement was signed by the parties and approved by an ALJ. The adherence to these formalities makes it binding pursuant to the longstanding requirement that such agreements be approved by the appropriate administrative authority, § 8-43-204(1)-(3) C.R.S. *See, e.g., Industrial Claim Appeals Office v. Orth*, 965 P.2d 1246, 1252 (Colo. 1998) (settlement binding on parties once approved by prehearing administrative law judge on behalf of director); *Employers Mutual Insurance Co. v. Jacoe*, 102 Colo. 515, 517, 81 P.2d 389, 390 (1938); *Industrial Comm'n v. London Guarantee and Accident Co.*, 66 Colo. 575, 577, 185 P. 344, 345 (1919) (settlement not binding on parties until approved by commission).

Settlement agreements are in the nature of contracts and the law governing the construction of contracts applies when interpreting them. *Cary v. Chevron U.S.A., Inc.*, 867 P.2d 117 (Colo. App. 1993). The interpretation of a contract is usually a matter of law and we may determine its meaning de novo, including whether it is ambiguous. *Fiberglas Fabricators, Inc. v. Klyberg*, 799 P.2d 371 (Colo. 1990). If the language used in the agreement is plain, clear and no absurdity is involved, the agreement must be enforced as written. *Three G. Corp. v. Daddis*, 714 P.2d 1333 (Colo. App. 1986). In determining whether a contract provision is ambiguous, the instrument must be construed as a whole and the language must be given a harmonious effect, giving words and phrases their ordinary meanings. *Allstate Insurance Co. v. Avis Rent a Car System, Inc.*, 947 P.2d 341 (Colo. 1997). An ambiguity arises when the contract is "reasonably

susceptible to more than one meaning." *Cheyenne Mountain School District v. Thompson*, 861 P.2d 711, 715 (Colo. 1993), quoting *Northern Ins. Co. of New York v. Ekstrom*, 784 P.2d 320, 323 (Colo. 1989). The claimant and the respondent do not allege that the agreement is ambiguous; however, both parties are persuaded that the agreement supports their conflicting positions.

We agree with the ALJ that the terms of paragraph 4 (e) are not ambiguous. However, we disagree with the meaning assigned to those terms by the ALJ. The first sentence in this paragraph states, in its initial clause "Claimant agrees to waive post-MMI medical benefits connected with the work injury and back surgery ...". The plain and clear meaning of these words excludes any liability for the cost of additional treatment provided by a physician to the claimant after the date of MMI. The clause is followed by one exception: "except for Cymbalta." Cymbalta is then explicitly described as a "medication." The plain meaning of these terms is to specify that the claimant has no ability to receive from the respondent a physician's services after MMI or any other treatment. The one exception is the benefit represented by Cymbalta, a medication. The cost of a medication is clearly distinct from the cost of a doctor's services. After the claimant secures a prescription from his doctor, he will go to a pharmacy and purchase a vial of Cymbalta. The terms of paragraph 4 (e) state that the claimant has waived the benefit represented by the cost of obtaining the doctor's prescription, but has retained the benefit represented by the charge for the container of Cymbalta.

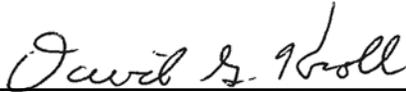
The ALJ describes how a prerequisite to obtaining Cymbalta involves a visit to a doctor to obtain a prescription. But knowledge of that requirement is common to both parties. In spite of that knowledge, the parties did not include any further exception to a waiver of post MMI medical benefits other than the specific liability for the Cymbalta itself. The ALJ finds that without a doctor's prescription this medical benefit for Cymbalta makes paragraph 4 (e) meaningless and incapable of performance. This analysis is mistaken. The claimant is not prohibited from seeing his doctor. It is simply his responsibility to pay for the doctor visit. He may secure payment for the doctor through Medicare, Medicaid, health insurance, veteran's benefits, a medical cost savings account, cash or any other payment method available to him. That is the plain implication of his waiver of post MMI medical benefits. Once he arranges payment for his physician visits, he may take advantage of paragraph 4 (e) by requesting the respondent to pay for the cost of his Cymbalta prescription. This procedure is not unduly complicated or difficult and does not constitute a frustration of the purpose implicated by paragraph 4 (e).

We also note that the requirement in paragraph 4 (e) that the claimant must sign a release for medical records cannot logically be seen as a direction that the respondent is liable for “all payments associated with physical or mental health examinations conducted either in person or via telemedicine for the prescribing, monitoring, and refilling of Cymbalta.”

Accordingly, we conclude that through the settlement the claimant has waived as a medical benefit the costs incurred for physician visits and treatment in this claim.

**IT IS THEREFORE ORDERED** that the ALJ’s order issued February 16, 2016, is reversed and set aside.

INDUSTRIAL CLAIM APPEALS PANEL

  
\_\_\_\_\_  
David G. Kroll

  
\_\_\_\_\_  
Brandee DeFalco-Galvin

ANTHONY MARCHESI  
W. C. No. 4-830-409-07  
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CERTIFICATE OF MAILING

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

\_\_\_\_\_ 6/28/2016 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

BURG SIMPSON ELDREDGE HERSH & JARDINE, P.C., Attn: NICK D FOGEL,  
ESQ/BOBBY D GREENE, ESQ, 40 INVERNESS DRIVE EAST, ENGLEWOOD, CO, 80112  
(For Claimant)

CITY AND COUNTY OF DENVER, Attn: ASHLEIGH M HEFFERNAN, ESQ, OFFICE OF  
THE CITY ATTORNEY - LITIGATION SECTION, 201 WEST COLFAX AVENUE DEPT  
1108, DENVER, CO, 80202 (For Respondents)

ALJ FELTER, % OFFICE OF ADMINISTRATIVE COURTS, ATTN: RONDA MCGOVERN,  
1525 SHERMAN STREET, 4<sup>TH</sup> FLOOR, DENVER, CO 80203

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-962-974-01

IN THE MATTER OF THE CLAIM OF

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

Claimants,

JOSE E. BALQUIER,

Decedent,

v.

ORDER

EVERGREEN CAISSONS, INC.,

Employer,

and

TRAVELERS,

Insurer,  
Respondents.

This matter is before us upon the respondents' motion for reconsideration of our June 2, 2016, order. We deny the motion for reconsideration.

Section 8-43-302 (1) (b), allows the panel to issue a corrected order to correct any errors caused by mistake or inadvertence within 30 days. The respondents request that we reconsider the June 2, 2016, order dismissing the respondents' petition to review without prejudice for lack of a final order. The respondents contend that the recent court of appeals opinion in *Trujillo v. ICAO*, 15 CA 1238 (Colo. App. June, 2, 2016) (*not selected for publication*) compels that the issue in this case should be addressed on the merits of the appeal.

The *Trujillo* case however is distinguishable. In *Trujillo*, the court of appeals determined that an order denying compensability was final and appealable because by denying compensability the order effectively denied the claimant's request for benefits.

JENNIFER M. MUNOZ BOTELLO

W. C. No. 4-962-974-01

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In contrast, in the present case, no benefits have been granted or denied. The ALJ specifically instructed the parties to schedule another hearing to determine the allocation of benefits between the dependents. Accordingly the ALJ's order does not actually award death benefits to the claimant. Under these circumstances the ALJ's order is interlocutory and not currently reviewable. Section 8-43-301(2), C.R.S

**IT IS THEREFORE ORDERED** that the respondents' motion for reconsideration of the June 2, 2016, order is denied.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



Kris Sanko

JENNIFER M. MUNOZ BOTELLO  
W. C. No. 4-962-974-01  
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CERTIFICATE OF MAILING

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

6/29/2016 by RP .

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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. 4-827-378-02

IN THE MATTER OF THE CLAIM OF  
TERRYL ROBINSON,

Claimant,

v.

ORDER

COMPUCREDIT CORP,

Employer,

and

CHARTIS CLAIMS INC,

Insurer,  
Respondents.

The claimant and respondents seek review of an order of Administrative Law Judge Walsh (ALJ) dated September 24, 2015, that ordered the respondents to pay for housekeeping and yard maintenance services for the claimant, and for a walker and a heating pad. The ALJ denied the claimant's request for a walk-in tub, a sleep number mattress, a treadmill and an Aqua Sport Spa. We affirm the order of the ALJ with the exception that the order regarding liability for housekeeping and yard maintenance expense is set aside and that matter is remanded for additional findings.

The claimant injured her low back and neck on December 10, 2009, when she fell on the ice in the employer's parking lot. The claimant worked as a manager at the respondent employer's check cashing store. Prior to her work injury the claimant had undergone a lumbar spine fusion surgery at the L 4-5 level. Following the 2009 work injury the claimant had an additional fusion surgery at the L 3-4 level. In early 2011, the claimant's treating physician, Dr. Rook, advised that the claimant could only function at the sedentary level. The claimant's pleadings and the ALJ's order indicate she lives in a house with her mother and 'significant other', James Cunningham.

On January 10, 2011, Dr. Rook wrote a prescription for the claimant to receive 8 hours per week of service for housekeeping and yardwork. This recommendation was increased on February 21, 2011, to 15 hours a week. In a note from March 20, 2011, Dr. Rook explained that the assistance with housework and yardwork was necessary because

the claimant was not able to manage her home or yard due to the limitations posed by her injury. The recommendation was revised again on December 5, 2011, to require two hours per day for every day of the week for cleaning of the floors, windows, bathrooms, kitchen, vacuuming, doing dishes, laundry, and shopping. The claimant was described as being unable to perform these tasks. Dr. Rook acknowledged the claimant requested a friend, Mr. Cunningham, be designated to perform these activities. The doctor approved that request as long as the friend charged no more than a rate comparable to a cleaning service and that he have medical insurance to cover any injuries. On January 7, 2015, Dr. Rook amended the request to require four hours per day of assistance and to now include also dressing, bathing, and transportation. At the hearing in the claim on July 15, 2015, Dr. Rook testified that the claimant had not been performing the house cleaning or yardwork functions when he recommended assistance with them in 2011 or at any time since. The claimant testified she normally does not need assistance using the toilet, taking a shower, getting out of bed, eating or getting dressed as long as she uses slip on shoes.

A previous surgeon, Dr. Lazar, recommended a wheeled walker for the claimant in 2010. A second surgeon, Dr. Kleiner, prescribed a walk-in tub which did not require the claimant to lift her legs to enter. A moist heating pad the claimant had been using ceased functioning and Dr. Rook suggested a replacement. In 2014, Dr. Rook recommended a treadmill to allow the claimant to strengthen her legs. At that time Dr. Rook additionally prescribed an adjustable mattress for the claimant. In February, 2015, the claimant's personal physician, Dr. Barrick, advised the claimant to acquire an Aquafit Sport therapy tub. This hot tub creates a current allowing for resistance therapy by swimming or walking against the current.

The respondents presented the testimony of Dr. Olsen. Dr. Olsen had previously examined and interviewed the claimant and wrote reports in July, 2011, August, 2011, January, 2012, March, 2013, April, 2014 and May, 2015. Dr. Olsen testified that EMG tests did not indicate the claimant would be sufficiently restricted that she would have difficulty entering and exiting a normal bath tub. The doctor explained the Medical Treatment Guidelines are unable to find that a different mattress, be it hard, soft, or a sleep number mattress, provides any effective relief for a back condition such as the claimant's. Dr. Olsen observed that when he last examined the claimant in 2013, she had arrived without a walker or cane and had no difficulty ambulating. He therefore felt a walker was unnecessary. The doctor noted a mechanized treadmill was actually a hazard for someone with a weakened back due to the likelihood of falling. He suggested a better method for exercise would be to walk outdoors, or in a shopping mall in the case of cold weather. Dr. Olsen advised that the Aquafit tub was inappropriate for the claimant.

Those devices he explained, are designed for athletes with strength beyond that possessed by the claimant. Because they have wider sides the chances of a fall are even more likely than on a treadmill due to the absence of any side rails to hold onto. Dr. Olsen described attendant care services as those pertinent to dressing, toileting functions, transfers in and out of bed or into a tub. He discussed how patients with back fusions have adequate function to not require assistance with these attendant care tasks. In regard to heavier lifting, such as in the case of heavy bags of trash or yard work, it was appropriate for the uninjured members of the household to perform those duties. He did not see indications that claimant was unable to clean a bathroom, change bed sheets or place or remove laundry in a washing machine.

After the conclusion of the hearing, the ALJ ruled the claimant had established the medical necessity for a wheeled walker and a moist heating pad. The ALJ was unpersuaded as to the need for an orthopedic or sleep number mattress, a treadmill, an Aquafit Sport Therapy Spa or a walk in tub. The ALJ resolved it was more likely than not that the claimant required essential services for activities of daily living as recommended by Dr. Rook for four hours per day and seven days per week to be paid at the fee schedule rate beginning September 15, 2015.

The claimant has appealed the decision to deny the provision of a walk in tub, a sleep number mattress, a treadmill and the Acqua Sport Spa. The claimant also requests a walker, however, the ALJ ordered a walker so we decline to discuss that item. The respondents appealed the decision to the extent the ALJ ordered them liable for essential services of daily living for 28 hours per week.

#### I.

The claimant argues on appeal that the treadmill, Acqua Sport Spa and sleep number bed are necessary for the claimant to develop strength in preparation for upcoming repeat surgery on her back. The claimant contends she needs a walk-in tub because she would be subjected to “embarrassment and degradation” should she be required to rely on the physical assistance from an unknown care giver to help her get into a standard bath tub.

Dr. Rook testified the claimant has no surgery scheduled for her back. The ALJ referenced the observation of Dr. Rook that the claimant is only capable of shuffling her feet while walking. The ALJ reasoned in that situation a treadmill would prove useless. The ALJ noted the same would be true in regard to the Aquafit Therapy Spa. He found that the Medical Treatment Guidelines do not support the claimant’s request for a sleep

number mattress. The ALJ concluded that the order for essential services which should include assistance into the bath tub, would render unnecessary a walk-in tub.

The weight and credibility to be assigned expert medical opinion is a matter within the fact-finding authority of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). The ALJ may accept all, part, or none of the testimony of a medical expert. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968); *see also Dow Chemical Co. v. Industrial Claim Appeals Office*, 843 P.2d 122 (Colo. App. 1992) (ALJ may credit one medical opinion to the exclusion of a contrary medical opinion). In addition, the ALJ's plausible inferences may not be disturbed if drawn from substantial evidence in the record. We have no authority to substitute our judgment for that of the ALJ concerning the credibility of witnesses and we may not reweigh the evidence on appeal. *Id.*; *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993).

We cannot say the ALJ here has made a decision not reasonably supported by the record. Here, the ALJ relied on observations from Dr. Rook as well as some from Dr. Olsen. This testimony at the hearing, and the reports of these doctors constitute substantial evidence in the record to support the findings and conclusions of the ALJ. We find no sufficient reason to overturn these decision of the ALJ.

## II.

The respondents contend on appeal that the ALJ's order for essential services is fatally ambiguous and that most of the services potentially included in his order are not intended to cure or relieve the claimant from the effects of her work injury. We conclude the ALJ's weighing of the evidence and his legal conclusions are inadequate to justify the authorization of these activities.

In regard to the recommendation for those tasks characterized as 'essential services', the ALJ found the claimant proved "she required the assistance of others to provide the prescribed essential services," that they were causally related and necessary. The ALJ stated in his conclusions of law that the respondents should be liable to pay for these services for four hours per day, every day, and they should include "all essential services recommended by the authorized treating physicians." These services are to be paid "at the fee schedule rate."

In January and February, 2011, Dr. Rook specified the services to be for housekeeping and yardwork. The claimant proposed that James Cunningham perform

these chores. Dr. Rook was agreeable so long as Mr. Cunningham “has her [sic] own insurance to cover her [sic] for any potential medical injuries.” In a December 5, 2011, report, Dr. Rook determined to abandon any recommendation for yard work and, instead, specified essential services to include cleaning floors, windows, bathrooms, kitchen, vacuuming, doing dishes, laundry and shopping, in addition to helping the claimant put on her shoes and socks. On January 7, 2015, Dr. Rook amended the description of essential services to also include dressing, bathing and transportation. Dr. Kleiner recommended the claimant “have access to all of the allowed benefits, including essential services which were awarded her” in order to assist with “any activities of daily living.” In his testimony at the July 15, 2015, hearing, Dr. Rook indicated the essential services encompassed “dressing and showering and taking her to and from appointments and cleaning her house and cleaning the yard.” Tr. at 34. The doctor stated the claimant does not perform the cleaning and yard work, but that if she did, it could aggravate her injury. He explained that the cleaning was necessary to prevent “bed bugs” and because the claimant suffers from “germophobia.” Tr. at 42. The category of ‘all essential services recommended’ is far from precise in this record.

Our review of the medical fee schedule does not reveal references to any of these tasks.

The claimant testified she can feed herself without assistance, as well as use the toilet without assistance. She indicated she can get out of bed without assistance as well as out of a chair without assistance. The claimant can shower. Tr. at 24-26. She can dress herself with the exception of shoes. Tr. at 9. As noted above, she would not accept assistance from an unknown care giver to get into the tub. She stated she does not require assistance to get out of the tub. Tr. at 13.

The ALJ cites to only one case in support of the order for essential services. However, the case mentioned, *Hebrew v. Dairy Queen*, W.C. No. 4-155-507 (October 25, 2002), did not approve an order for essential services. Instead, it held the order in that case was not reviewable.

The Court of Appeals has been careful to recognize limits in regard to the authorization of household chores as a medical benefit. In *Kraemer & Sons v. Downey*, 852 P.2d 1286 (Colo. App. 1992), the claimant sustained a spinal cord injury which left him paralyzed below the waist. The claimant’s physician testified the claimant required assistance with eating, bathing, preparing himself for bed, turning in bed to prevent bedsores and showering. The respondents provided a home health aide in the morning to secure this assistance, but the claimant’s wife performed the tasks in the evening. The

court approved a payment to the wife at the rate paid the attendant. The payment however, was specified to be only for services that were “in addition to her normal household duties.” The court concluded:

... the employer, by statute, has the affirmative duty of furnishing this kind of nursing services. If he has not done so, and if the wife then takes over these duties *in addition to her regular household work* and does exactly what a hired nurse would have to do, the charge is proper. ... Of course, *compensation is not awarded to a spouse if the only services being rendered to the claimant are ordinary household services.* 852 P.2d at 1288. (italics provided).

Similarly, in *Suetrack USA v. Industrial Claim Appeals Office*, 902 P.2d 854 (Colo. App. 1995), a wife’s assistance to a claimant in the form of assistance to get him in and out of bed, aiding with walking and maintaining his hygiene was found payable and the liability of the respondents. However, the Court held that those tasks were compensable “unless such services are ordinary household tasks.” 902 P.2d at 855.

The physician in *Country Squire Kennels v. Tarshis*, 899 P. 2d 362 (Colo. App. 1995), recommended house cleaning services when the claimant’s low back injury limited her ability to clean her house. The Court determined house cleaning services in those circumstances would not qualify as a compensable medical expense:

Further, because the housekeeping services do not enable her to obtain medical or nursing treatment and are not relatively minor compared to the very limited medical or nursing treatment needed by the claimant, those housekeeping services are not incident to medical or nursing treatment and, thus, are not compensable. 809 P.2d at 365.

The claimant argues that the ruling in *Tarshis* was changed by the decision in *Bellone v. Industrial Claim Appeals Office*, 940 P.2d 1116 (Colo. App. 1997). The Court in *Bellone* approved the payment for child care services in a case where the claimant sustained a traumatic brain injury. However, the evidence in *Bellone* included medical evidence that the claimant, who was a single parent, required the child care assistance to allow her to avoid becoming overwhelmed, fatigued and thereby decrease her susceptibility to depression and seizures. The Court concluded the child care services were therefore “medical” in nature and were compensable.

The claimant cites to several unpublished decisions of the Court of Appeals which it is claimed have abandoned the ruling in *Tarshis* based on the decision in *Bellone*. Colorado Appellate Rule 35 (f) provides that only published opinions of the Court are to be followed as precedent. The Colorado Court of Appeals has expressly declared that “[c]itation of unpublished opinions is forbidden,” with the exception of explaining the case history, establishing the doctrines of law of the case, *res judicata*, or collateral estoppel, or citing to opinions that were designated as "Not Selected for Official Publication" and were announced between January 1, 1970 and November 1, 1975, but nevertheless were published in the Pacific Second Reporter. As a result, the claimant’s reference to and reliance upon unpublished opinions is inappropriate here. Cases regarding housekeeping services rendered subsequent to those cited by the claimant do not support her argument. In *Cross v. Microglide, Inc.*, W.C. No. 4-355-764 (September 2, 2003), *aff’d. Cross v. Industrial Claim Appeals Office*, (Colo. App. No 03CA1807, October 7, 2004) (not selected for publication), the claimant requested payment to her husband pursuant to a prescription from her treating doctor for “essential services”. The claimant testified her husband performed housekeeping chores such as vacuuming, laundry, changing bedding, shopping, cooking, cleaning bathrooms, watering plants, and the cleaning of windows and curtains. The Court affirmed the denial of the request for payment for these services. It was found the record supported the ALJ’s conclusion the services neither cured nor relieved the effects of the injury or enabled claimant to obtain treatment. In *Schramek v. Chico’s FAS*, W.C. No. 4-601-867 (June 14, 2011) *aff’d*, *Schramek v. Industrial Claim Appeals Office*, (Colo. App. No. 11CA1385, April 12, 2012) (not selected for publication), the claimant’s physician had prescribed assistance for activities such as vacuuming, mopping floors, cleaning the bathroom or cleaning the kitchen. The Court affirmed the ALJ’s ruling that these duties were not medical treatment to cure and relieve the effects of the injury or incident to obtaining medical treatment. The court noted the finding that “claimant suffers pain and that many activities that she performs cause her additional pain is not inconsistent with this legal standard.”

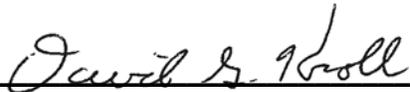
Here, the ALJ made no findings that the housekeeping services or yard work were required to cure and relieve the claimant from the effects of the compensable injury or allowed her to obtain medical treatment. The record indicates the claimant has not performed these activities for four years. The only attendant care services other than housekeeping tasks approved by the ALJ appear to be assisting the claimant into the bath tub and to put her shoes and socks on. The claimant asserts she would not accept assistance to enter the tub. The nature of yard work for the claimant is unclear. There is no description of trees, bushes, flowers or even grass. The number of hours per week, 28,

allotted to the performance of these essential services does not appear to be based on anything but speculation. It is unknown who has accomplished these chores during the preceding four years. The evidence that it is either necessary for the claimant to perform these tasks, or that their performance would affect her injury, is scarce. It would be difficult for the ALJ to determine if the assignment of yard work or cleaning to someone else would represent a cure or relief for the claimant's symptoms. Nonetheless, that is the requirement of both *Tarshis* and *Bellone*.

We therefore set aside the portion of the ALJ's order pertinent to housekeeping, yard work and attendant care services ("essential services") and remand the matter to an ALJ for further findings. On remand, the ALJ must make findings as to which activities are being authorized and whether each either cures or relieves the claimant from the effects of her injury or is incidental to obtaining medical treatment. If it is found such chores are justified under this standard, the ALJ should specify how many hours are authorized for any such tasks and the basis for calculating the amount of payment for those services. At the ALJ's discretion, additional evidentiary proceedings may be convened for this purpose.

**IT IS THEREFORE ORDERED** that the ALJ's order issued September 24, 2015, is affirmed in regard to the denial and authorization of specified medical devices and is set aside and remanded for further findings pertinent to the request for essential services .

INDUSTRIAL CLAIM APPEALS PANEL

  
\_\_\_\_\_  
David G. Kroll

  
\_\_\_\_\_  
Kris Sanko

TERRYL ROBINSON  
W. C. No. 4-827-378-02  
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CERTIFICATE OF MAILING

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

\_\_\_\_\_ 7/15/2016 \_\_\_\_\_ by \_\_\_\_\_ KG \_\_\_\_\_ .

CHARTIS CLAIMS INC, Attn: LORI WATSON, PO BOX 25971, SHAWNEE MISSION, KS,  
66225 (Insurer)

PATTIE J RAGLAND, ESQ, 4030 W 103RD COURT, WESTMINSTER, CO, 80031 (For  
Claimant)

GREGORY K CHAMBERS, ESQ. C/O DWORKIN, CHAMBERS, WILLIAMS, YORK,  
BENSON & EVANS P.C., 3900 E MEXICO AVE STE 1300, DENVER, CO, 80210 (For  
Respondents)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-933-753-02

IN THE MATTER OF THE CLAIM OF

MARK SMITH,

Claimant,

v.

FINAL ORDER

NPC INTERNATIONAL,

Employer,

and

OLD REPUBLIC INSURANCE,

Insurer,  
Respondents.

The claimant seeks review of an order of Administrative Law Judge Felter (ALJ) dated March 22, 2016, that granted the respondents' motion for summary judgment to dismiss the claimant's request for penalties. We affirm.

The claimant requested a hearing seeking penalties for the respondents' alleged failure to timely file general and final admissions of liability. The following facts are not disputed. The claimant sustained an injury on October 27, 2013. The respondents filed a general admission of liability on November 26, 2013, admitting for the claim as a medical only claim. The respondents filed another general admission of liability on December 3, 2013, admitting for temporary disability benefits. The claimant continued to receive temporary disability benefits until he was released to return to work with no impairment in February of 2014. The respondents filed a final admission of liability on September 23, 2014. The final admission of liability denied liability for post-MMI treatment and also stated in the general remarks section that "[a]ny and all benefits and penalties not specifically admitted to are hereby denied." The claimant did not file an objection or an application for hearing within 30 days of September 23, 2014.

On January 6, 2016, the claimant filed an application for hearing on the issue of penalties attaching a detailed letter of his request. In that document the claimant cites to §8-43-203(2)(a), C.R.S. and states that he is seeking penalties for failure to timely admit or deny liability for the alleged untimely general admission and final admission of

liability. The claimant noted that the initial general admission was timely filed but that he notified the insurer that he was entitled to temporary disability benefit as early as November 13, 2013, and a revised general admission admitting for the temporary disability benefits was not filed until February 4, 2014, 63 days after he notified the respondents. The claimant also alleged that he was owed temporary total disability benefits but that the respondents did not file an admission for temporary total disability benefits until September 23, 2014, which was 294 days late. The claimant also alleged that the final admission was filed 136 days after the maximum medical improvement (MMI) report was sent to the carrier.

The respondents filed a motion for summary judgment arguing that the issue of penalties was closed because the claimant failed to object and file an application on the penalty issues within 30 days of the final admission. The respondents also asserted that the claimant's request for penalties was past the one year statute of limitations in §8-43-304 (5), C.R.S. and, therefore, the claimant's request was barred. The ALJ granted the respondents' motion finding that the issues were closed pursuant to §8-43-203 (2)(b)(II), C.R.S. The ALJ also found that the claimant's claim for penalties pursuant to §8-43-304 (1), was barred by the one year statute of limitation in §8-43-304(5), C.R.S. The ALJ, therefore, denied and dismissed the claimant's request for penalties.

On appeal the claimant contends the ALJ misapplied the relevant penalty law and that there is a dispute of material fact regarding the timeliness of the general admissions. The claimant asserts that he was requesting penalties pursuant to §8-43-203 (2)(a) which provides for one day's compensation for each day's failure to file and the relevant statute of limitation for this section is seven years pursuant to §8-43-203 (2)(c), C.R.S. The claimant's arguments notwithstanding, we affirm the ALJ's grant of the motion for summary judgement based upon the fact that the issue of penalties was closed by the claimant's failure to timely object to the final admission of liability which denied liability for penalties.

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

MARK SMITH

W. C. No. 4-933-753-02

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

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

As pointed out by the respondents, it appears that the penalty in §8-43-203(2)(a), is not applicable here because the respondents timely filed the initial general admission of liability to comply with the requirement in §8-43-203(1)(a), C.R.S. Thus, in order to be successful on a penalty claim, the claimant must proceed under §8-43-304(1), C.R.S. *But see, Allison v. Industrial Claim Appeals Office*, 916 P.2d 623 (Colo. App. 1995)(respondents' failure to admit liability for the correct temporary disability benefits did not support the imposition of penalties under § 8-43-304). In any event, we do not decide this question because regardless of the applicable penalty provision, the issue of penalties was closed by the claimant's failure to timely object to the September 23, 2014, final admission.

An uncontested final admission of liability automatically closes a case as to the issues admitted in the final admission. Section 8-43-203(2)(b)(II)(A), C.R.S. Section 8-43-203(2)(b)(II)(A), is part of a statutory scheme designed to promote, encourage, and ensure prompt payment of compensation to an injured worker without the necessity of a formal administrative determination in cases not presenting a legitimate controversy. *Dyrkopp v. Industrial Claim Appeals Office*, 30 P.3d 821 (Colo. App. 2001); *Cibola Construction v. Industrial Claim Appeals Office*, 971 P.2d 666 (Colo. App. 1998).

MARK SMITH

W. C. No. 4-933-753-02

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Here, the general remarks section of the September 23, 2014, final admission of liability stated that “[a]ny and all benefits & penalties not specifically admitted to are hereby denied.” Contrary to the claimant’s argument, this language closes the issue of penalties. *Dyrkopp v. Industrial Claim Appeals Office, supra*. In *Dyrkopp* the court held a final admission of liability closed the issue of permanent benefits where the claimant failed to object to the final admission, the final admission clearly admitted for permanent partial disability benefits, there was no "x" in the space for admitting permanent total disability benefits, and the final admission contained the admonition that benefits or penalties not admitted "are hereby specifically denied." The court noted that because the final admission specifically stated that benefits not admitted were denied, and because the claimant was warned to object if she disagreed with the type and amount of benefits, the claimant’s failure to timely contest the final admission closed the issues. *See also Tidwell v. Department of Corrections*, W.C. No. 4-150-549 (May 2, 1994)(workable definition of an "admitted issue" is an issue specifically mentioned in the final admission, and concerning which the respondents have affirmatively taken a position, either by agreeing to pay benefits, or by denying liability to pay benefits).

It is undisputed that the claimant did not file an objection or an application for hearing within 30 days of the September 23, 2014, admission of liability and, therefore, the issue of penalties was closed. Section 8-43-203 (2)(b)(II)(A), C.R.S. We conclude that the ALJ properly granted the respondents’ motion for summary judgment.

The claimant also argues that the ALJ failed to address his argument that the respondents did not comply with Office of Administrative Courts (OAC) Rule 16 when the motion for summary judgment was filed. We are not persuaded to disturb the ALJ’s order on this ground. OAC Rule 16 provides,

[e]very motion must include a certification by the party or counsel filing the motion that he or she has conferred, or attempted to confer, with opposing counsel and unrepresented parties, and must also include a statement regarding whether the motion is contested, uncontested, or stipulated. If no conference has occurred, an explanation must be included in the motion.

Under § 8-43-207(1)(g), C.R.S., the ALJ is vested with wide discretion in the conduct of hearings. Under the particular circumstances here, we are unable to conclude that the ALJ's determination to consider the respondents' motion is beyond the bounds of reason, or is unsupported by the evidence. *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867, (Colo. App. 2001). The claimant here was afforded the opportunity to respond to the respondents' motion and present his arguments. Moreover, the claimant

does not state what additional arguments or evidence he would have provided had the respondents conferred with the claimant prior to filing the motion. *Cf. Larsen v. Archdiocese of Denver*, 631 P.2d 1163 (Colo. App. 1981) (where no formal offer of proof, reviewing court cannot determine without such offer whether or not claimed error is prejudicial). Thus, the claimant has not established a basis for reversing the ALJ's order on this ground.

**IT IS THEREFORE ORDERED** that the ALJ's order dated March 22, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

  
\_\_\_\_\_  
Brandee DeFalco-Galvin

  
\_\_\_\_\_  
Kris Sanko

MARK SMITH  
W. C. No. 4-933-753-02  
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CERTIFICATE OF MAILING

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

\_\_\_\_\_ 7/15/2016 \_\_\_\_\_ by \_\_\_\_\_ KG \_\_\_\_\_ .

MARK SMITH, 6400 S DAYTON, H-8, CENTENNIAL, CO, 80111 (Claimant)  
OLD REPUBLIC INSURANCE, Attn: EVIE MAES, C/O: GALLAGHER BASSET  
SERVICES, INC, PO BOX 4068, ENGLEWOOD, CO, 80155 (Insurer)  
RITSEMA & LYON, P.C., Attn: TAMA L LEVINE, ESQ, 999 18TH ST, STE 3100, DENVER,  
CO, 80202 (For Respondents)

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-893-631-06

IN THE MATTER OF THE CLAIM OF  
LEAH TURNER,

Claimant,

v.

ORDER OF REMAND

CHIPOTLE MEXICAN GRILL,

Employer,

and

AMERICAN ZURICH INSURANCE  
COMPANY,

Insurer,  
Respondents.

The respondents seek review of an order of Administrative Law Judge Cannici (ALJ) dated February 11, 2016, that struck their 24-month Division-sponsored independent medical examination (DIME) and denied and dismissed their request to recover an overpayment. We set aside the ALJ's order and remand for further findings and a new order.

This matter went to hearing on whether the 24-month DIME performed by Dr. Beatty should be stricken for the respondents' failure to follow the procedure outlined in §8-42-107(8)(b)(II)(B), C.R.S., and whether the respondents were entitled to recover an overpayment in the amount of \$97,641.12. During the hearing, the parties stated that they did not have any witnesses to call. Rather, the parties agreed to present their cases to the ALJ based on their admitted exhibits and their position statements.

The ALJ subsequently entered his order finding that the claimant suffered admitted industrial injuries on May 9, 2012. The respondents filed a General Admission of Liability, specifying that the claimant was entitled to receive Temporary Total Disability (TTD) benefits beginning on July 16, 2012, in the amount of \$732.57 per week.

On July 24, 2014, the respondents filed a Notice and Proposal to Select a DIME. On July 28, 2014, however, the respondents filed a Notice of Failed IME Negotiation.

LEAH TURNER

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On July 28, 2014, the respondents filed an Application for a 24-month DIME. The Application specified the claimant's left shoulder as the body part to be addressed. The respondents listed maximum medical improvement (MMI) and impairment rating as issues for the DIME physician to address.

The claimant subsequently underwent the 24-month DIME on October 20, 2014, with Dr. Beatty. Dr. Beatty determined that the claimant had reached MMI on June 15, 2012, for her left shoulder and cervical spine injuries. He assigned a 16% whole person permanent impairment rating.

Thereafter, Dr. Beatty reviewed extensive video surveillance and medical records. On January 27, 2015, Dr. Beatty issued a supplemental report concluding that the claimant reached MMI on June 15, 2012, with a 0% whole person permanent impairment rating.

The respondents filed a Final Admission of Liability (FAL) on February 13, 2015, consistent with Dr. Beatty's MMI date of June 15, 2012, and 0% whole person impairment rating. Since the date of MMI preceded the first TTD payment made to the claimant, the respondents asserted an overpayment of all TTD benefits paid from July 16, 2012, and continuing for a total amount of \$97,641.12.

On March 11, 2015, the claimant filed an Application for Hearing. The claimant specifically noted in her Application that she was seeking to strike the 24-month DIME because of "failure to follow procedures set forth in C.R.S. §8-42-107(8)(b)(II)(A-D)."

The ALJ ultimately struck the 24-month DIME performed by Dr. Beatty on October 20, 2014, based specifically on the respondents' failure to follow the procedures outlined in §8-42-107(8)(b)(II)(B), C.R.S. The ALJ ruled that the plain language of §8-42-107(8)(b)(II)(B), C.R.S. "requires the moving party to inquire in writing from an ATP whether a claimant has reached MMI." He further found that inquiring of an ATP in writing is a condition precedent to obtaining a 24-month DIME. However, the ALJ specifically found that the respondents violated §8-42-107(8)(b)(II)(B), C.R.S. because "the record is devoid of evidence that *an ATP addressed in writing* whether Claimant had reached MMI prior to the 24-month DIME." (emphasis added). Since the ALJ struck the 24-month DIME, he determined that there had been no MMI or impairment determinations for the claimant's May 9, 2012, industrial injuries. The ALJ therefore held that the respondents' FAL was improperly filed, and it was premature for the respondents to recover an overpayment. Thus, the ALJ denied and dismissed the respondents' request for an overpayment in the amount of \$97,641.12. Further, the ALJ

rejected the respondents' contention that the claimant waived the right to object to the validity of the 24-month DIME process. The ALJ found that the claimant's Application specifically noted she was seeking to strike the 24-month DIME due to the respondents' "failure to follow procedures set forth in C.R.S. §8-42-107(8)(b)(II)(A-D)." Moreover, the ALJ held that Dr. Beatty lacked authority pursuant to statute to address the claimant's permanent impairment rating.

#### I.

Initially, we address the respondents' contention that the claimant waived her right to contest the validity of the 24-month DIME under §8-42-107(8)(b)(II)(A)-(D), C.R.S. The respondents reason that the claimant fully participated in the 24-month DIME process, and did not raise any objection until after the process had been concluded and a negative report had been received. The respondents argue that the claimant should have, but failed to, object to the following pleadings prior to undergoing the 24-month DIME: the Notice and Proposal to Select a DIME; the Notice of Failed IME Negotiation; and, the Application for a 24-month DIME. We conclude that additional findings and a new order are required on this issue.

Generally, waiver constitutes an intentional relinquishment of a known right. Waiver may be explicit, or it may be implied where a party engages "in conduct which manifests an intent to relinquish the right or privilege or acts inconsistently with its assertion." *Johnson v. Industrial Commission*, 761 P.2d 1140, 1147 (Colo. 1988). A waiver must be made with full knowledge of the relevant facts, and the conduct should be free from ambiguity and clearly manifest the intention not to assert the right. *Id.*; *Department of Health v. Donahue*, 690 P.2d 243 (Colo. 1984).

The question of whether a party waived a right is one of fact for determination by the ALJ. *See Johnson v. Industrial Commission, supra*. Consequently, we must uphold the ALJ's order if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires us to defer to the ALJ's resolution of conflicts in the evidence, his credibility determinations, and the plausible inferences he drew from the evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

We conclude that the ALJ's order lacks sufficient findings of fact on the issue of waiver. We recognize that the ALJ held that the claimant did not waive the right to challenge the propriety of the 24-month DIME process. As noted above, the ALJ reasoned that this was because the claimant's Application specifically stated she was seeking to strike the 24-month DIME due to the respondents' failure to follow the procedures set forth in §8-42-107(8)(b)(II)(A-D), C.R.S. However, the ALJ did not

specifically address the respondents' contention that the claimant waived the right to contest the validity of the 24-month DIME by failing to object to it prior to undergoing it. We may not make findings of fact initially. Accordingly, it is necessary to remand the matter for the ALJ to specifically address the respondents' contention in this regard. Section 8-43-301(8), C.R.S. (panel may remand an order on the basis that the findings of fact are not sufficient to permit appellate review).

## II.

To the extent the ALJ determines that the claimant did not waive her right to contest the validity of the 24-month DIME process under §8-42-107(8)(b)(II)(A)-(D), C.R.S., then it is necessary for the ALJ to also address the respondents' contention regarding non-compliance under §8-42-107(8)(b)(II)(B), C.R.S. The respondents contend the claimant failed to present any evidence that they failed to comply with §8-42-107(8)(b)(II)(B), C.R.S. We conclude the ALJ applied an incorrect standard on this issue and remand for new findings and a new order.

Section 8-42-107(8)(b)(II), C.R.S. provides as follows:

(II) If either party disputes a determination by an authorized treating physician on the question of whether the injured worker has or has not reached maximum medical improvement, an independent medical examiner may be selected in accordance with section 8-42-107.2; except that, if an authorized treating physician has not determined that the employee has reached maximum medical improvement, the employer or insurer may only request the selection of an independent medical examiner if all of the following conditions are met:

(A) At least twenty-four months have passed since the date of injury;

(B) *A party has requested in writing* that an authorized treating physician determine whether the employee has reached maximum medical improvement;

(C) Such authorized treating physician has not determined that the employee has reached maximum medical improvement; and

(D) A physician other than such authorized treating physician has determined that the employee has reached maximum medical improvement. (emphasis added)

Initially, we recognize the ALJ essentially recited the appropriate law under §8-42-107(8)(b)(II)(B), C.R.S. that a party must request in writing that an ATP determine whether the claimant has reached MMI. Order at 3 ¶10; Order at 4 ¶6; Order at 5 ¶9. Nevertheless, the ALJ also twice found that the respondents failed to comply with §8-42-107(8)(b)(II)(B), C.R.S. because “the record is devoid of evidence that *an ATP addressed in writing* whether Claimant had reached MMI prior to the 24-month DIME.” (emphasis added) Order at 3 ¶10; Order at 5 ¶9. Since the applicable standard is whether the respondents here requested in writing that an ATP determine whether the claimant is at MMI, it is clear the ALJ applied an incorrect standard. Consequently, it is necessary to remand the matter to the ALJ to apply the correct standard when determining whether the respondents failed to comply with §8-42-107(8)(b)(II)(B), C.R.S.

### III.

Last, it also is necessary to address the respondents’ contention that the ALJ erred in determining the DIME physician is not authorized to address permanent impairment. We agree.

Section 8-42-107(8)(b)(III), C.R.S. provides as follows:

(III) Notwithstanding paragraph (c) of this subsection (8), if the independent medical examiner selected pursuant to subparagraph (II) of this paragraph (b) finds that the injured worker has reached maximum medical improvement, *the independent medical examiner shall also determine the injured worker's permanent medical impairment rating.* The finding regarding maximum medical improvement and permanent medical impairment of an independent medical examiner in a dispute arising under subparagraph (II) of this paragraph (b) may be overcome only by clear and convincing evidence. A hearing on this matter shall not take place until the finding of the independent medical examiner has been filed with the division. (emphasis added)

Thus, contrary to the ALJ’s order, §8-42-107(8)(b)(III), C.R.S. specifically authorizes the 24-month DIME physician to determine permanent medical impairment if he finds the claimant has reached MMI. This part of the ALJ’s order is therefore in error.

**IT IS THEREFORE ORDERED** that the ALJ’s order dated February 11, 2016, is set aside and the matter is remanded for the ALJ to enter additional findings and a new order consistent with the views expressed herein.

LEAH TURNER  
W. C. No. 4-893-631-06  
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INDUSTRIAL CLAIM APPEALS PANEL

  
\_\_\_\_\_  
Brandee DeFalco-Galvin

  
\_\_\_\_\_  
Kris Sanko

LEAH TURNER  
W. C. No. 4-893-631-06  
Page 7

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 6/30/2016 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

BACHUS & SCHANKER, LLC, Attn: JAMES W. OLSEN, ESQ., 1899 WYNKOOP STREET,  
SUITE 700, DENVER, CO, 80202 (For Claimant)  
THOMAS POLLART & MILLER LLC, Attn: BRAD J. MILLER, ESQ., 5600 SOUTH  
QUEBEC STREET, SUITE 220-A, GREENWOOD VILLAGE, CO, 80111 (For Respondents)  
ALJ CANNICI, % OFFICE OF ADMINISTRATIVE COURTS, ATTN: RONDA  
MCGOVERN, 1525 SHERMAN STREET, 4<sup>TH</sup> FLOOR, DENVER, CO 80203

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-859-506-02

IN THE MATTER OF THE CLAIM OF  
CHRISTOPHER ZVOLANEK,

Claimant,

v.

FINAL ORDER

BLUE CANYON BAR & GRILL,

Employer,

and

PINNACOL ASSURANCE,

Insurer,  
Respondents.

The *pro se* claimant seeks review of an order of Administrative Law Judge Nemechek (ALJ) dated January 27, 2016, that denied and dismissed the claimant's claim for benefits with prejudice for failure to comply with discovery orders. We affirm.

The claimant filed an application for hearing seeking a determination of compensability, medical benefits, compensation benefits, penalties and other issues. The respondents sent authorizations for releases of medical records, employment records and other information. The claimant did not return the requested releases and on October 15, 2015, a Pre-hearing ALJ (PALJ) issued an order compelling the claimant to provide fully executed authorizations by October 26, 2015. The respondents also obtained an order to conduct discovery and sent the claimant interrogatories and requests for production. The claimant also failed to respond to these and a PALJ issued an order requiring the claimant to respond to the interrogatories and requests for production by October 9, 2015. The claimant did not comply with this order. The claimant returned the executed releases to the Division of Workers' Compensation but did not send a copy to the respondents' counsel.

The respondents filed a motion to dismiss on November 13, 2015, for the claimant's failure to abide by the various orders issued in the case. The claimant did not respond to the motion to dismiss and it was granted on December 2, 2015. The claimant subsequently filed a motion for reconsideration which was granted by order dated

CHRISTOPHER ZVOLANEK

W. C. No. 4-859-506-02

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January 15, 2016. This order gave the claimant an additional week to provide the executed releases to the respondents' counsel and to respond to the outstanding discovery without objection.

The claimant filed documents on January 22, 2015, but the ALJ found that the claimant failed to respond to discovery and failed to comply with the discovery orders in this case. The ALJ found the claimant's responses were not responsive to the discovery requests. Rather than responding to the questions, the claimant stated that the interrogatories and requests to produce created prejudice and made assertions that the respondents' requests were unfair and meant to harass the claimant. The claimant also responded requesting that he be given an American Sign Language interpreter to read the respondents' interrogatories. The ALJ, however, found that the claimant was provided an interpreter at the pre-hearing conference and has access to the OAC TTY line, which he utilized and met directly with OAC personnel. The claimant also communicated by way of handwritten notes and was advised that an interpreter would be provided at hearing. The ALJ further found that the claimant's request that an interpreter prepare the discovery responses is beyond the scope of the interpreter's role. The ALJ noted that the claimant has been able to prepare and file multiple pleadings and could have prepared the responses to the interrogatories and requests for production but failed to do so. Consequently, the ALJ determined that the claimant willfully violated the discovery order and pursuant to §8-43-207(1)(e), C.R.S. dismissal was appropriate.

On appeal the claimant renews his request for an American Sign Language interpreter to read the interrogatories and requests for production to him. The respondents have not filed a Brief in Opposition to Review. We perceive no reversible error by the ALJ.

Workers' Compensation Rule of Procedure 9-1 applies to discovery in workers' compensation procedures. Rule 9-1(E) provides that "[i]f any party fails to comply with the provisions of this rule and any action governed by it, an administrative law judge may impose sanctions upon such party pursuant to statute and rule." Further, § 8-43-207(1)(e), C.R.S. permits an ALJ to impose the sanctions provided in the rules of civil procedure for the "willful failure to comply with permitted discovery." In order for a discovery violation to be considered "willful" the ALJ must determine that the conduct was deliberate or exhibited "either a flagrant disregard of discovery obligations or constitutes a substantial deviation from reasonable care in complying with discovery obligations." *Reed v. Industrial Claim Appeals Office*, 13 P.3d 810, 813 (Colo. App. 2000). Rule 9-1(G) also provides that the failure to comply with an order to compel shall be presumed willful.

The sanctions that can be imposed for the willful failure to comply with permitted discovery are various and range from the assessment of costs and fees to the outright dismissal of a claim or defense. See C.R.C.P. 37. The ALJ has wide discretion in determining whether a discovery violation has occurred and, if so, the appropriate sanction to be imposed. See § 8-43-207(1)(e) and (p), C.R.S.; *Sheid v. Hewlett Packard*, 826 P.2d 396 (Colo. App. 1991). While it is true that dismissal of one or more claims for relief may be a proper sanction under C.R.C.P. 37 (b)(2)(C), it is "the severest form of sanction" available. See *Prefer v. PharmNetRx*, 18 P.3d 844, 850 (Colo. App. 2000); see also *Sheid v. Hewlett Packard*, *supra*. Because the ALJ's determinations in this respect are discretionary, however, we may only disturb the ALJ's order if it exceeds the bounds of reason, such as where it is wholly unsupported by the evidence or is contrary to applicable law. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993); *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867 (Colo. App. 2001).

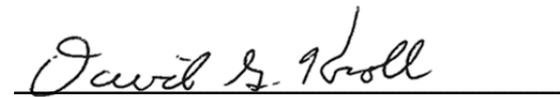
The ALJ found here that the claimant has had outstanding interrogatories and requests for production in his possession in excess of 6 months. The claimant was given additional time when the motion for reconsideration was granted. The claimant, however, failed to comply with the PALJ's discovery order. The ALJ also discussed the claimant's request for an interpreter to read the interrogatories to the claimant and we do not disagree with his conclusions in this regard. The claimant has not provided a reason that an interpreter is necessary for preparing the responses to interrogatories and request for production, especially in view of the ALJ's findings that the claimant has completed and filed other pleadings in the claim. The record also discloses that the claimant was provided with notice and an opportunity to be heard regarding the respondents' motion to dismiss and to provide the basis for his failure to respond to the proffered discovery requests and to comply with the PALJ's discovery order. See *Hendricks v. Industrial Claim Appeals Office*, 809 P.2d 1076 (Colo. App. 1990). Thus, we are unable to conclude that the ALJ abused his discretion in dismissing the claimant's claim with prejudice. As noted above, the ALJ has wide discretion in determining whether a discovery violation has occurred and, if so, the appropriate sanction to be imposed. See § 8-43-207(1)(e) and (p), C.R.S.; *Sheid v. Hewlett Packard*, *supra*. Moreover, the claimant's failure to respond to discovery requests for over six months was not harmless and has delayed the adjudication in this claim. Under these circumstances, therefore, we will not disturb the ALJ's order. Section 8-43-301(8), C.R.S.

CHRISTOPHER ZVOLANEK  
W. C. No. 4-859-506-02  
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**IT IS THEREFORE ORDERED** that the ALJ's order dated January 27, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

  
\_\_\_\_\_  
Brandee DeFalco-Galvin

  
\_\_\_\_\_  
David G. Kroll

CHRISTOPHER ZVOLANEK  
W. C. No. 4-859-506-02  
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CERTIFICATE OF MAILING

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

\_\_\_\_\_ 7/13/2016 \_\_\_\_\_ by \_\_\_\_\_ KG \_\_\_\_\_ .

CHRISTOPHER ZVOLANEK, 17484 WEST 10TH AVENUE, #204, GOLDEN, CO, 80401  
(Claimant)  
PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ., 7501 E. LOWRY  
BLVD., DENVER, CO, 80230 (Insurer)  
RUEGSEGGER SIMONS SMITH & STERN LLC, Attn: VITO A RACANELLI, ESQ., 1401  
SEVENTEENTH STREET, SUITE 900, DENVER, CO, 80202 (For Respondents)

15CA1481 Sanchez v ICAO 03-17-2016

COLORADO COURT OF APPEALS

DATE FILED: March 17, 2016  
CASE NUMBER: 2015CA1481

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Court of Appeals No. 15CA1481  
Industrial Claim Appeals Office of the State of Colorado  
WC No. 4-952-153

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Keith Sanchez,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, Pinnacol Assurance,  
and Honnen Equipment Company,

Respondents.

---

ORDER REVERSED AND CASE  
REMANDED WITH DIRECTIONS

Division VI  
Opinion by JUDGE FREYRE  
Navarro and Vogt\*, JJ., concur

**NOT PUBLISHED PURSUANT TO C.A.R. 35(f)**  
Announced March 17, 2016

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Mark D. Elliot, Alonit Katzman, The Elliot Law Offices, P.C., Arvada, Colorado,  
for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Harvey D. Flewelling, Denver, Colorado, for Respondents Honnen Equipment  
Company and Pinnacol Assurance

\*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art.  
VI, § 5(3), and § 24-51-1105, C.R.S. 2015.

In this workers' compensation action, claimant, Keith Sanchez, seeks review of a final order of the Industrial Claim Appeals Office (Panel), which affirmed an order denying and dismissing his claim for benefits. An administrative law judge (ALJ) found that claimant had not established that his injury was caused by his work activities. We disagree and set aside the order affirming the ALJ's decision.

### I. Background

Claimant performs general maintenance and in-depth repair to hydraulic crane mechanisms for employer, Honnen Equipment Company. In May 2014, claimant's right knee "pop[ped]" when he stood up from a kneeling position and began "popping and grinding" as he tried to "walk it off." He informed his supervisor of his knee injury and was directed to a clinic for medical attention.

Employer referred claimant to Aviation & Occupational Medicine, where claimant saw Dr. Michael Ladwig. Dr. Ladwig initially diagnosed claimant with a right knee strain and opined there was a 51% chance the injury was work-related. He referred claimant to an orthopedic surgeon, Dr. Mark Failinger, for an MRI. The MRI revealed that claimant suffered a "[s]omewhat complex but

mostly horizontal tear of the body and posterior junctional zone of the medial meniscus.” In addition, the MRI impressions indicated claimant also suffered a “mild MCL sprain and mild posteromedial corner sprains/strains,” and a “mild strain of the popliteus.” Based on these findings, the orthopedic surgeon recommended surgery to repair the tear.

Although Dr. Failinger checked the box indicating that his “objective findings [are] consistent with history and/or work related mechanism of injury/illness,” employer and its insurer contested the claim. A physician retained by employer and its insurer to independently examine claimant, Dr. James Lindberg, concluded that claimant’s injury was not likely work-related because “standing up and feeling the knee pop would not cause an MCL sprain or posterior medial corner sprain and strain.” According to Dr. Lindberg, these findings would be secondary to a much more significant injury, and he opined, “I do not believe that this injury took place standing up at work and feeling a pop.” Dr. Lindberg expounded on his opinion at the hearing, testifying that there was a “ten percent” chance the horizontal meniscus tear would occur as claimant described, and a “zero percent” chance that the corner

sprains/strains could have resulted from mechanism of injury described by claimant.

Although there was no evidence that claimant's knee had exhibited any symptoms prior to the work-related incident, the ALJ found Dr. Lindberg persuasive, crediting his explanation "that the specific tear sustained by [c]laimant is not the type of meniscal tear most commonly associated with acute, work-related injuries." The ALJ also noted Dr. Lindberg's opinion that there "was simply no mechanism of injury described in the medical records that accounted for [c]laimant's injuries." The ALJ concluded that the "temporal proximity" of claimant's symptoms to his work did not establish that claimant suffered a work-related injury. He therefore denied and dismissed claimant's claim.

On review, the Panel affirmed. It rejected claimant's contention that the ALJ had improperly considered testimony concerning his prior drug convictions. The Panel was also unpersuaded by claimant's arguments that the ALJ had misinterpreted Dr. Lindberg's opinion and that the ALJ applied the wrong legal standard when analyzing the cause of his injury. The Panel therefore affirmed the ALJ's order. Claimant now appeals.

## II. Applicable Legal Standard

Claimant contends that the ALJ applied the wrong legal standard in concluding that he had failed to establish a causal link between his injury and his work activities. Claimant argues that because the ALJ did not explicitly find his knee injury attributable to a pre-existing condition, the injury “is compensable as a matter of law under settled case law.” Citing *City of Brighton v. Rodriguez*, 2014 CO 7, claimant reasons that his injury was caused by a “neutral risk” and is compensable because it would not have occurred “but for” his work activities. We agree.

### A. Applicable Law

A work-related injury may be compensable if it arose out of the course and scope of the injured worker’s employment.

§ 8-41-301(1)(b), C.R.S. 2015. “For an injury to occur ‘in the course of’ employment, the claimant must demonstrate that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions.” *Madden v. Mountain W. Fabricators*, 977 P.2d 861, 863 (Colo. 1999). To establish that an injury arose out of an employee’s employment, “the claimant must show a causal connection between

the employment and injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract.”

*Id.*

A pre-existing condition “does not disqualify a claimant from receiving workers’ compensation benefits.” *Duncan v. Indus. Claim Appeals Office*, 107 P.3d 999, 1001 (Colo. App. 2004). A claimant may be compensated if a work-related injury “aggravates, accelerates, or combines with” a worker’s pre-existing infirmity or disease “to produce the disability for which workers’ compensation is sought.” *H & H Warehouse v. Vicory*, 805 P.2d 1167, 1169 (Colo. App. 1990). Moreover, an otherwise compensable injury does not cease to arise out of a worker’s employment simply because it is partially attributable to the worker’s pre-existing condition. See *Subsequent Injury Fund v. Thompson*, 793 P.2d 576, 579 (Colo. 1990); *Seifried v. Indus. Comm’n*, 736 P.2d 1262, 1263 (Colo. App. 1986) (“[I]f a disability were 95% attributable to a pre-existing, but stable, condition and 5% attributable to an occupational injury, the resulting disability is still compensable if the injury has caused the dormant condition to become disabling.”)

Determining whether “an employee’s injuries arose out of an employment relationship depends largely on the facts presented in a particular case.” *In re Question Submitted by the U.S. Court of Appeals for the Tenth Circuit*, 759 P.2d 17, 20 (Colo. 1988). The fact finder must examine the “totality of the circumstances . . . to see whether there is a sufficient nexus between the employment and the injury.” *Id.* (quoting *City & Cty. of Denver Sch. Dist. No. 1 v. Indus. Comm’n*, 196 Colo. 131, 133, 581 P.2d 1162, 1163 (1978)). And, the mere fact that an injury occurred at work does not necessarily make it compensable. *Brighton*, ¶ 29.

In *Brighton*, the Colorado Supreme Court abrogated a line of cases that had barred recovery if the cause of a claimant’s injury, often a fall, was “unexplained.” *Id.* at ¶ 35 n.9. The employer in *Brighton* compensated a worker who had fallen down some stairs, even though the worker could not remember what caused her to fall. The supreme court held that because the claimant’s “fall would not have occurred *but for* the fact that the conditions and obligations of her employment — namely, walking to her office during her work day — placed her on the stairs where she fell, her

injury ‘arose out of’ employment and is compensable.” *Id.* at ¶ 36 (emphasis added).

The supreme court explained that workplace injuries fall into one of three categories: “(1) employment risks, which are directly tied to the work itself; (2) personal risks, [or purely idiopathic injuries] which are inherently personal or private to the employee him- or herself; and (3) neutral risks, which are neither employment related nor personal.” *Id.* at ¶¶ 19, 22. The court placed unexplained falls in this third category, and held that such injuries arise out of employment and are compensable if, under the positional-risk test, it can be shown the injury “would not have occurred *but for* employment.” *Id.* at ¶¶ 24, 25 (emphasis added).

#### B. Claimant’s Injury Fell Under the Neutral Risk Category

Claimant asserts that in the absence of a specific causal finding that his injury was attributable to a pre-existing condition the injury’s cause is essentially unexplained and should have been analyzed under *Brighton*. His argument implies that if an ALJ does not identify the precise cause of an injury, the injury is unexplained and must be analyzed under the neutral risk category. But, *Brighton* states that “[d]emanding more precision about the exact

mechanism of a fall is inconsistent with the spirit of a statute that is designed to compensate workers for workplace accidents regardless of fault.” *Brighton*, ¶ 30. Therefore, we do not read *Brighton* as issuing a mandate either that the precise cause of every claimed workers’ compensation injury must be identified by the ALJ or that an injury automatically falls into the third, or neutral, category, simply because a precise cause is not expressly found. Nevertheless, for the reasons set forth below, we agree that claimant’s injury should have been analyzed as a neutral risk. See *id.* at ¶ 31.

The ALJ implicitly found that claimant’s injury was caused by a pre-existing knee condition. The ALJ was persuaded by Dr. Lindberg, who opined that the “horizontal, internal tear, also known as a ‘shear tear,’” claimant exhibited is generally a chronic condition, not acute. Dr. Lindberg also estimated that there was only a “ten percent” chance that the activity described by claimant caused his meniscal tear. Further, he testified that there was a “zero” percent chance that claimant’s knee sprains could have been caused by kneeling and standing. The ALJ expressly credited these opinions. Thus, the ALJ’s unequivocal finding that the work-related

activity to which claimant attributed his injury did not cause his knee condition also amounted to an implicit finding that claimant's condition was chronic and likely pre-existing. Though not explicitly stated in his order, the ALJ effectively placed claimant's injury in the "*purely idiopathic personal*" risk category, for injuries that 'are generally not compensable under the Act, unless an exception applies.'" *Brighton*, ¶ 22.

We review de novo whether the ALJ applied the correct legal standard. *See Freedom Colo. Info., Inc. v. El Paso Cty. Sheriff's Dep't*, 196 P.3d 892, 897-98 (Colo. 2008) ("[W]e review de novo whether the district court applied the correct legal standard to its review of the custodian's determination. . . . We review questions of law de novo. . . . Whether a trial court or the court of appeals has applied the correct legal standard to the case under review is a matter of law.") (citations omitted); *Visible Voices, Inc. v. Indus. Claim Appeals Office*, 2014 COA 63, ¶ 11 ("[W]hether the Panel applied the correct legal standard or legal test raises a question of law that we review de novo."). Consequently, whether claimant's injury was correctly categorized as resulting from an employment

risk, a personal risk, or a neutral risk is a question of law we review de novo.

It is undisputed that claimant's injury was entirely asymptomatic before he knelt under and arose from working under the crane. Claimant unequivocally stated, and employer does not dispute, that claimant had no knee injuries prior to the May 2014 work-related incident. Indeed, the record is devoid of any medical records or other evidence demonstrating that claimant had any issues whatsoever with his knee before he stood up from kneeling under the crane and feeling it "pop." Claimant consistently conveyed the mechanism and onset of symptoms in testimony and to his various medical treaters and providers.

The evidence establishes that claimant's knee pop occurred at work and while he was engaged in work-related activities. Reviewing claimant's consistent and undisputed explanation of the mechanism of his injury, in our view his knee would not have "popped" *but for* his actions at work. We conclude that this places him in the "neutral risk" category, which should have been analyzed under the positional risk test. *Brighton*, ¶¶ 25-26.

Applying the positional risk test to claimant's injury, we conclude that his injury arose out his employment because it would not have occurred "but for" his kneeling and standing while working on the crane. Working on the crane required him to kneel down and stand up repeatedly and placed him "in the position where he . . . was injured." *Brighton*, ¶ 27.

Accordingly, we conclude that the ALJ applied the wrong legal standard when he determined that claimant's injury was not work-related. Placing claimant's injury in the neutral risk category and applying the positional risk test, we conclude that claimant's injury is compensable.

### III. Claimant's Remaining Arguments

Having concluded that the ALJ applied the incorrect legal standard when analyzing the work-relatedness of claimant's injury, we need not reach claimant's remaining issues. We therefore decline to address whether the ALJ erred in permitting questioning about claimant's past criminal conviction or whether the ALJ misinterpreted the opinion of an orthopedic surgeon under *Hall v. Industrial Claim Appeals Office*, 757 P.2d 1132 (Colo. App. 1988).

#### IV. Conclusion

The order is set aside and the case is remanded with directions that an order be entered in accordance with this opinion.

JUDGE NAVARRO and JUDGE VOGT concur.

15CA0945 Pederson v. ICAO 06-16-2016

COLORADO COURT OF APPEALS

DATE FILED: June 16, 2016  
CASE NUMBER: 2015CA945

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Court of Appeals No. 15CA0945  
Industrial Claim Appeals Office of the State of Colorado  
WC No. 4-894-819

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Lelah Pederson,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado; Jonathan P. Bayne,  
DDS, P.C.; and Northern Insurance Company of New York,

Respondents.

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ORDER REVERSED AND CASE  
REMANDED WITH DIRECTIONS

Division III  
Opinion by JUDGE RICHMAN  
Graham and Nieto\*, JJ., concur

**NOT PUBLISHED PURSUANT TO C.A.R. 35(e)**  
Announced June 16, 2016

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Turner, Roepke, and Mueller, LLC, Kimberly J. Roepke, Colorado Springs,  
Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

The Kitch Law Firm, P.C., Michelle L. Prince, Evergreen, Colorado, for  
Respondents Jonathan P. Bayne and Northern Insurance Company of New  
York

\*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art.  
VI, § 5(3), and § 24-51-1105, C.R.S. 2015.

In this workers' compensation action, we have been asked to address whether, under section 8-42-104(5), C.R.S. 2015, an impairment rating of zero, issued in a prior division-sponsored independent medical examination (DIME) against one employer, bears on the apportionment of a later claim against a second employer. The Industrial Claim Appeals Office (Panel) held that a second employer is not bound by the earlier DIME impairment rating, and permitted apportionment according to the impairment rating calculated by a later DIME physician. We conclude that under the facts of this case this result is a misapplication of the apportionment statute. We therefore set aside the Panel's final order and remand the case with directions to return the case to the ALJ for entry of an order recalculating claimant's award without any apportionment.

### I. Background

The facts of this case are generally undisputed. Claimant, Lelah Pederson, has sustained two work-related injuries to her neck which she attributed to her two separate employments as a dental hygienist. Her first injury arose in 2009. She filed a claim and an authorized treating physician (ATP) rated claimant's impairment as

a result of the 2009 injury at fifteen percent of the whole person. By the time claimant was seen by the selected DIME physician, Dr. Jeffrey A. Wunder, she had been asymptomatic for four months. Dr. Wunder therefore gave claimant a zero percent impairment rating, concluding that any lingering symptoms she had were “related to an underlying condition which is non-occupational.” Claimant’s then-employer, Ronald Cockrell, DDS, P.C., filed a final admission of liability (FAL) based on Dr. Wunder’s zero impairment rating. It is undisputed that claimant did not challenge this FAL. Subsequently the employer settled her claim for \$6000, but the settlement agreement is not part of the record.

Claimant stopped working for a period of approximately one and a half years after her 2009 injury. In 2010, she returned to work in the dental field for a different employer, Jonathan P. Bayne, DDS, P.C. According to her sworn interrogatory response, she remained symptom-free until 2012 when her neck pain returned. She then filed a new claim for workers’ compensation benefits against Dr. Bayne. After an ALJ determined her claim was compensable, she received treatment from a different ATP. He placed claimant at maximum medical improvement (MMI) in March

2014 and calculated her impairment at twenty-one percent of the whole person.

Dr. Bayne did not admit to the impairment rating, instead requesting a DIME. The DIME physician chosen to examine claimant for this claim, Dr. John Ogrodnick, calculated claimant's total impairment as seventeen percent of the whole person. He acknowledged Dr. Wunder's earlier opinion that claimant had a zero impairment rating in connection with her 2009 claim; however, in an apparent exercise of his medical judgment, he disagreed with that opinion. Dr. Ogrodnick concluded to the contrary that "because her symptoms resolved when she stopped working and came back when she was working," her current injury was necessarily partially attributable to her first workers' compensation claim. He therefore apportioned part of claimant's impairment to her first work injury, relying in part on the impairment rating of the ATP in the first case, resulting in a final impairment of nine percent of the whole person related to her work for Dr. Bayne.

Dr. Bayne filed a FAL and claimant objected. Claimant challenged Dr. Ogrodnick's apportionment of her injury, arguing that her impairment rating should not have been reduced because

Dr. Wunder had not assigned her an impairment rating relative to the 2009 injury; rather he found her impairment to be zero. Apportioning her injury, she claimed, constituted a clear error by Dr. Ogrodnick. The ALJ concluded that the disparity between the DIME physicians' apportionment was merely "a difference of opinion" insufficient to overcome Dr. Ogrodnick's opinion by clear and convincing evidence. The ALJ therefore denied and dismissed claimant's request "to set aside Dr. Ogrodnick's DIME opinion regarding apportionment."

On review, the Panel affirmed the ALJ's order<sup>1</sup>. Interpreting claimant's argument as based on issue preclusion, the Panel ruled that Dr. Wunder's DIME opinion had no preclusive effect on claimant's second workers' compensation claim. The Panel concluded that issue preclusion did not apply because (1) the claims involved different litigant-employers, and (2) claimant's second employer, Dr. Bayne, did not have a full and fair "opportunity to litigate the issue." The Panel therefore determined that Dr. Ogrodnick was not bound by Dr. Wunder's DIME report

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<sup>1</sup> Claimant had also sought penalties for employer/insurer's failure to timely pay out-of-pocket expenses she had incurred. That portion of the Panel's order was not appealed and is not before us.

and that the ALJ did not err in finding claimant had failed to overcome Dr. Ogrodnick's apportionment of her injury. Claimant now appeals.

## II. Application of Apportionment Statute

Claimant contends that the DIME physician, the ALJ, and the Panel all erred by reducing her impairment rating. She argues that because Dr. Wunder assigned her a zero percent impairment rating attributable to her prior work injury, she did not have a "permanent medical impairment" to the same body part within the meaning of section 8-42-104(5). Thus, she reasons, one of the statutory criteria for reducing an impairment rating was not met, making apportionment inapplicable in her case. We agree.

### A. Statute at Issue

The Colorado Workers' Compensation Act (Act) provides for a reduction in an award if part of a worker's injury is attributable to a prior compensable injury to the same body part. The Act states:

(5) In cases of permanent medical impairment, the employee's award or settlement shall be reduced:

(a) When an employee has suffered more than one permanent medical impairment to the same body part and has received an award or

settlement under the “Workers’ Compensation Act of Colorado” or a similar act from another state. The permanent medical impairment rating applicable to the previous injury to the same body part, established by award or settlement, shall be deducted from the permanent medical impairment rating for the subsequent injury to the same body part.

§ 8-42-104(5).

#### B. Law Governing Statutory Interpretation

We turn first to the rules governing statutory construction to guide us in determining which provisions apply here. When we interpret a provision of the Act, if its language is clear “we interpret the statute according to its plain and ordinary meaning.” *Davison v. Indus. Claim Appeals Office*, 84 P.3d 1023, 1029 (Colo. 2004). In addition, “when examining a statute’s language, 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)).

We review statutory construction de novo. *Ray v. Indus. Claim Appeals Office*, 124 P.3d 891, 893 (Colo. App. 2005), *aff'd*, 145 P.3d 661 (Colo. 2006). Although we give deference to the Panel's reasonable interpretations of the statute it administers, *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), 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). In general, "an administrative agency's interpretation of its own regulations is . . . entitled to great weight and should not be disturbed on review unless plainly erroneous or inconsistent with such regulations." *Jiminez v. Indus. Claim Appeals Office*, 51 P.3d 1090, 1093 (Colo. App. 2002); *see also Support, Inc. v. Indus. Claim Appeals Office*, 968 P.2d 174, 175 (Colo. App. 1998).

C. Claimant Did Not Have an Impairment Under Section 8-42-104

The statute at issue here unambiguously states that to apportion an injury, a claimant must have (1) suffered a prior "permanent medical impairment to the same body part" and (2) received an award or settlement as a result of the earlier

impairment. It is undisputed that claimant received a settlement from the insurer for her claim against Dr. Cockrell in the amount of \$6000, but as the settlement agreement is not part of the record, we do not know the basis for this settlement. But, we agree with claimant that the record does not show that she suffered a “permanent medical impairment to the same body part.”

“The statute does not define the term ‘medical impairment.’ Generally, ‘medical impairment’ refers to a total or partial loss of the physical function of a member of the body, or of the body as a whole.” *Boice v. Indus. Claim Appeals Office*, 800 P.2d 1339, 1340-41 (Colo. App. 1990); accord *Turner v. City & Cty. of Denver*, 867 P.2d 197, 199 (Colo. App. 1993). “An impairment relates to an alteration of an individual’s health status as assessed by medical means.” *Lambert & Sons, Inc. v. Indus. Claim Appeals Office*, 984 P.2d 656, 658 (Colo. App. 1998).

In this case, Dr. Wunder determined claimant had not suffered a permanent impairment as a result of the injury she sustained to her neck while working for Dr. Cockrell. He assigned her a zero percent permanent impairment rating relative to that injury, which, in our view, is simply another way of noting that claimant had no

ratable impairment associated with her first claim. He noted, too, that she was asymptomatic when he saw her. Thus, Dr. Wunder concluded that claimant had not sustained any loss of function to her neck as a result of her first work-related injury. According to claimant, she remained asymptomatic for more than two years after Dr. Wunder examined her.

We therefore conclude that claimant had not suffered a prior, “permanent medical impairment” within the meaning of section 8-42-104(5). Accordingly, the first prong of the apportionment statute could not be met, and no reduction should have been taken for claimant’s prior injury.

#### D. Claimant Overcame Dr. Ogrodnick’s DIME Opinion

Nevertheless, Dr. Ogrodnick reduced claimant’s impairment rating for the current injury from seventeen percent of the whole person to nine percent of the whole person because he concluded that a portion of claimant’s current impairment was attributable to her prior work injury. Claimant contends that so apportioning her impairment constituted an error which overcame Dr. Ogrodnick’s reduction of her impairment rating. We agree.

A DIME’s opinion “concerning a claimant’s impairment rating is binding on the parties unless overcome by clear and convincing evidence.” *Wilson v. Indus. Claim Appeals Office*, 81 P.3d 1117, 1118 (Colo. App. 2003); § 8-42-107(8)(c), C.R.S. 2015. “Clear and convincing evidence means evidence which is stronger than a mere ‘preponderance’; it is evidence that is highly probable and free from serious or substantial doubt.” *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App. 1995). “Clear and convincing evidence is evidence demonstrating it is ‘highly probable’ the DIME physician’s rating is incorrect. Therefore, to overcome the DIME physician’s opinion, the evidence must establish that it is incorrect.” *Leming v. Indus. Claim Appeals Office*, 62 P.3d 1015, 1019 (Colo. App. 2002) (internal citation omitted).

Where a physician has failed to follow established medical guidelines for rating a claimant’s impairment in a DIME, the DIME’s opinion has been successfully overcome by clear and convincing evidence. *See, e.g., Am. Comp. Ins. Co. v. McBride*, 107 P.3d 973, 981 (Colo. App. 2004) (DIME physician’s deviation from medical standards in rating the claimant’s back injury constituted error sufficient to overcome the DIME); *Mosley v. Indus. Claim Appeals*

*Office*, 78 P.3d 1150, 1153 (Colo. App. 2003) (DIME physician's impairment rating overcome by clear and convincing evidence where DIME physician failed to rate impairment to the claimant's thoracic spine). Similarly, when a DIME physician's opinion is contrary to the Act, it is grounds for overcoming the DIME because the DIME report is legally incorrect.

We recognize that Dr. Ogrodnick made a medical determination when evaluating claimant that a portion of her current injury was attributable to a prior injury. However, the statute sets forth legal criteria for reduction of awards due to a prior permanent medical impairment to the same body part. As noted, that legal criterion depends on whether there was a "permanent medical impairment to the same body part," and based on the record here, the zero rating assigned by Dr. Wunder did not establish permanent medical impairment. Thus, while Dr. Ogrodnick was free to opine from a medical standpoint that claimant's current injury had a relation to a prior injury, that opinion does not overcome the statutory requirement necessary to permit an apportionment.

A line of precedential cases has held that apportionment is inappropriate if a claimant's prior injury was asymptomatic when the second injury occurred. In particular, it has been held that "a preexisting condition which was dormant or asymptomatic prior to an industrial injury cannot be evaluated adequately for purposes of apportionment." *Askew v. Indus. Claim Appeals Office*, 927 P.2d 1333, 1338 (Colo. 1996). Similarly, apportionment is improper if an injured worker "has fully recovered from a past disability so that the prior injury does not contribute to any present disability." *Mountain Meadows Nursing Ctr. v. Indus. Claim Appeals Office*, 990 P.2d 1090, 1091 (Colo. App. 1999); *see also Lambert & Sons, Inc.*, 984 P.2d at 658 ("Thus, if a claimant has a prior impairment rating, but is asymptomatic at the time of the subsequent injury, apportionment is not appropriate."); *see also City & Cty. of Denver v. Indus. Claim Appeals Office*, 58 P.3d 1162, 1164 (Colo. App. 2002) (once original causation was determined, the earlier resolution "was no longer open to question.") Thus, Colorado has long recognized that apportionment is inappropriate in cases such as this where the evidence and prior DIME report establish that claimant was asymptomatic until the new injury.

We agree with the Panel that apportionment is intended to prevent a claimant from receiving a double recovery for the same compensable injury. But, here claimant was not awarded any permanent partial disability benefits for the portion of her impairment Dr. Ogrodnick attributed to the 2009 injury. And, because of Dr. Ogrodnick's apportionment, she was only awarded approximately half of her full impairment for the current 2012 work related injury. We recognize that claimant received a settlement for the 2009 injury, but, as stated above, the settlement agreement is not part of the record. We therefore do not know the basis for that settlement, whether that settlement constituted compensation for her injury, or for some other costs she incurred as result of her injury.

Generally, whether a party has overcome a DIME opinion is a question of fact within an ALJ's discretion, and will not be set aside if the decision is "supported by substantial evidence in the record." *Meza v. Indus. Claim Appeals Office*, 2013 COA 71, ¶ 31; *Wilson*, 81 P.3d at 1118 ("Whether the DIME physician correctly applied the AMA Guides, and whether the rating itself has been overcome, are questions of fact for determination by the ALJ, and not, as claimant

asserts, questions of law.”). But, an ALJ abuses his or her discretion when the order in question “is beyond the bounds of reason, as where it is . . . contrary to law.” *Heinicke v. Indus. Claim Appeals Office*, 197 P.3d 220, 222 (Colo. App. 2008).

Here, we have determined that section 8-42-104(5) required the existence of a compensable, prior impairment in order for apportionment to apply. Because Dr. Wunder attributed no impairment to the injury claimant sustained while working for Dr. Cockrell and noted that claimant was asymptomatic when he examined her, claimant had no prior “permanent medical impairment” under the statute. *See* § 8-42-104(5); *Askew*, 927 P.2d at 1338. In the absence of an existing “permanent medical impairment,” the ALJ misapplied section 8-42-104(5), and abused his discretion when he concluded that claimant had not overcome the DIME.

### III. Remaining Issues

Having determined that the apportionment statute does not apply here, we need not reach employer’s contention that issue preclusion did not bind Dr. Ogrodnick to Dr. Wunder’s earlier DIME opinion. Whether Dr. Wunder’s opinion constituted a mere

difference of opinion with Dr. Ogrodnick or precluded Dr. Ogrodnick from reaching a different conclusion is irrelevant because employer could not establish one of the two elements of the apportionment statute – it could not show that claimant had sustained a prior “permanent medical impairment.” § 8-42-104(5).

#### IV. Conclusion

Because section 8-42-104 does not permit apportionment under these circumstances, claimant’s impairment should not have been apportioned between her current injury and her prior claim. Neither Dr. Ogrodnick nor the ALJ should have reduced claimant’s impairment rating related to the injury she sustained while in Dr. Bayne’s employ.

Accordingly, the Panel’s order is set aside and the case is remanded with directions to enter a new order recalculating claimant’s whole person impairment without any apportionment of her prior injury.

JUDGE GRAHAM and JUDGE NIETO concur.

15CA1238 Trujillo v ICAO 06-23-2016

COLORADO COURT OF APPEALS

DATE FILED: June 23, 2016  
CASE NUMBER: 2015CA1238

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Court of Appeals No. 15CA1238  
Industrial Claim Appeals Office of the State of Colorado  
WC No. 4-940-537-02

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Frank Trujillo,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, Goodrich Corporation,  
and New Hampshire Insurance Company,

Respondents.

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ORDER AFFIRMED

Division A  
Opinion by CHIEF JUDGE LOEB  
Márquez\* and Casebolt\*, JJ., concur

**NOT PUBLISHED PURSUANT TO C.A.R. 35(e)**  
Announced June 23, 2016

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Michael W. Seckar, P.C., Lawrence D. Saunders, Pueblo, Colorado, for  
Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Ritsema & Lyon, P.C., Derek T. Frickey, Colorado Springs, Colorado, for  
Respondents Goodrich Corporation and New Hampshire Insurance Company

\*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art.  
VI, § 5(3), and § 24-51-1105, C.R.S. 2015.

In this workers' compensation action, claimant, Frank Trujillo, seeks review of a final order of the Industrial Claim Appeals Office (Panel) affirming the denial and dismissal of his claim for benefits. We affirm.

## I. Background

The relevant facts of this case are undisputed. Claimant has worked for employer, Goodrich Corporation, as a machinist since 1997. In 2013, claimant changed positions from machinist to finisher. Sometime after changing positions, he developed bilateral pain in his thumbs and wrists. He filed a claim for workers' compensation benefits, alleging that he had suffered an occupational disease to his wrists and thumbs as a result of repetitive motion required by his job. A physician retained by employer disagreed that claimant's injury was work-related and opined that claimant suffered from pre-existing bilateral osteoarthritis.

Claimant applied for a hearing, and requested temporary total disability (TTD), temporary partial disability (TPD), and medical benefits commencing on the onset date of his claimed occupational

disease. In its response to the application for hearing, employer acknowledged that TTD, TPD, and medical benefits were at issue.

After conducting a hearing, the transcript of which has not been provided to us and is not part of the record on appeal, the ALJ found that claimant's injuries were not related to his employment and therefore not compensable. The parties both state before us that they "agreed on the record at the hearing to narrow the issues to solely the issue of compensability," but we cannot confirm this assertion because no transcript of the hearing has been provided to us. Regardless, the ALJ's order reflects that the issue to be decided was "Whether the claimant has proven, by a preponderance of the evidence, that he sustained an occupational disease, or injury, arising out of and in the course of his employment with the respondent-employer." However, in his final order, the ALJ expressly ruled that "claimant's claim for benefits . . . is denied and dismissed." The ALJ then advised that any petition to review the order must be filed "within twenty (20) days after mailing or service of the order." By including this language, the ALJ effectively implied that the order was final and appealable.

Claimant sought review with the Panel, arguing that the ALJ's order was not final because it did not deny a specific benefit. If the order was deemed final, he challenged the definition of occupational disease the ALJ cited in his order. Although employer agreed that the ALJ's decision was not final, the Panel held that the order was final and appealable, and further found no error in the ALJ's analysis of claimant's alleged occupational disease. Claimant now appeals.

## II. Finality of ALJ's Order

We first address claimant's assertion that the Panel erred in holding that the ALJ's order was final and appealable. Claimant contends, and employer agrees, that the ALJ's order was not final because it only addressed compensability and did not expressly deny a specific benefit. Relying on "a long line of [Panel] cases interpreting" section 8-43-301(2), C.R.S. 2015, claimant argues that because "no specific benefits were listed in the order as being at issue, the denial of the claim did not deny any specific benefit," thereby rendering the order neither final nor appealable. We are not persuaded that the Panel erred.

Section 8-43-301(2) permits “[a]ny party dissatisfied with an order that requires any party to pay a penalty or benefits or denies a claimant any benefit or penalty [to] file a petition to review with the division.” Thus, to be final and appealable, an ALJ’s order “must grant or deny benefits or penalties.” *Flint Energy Servs., Inc. v. Indus. Claim Appeals Office*, 194 P.3d 448, 449-50 (Colo. App. 2008). An order that does not meet this test is not final and deprives the reviewing court of jurisdiction to consider the appeal. *See Ortiz v. Indus. Claim Appeals Office*, 81 P.3d 1110, 1111 (Colo. App. 2003) (holding that the court of appeals lacked jurisdiction to review an order striking claimant’s request for a division-sponsored independent medical examination because the order “did not, on its face, grant or deny claimant any penalty or benefits”).

Although both parties point out that the only issue identified by the ALJ here was compensability, we agree with the Panel that the order effectively denied claimant’s request for benefits. The ALJ’s finding that the claim was not compensable had the practical effect of denying claimant all benefits. In the past, divisions of this court have treated findings of no compensability as final and reviewable because such decisions necessarily deny a claimant’s

request for benefits. *See, e.g., Kater v. Indus. Comm'n*, 728 P.2d 746, 747 (Colo. App. 1986) (reviewing Commission's finding that claimant's injury was not compensable because it arose out of voluntary horseplay and not a work-related activity).

Moreover, claimant here requested TTD, TPD, and medical benefits in his application for hearing. He reiterated this request in his pre-hearing case information sheet, in which he identified medical, TPD, and TTD benefits as compensation he was seeking from employer. In addition, in his post-hearing position statement, claimant requested that the ALJ order employer to pay his medical treatment provided by Dr. Douglas Scott. Finally, the ALJ's order expressly denied and dismissed claimant's "claim for benefits." We therefore agree with the Panel that in this case specific benefits were requested and denied.

Accordingly, the ALJ's order was final and appealable and both the Panel and this court have jurisdiction to consider the issues raised on their merits.

### III. Legal Standard Applicable to Occupational Diseases

Having determined that we have jurisdiction to consider claimant's appeal, we turn to claimant's contention that the ALJ

applied the incorrect legal standard when he determined that claimant had not suffered an occupational disease. Claimant argues that the ALJ's recitation of the definition of occupational disease adopted by a division of this court – which allegedly incorporated the word “prolonged” into the definition – conflicts with the statutory definition of the term set out in section 8-40-201(14), C.R.S. 2015, which does not use the word “prolonged.” See *Colo. Mental Health Inst. v. Austill*, 940 P.2d 1125, 1128 (Colo. App. 1997) (“An occupational disease arises not from an accident but from a *prolonged exposure* occasioned by the nature of the employment.”) (emphasis added). We discern no error in the ALJ's citation to *Colorado Mental Health Institute* nor do we perceive that the ALJ applied an incorrect legal standard as to the definition of the term “occupational disease.”

A claimant seeking benefits for an occupational disease must establish the existence of the disease and that it was directly and proximately caused by the claimant's employment or working conditions. *Wal-Mart Stores, Inc. v. Indus. Claims Office*, 989 P.2d 251, 252 (Colo. App. 1999). An occupational disease arises not from an accident but from multiple exposures over time occasioned

by the nature of the employment. § 8-40-201(14); *Colo. Mental Health Inst.*, 940 P.2d at 1128. A claimant must show that his or her disability was caused by an occupational disease that had its origin in work-related functions and was sufficiently related to those functions to be considered part of the employment contract. *Cabela v. Indus. Claim Appeals Office*, 198 P.3d 1277, 1279-80 (Colo. App. 2008).

Claimant contends that the ALJ erred by citing to and relying on *Colorado Mental Health Institute's* definition of occupational disease, which he argues conflicts with the statutory definition.

Section 8-40-201(14) defines occupational disease as

a disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

The statute does not include the word “prolonged” as did the division in *Colorado Mental Health Institute*.

However, we do not perceive that the use of the words “prolonged exposure” in *Colorado Mental Health Institute* conflicts with the statute. As we read the statutory definition, the General Assembly intended to distinguish “occupational diseases” from acute, accidental, work-related injuries. The statutory definition acknowledges that an occupational disease results from more than one exposure over time to an environment or action at work that by its very repetitiveness causes an illness or injury. Our supreme court expounded on this distinction when it noted that “an ‘accident’ is traceable to a particular time, place and cause, whereas an ‘occupational disease’ is acquired in the usual and ordinary course of employment and is recognized from common experience to be incidental thereto.” *Colo. Fuel & Iron Corp. v. Indus. Comm’n*, 154 Colo. 240, 248, 392 P.2d 174, 179 (1964). “Historically, a distinction has existed between ‘occupational diseases’ and ‘accidents/injuries,’ . . . which has traditionally been justified by the difficulty in determining the cause of the claimed occupational disease.” *Anderson v. Brinkhoff*, 859 P.2d 819, 822 (Colo. 1993) (citations omitted). As the supreme court has interpreted the statutory definition, occupational diseases are necessarily limited

“to those diseases which result from working conditions which are characteristic of the vocation.” *Id.* at 823. And, as a division of this court explained the distinction, “the term ‘accident’ refers to an event traceable to a particular time, place, and cause. . . . An ‘occupational disease,’ on the other hand, is acquired in the ordinary course of employment and is a natural incident of the employment.” *Delta Drywall v. Indus. Claim Appeals Office*, 868 P.2d 1155, 1157 (Colo. App. 1993) (citations omitted); *see also Campbell v. IBM Corp.*, 867 P.2d 77, 81 (Colo. App. 1993) (“The traditional test for distinguishing between accidental and occupational injuries is whether the injury can be traced to a particular time, place, and cause.”).

In our view, the division in *Colorado Mental Health Institute* was merely attempting to accentuate this distinction when it included the word “prolonged” in its definition of “occupational disease.” Consequently, we perceive no conflict between the statute and the definition set out in *Colorado Mental Health Institute*, and thus, conclude the ALJ did not err by citing to both in his order.

Accordingly, we conclude that the ALJ did not apply an incorrect legal standard when he found that claimant did not suffer

an occupational disease to his bilateral thumbs or wrists. We therefore perceive no basis for setting aside the ALJ's order denying and dismissing claimant's claim for benefits or the Panel's order affirming the ALJ. *See* § 8-43-308, C.R.S. 2015.

The order is affirmed.

JUDGE MÁRQUEZ and JUDGE CASEBOLT concur.

**The Supreme Court of the State of Colorado**  
2 East 14<sup>th</sup> Avenue • Denver, Colorado 80203

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**2016 CO 53**

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**Supreme Court Case No. 15SC87**  
*Certiorari to the Colorado Court of Appeals*  
Court of Appeals Case No. 13CA1798

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**Petitioner:**

Pinnacol Assurance,

v.

**Respondents:**

Norma Patricia Hoff; Hernan Hernandez; Alliance Construction & Restoration, Inc.; MDR Roofing, Inc.; and Industrial Claim Appeals Office of the State of Colorado.

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**Judgment Reversed**

*en banc*

June 27, 2016

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**No appearance by or on behalf of Hernan Hernandez; Alliance Construction & Restoration, Inc.; MDR Roofing, Inc.; and Industrial Claim Appeals Office of the State of Colorado.**

**JUSTICE HOOD** delivered the Opinion of the Court.

**JUSTICE GABRIEL** concurs.

**JUSTICE COATS** dissents, and **CHIEF JUSTICE RICE** and **JUSTICE EID** join in the dissent.

¶1 In this workers' compensation insurance case, we consider whether an insurer had a legal obligation to notify a non-insured holder of a certificate of insurance when the insurance policy evidenced by the certificate was cancelled. Based on the certificate at issue here and the relevant statute, we conclude that the insurer had no such obligation. We therefore reverse the court of appeals' judgment to the contrary.

## I. Facts

¶2 Norma Hoff owns a house that she rents out through a property management agency. When the roof of the house sustained hail damage, Hoff and her husband contracted with Alliance Construction & Restoration, Inc. ("Alliance") to repair it. Without Hoff's knowledge, Alliance subcontracted the roofing job to MDR Roofing, Inc. ("MDR"). MDR employed Hernan Hernandez as a roofer.

¶3 While working on Hoff's roof, Hernandez fell from a ladder and suffered serious injuries. He sought medical and temporary total disability benefits for these work-related injuries, but MDR's insurer, Pinnacol Assurance ("Pinnacol"), denied the claim because MDR's insurance coverage had lapsed. Neither Hoff nor Alliance had workers' compensation insurance. Hernandez then brought an action under the Workers' Compensation Act ("WCA" or "the Act"), §§ 8-40-101 to 8-47-209, 8-55-101 to -105, C.R.S. (2015), seeking benefits against MDR, Alliance, Hoff, and Pinnacol.

¶4 The facts relevant to this claim are best summarized chronologically.

¶5 In July 2010, MDR applied for workers' compensation insurance from Pinnacol through Pinnacol's agent, Bradley Insurance Agency ("Bradley"). Shortly thereafter, Pinnacol issued a policy to MDR.

¶6 In October 2010, before starting the roofing job on Hoff's property, Alliance obtained from Bradley a certificate of insurance<sup>1</sup> which verified that MDR had a workers' compensation insurance policy in effect from July 9, 2010, to July 1, 2011.

¶7 On February 10, 2011, Pinnacol informed MDR by certified letter that MDR's insurance policy would be cancelled if Pinnacol did not receive payment of a past-due premium by March 2, 2011. Pinnacol also mailed a copy of this letter to Bradley. Alliance was not notified of the pending cancellation.

¶8 MDR did not pay the past-due premium, and the policy was therefore cancelled effective March 3, 2011. Pinnacol sent letters to MDR and Bradley advising them of the cancellation, but it did not send a letter to Alliance.

¶9 One week later, on March 10, 2011, Hernandez's injuries occurred.

¶10 On March 11, 2011, MDR's owner went to Bradley's office and asked to reinstate the policy. Bradley personnel informed MDR's owner that the policy could be reinstated only if the owner paid the outstanding premium, paid a reinstatement fee, and signed a "no-loss" letter, which is a statement by an insured certifying that no injuries have occurred since the insured's policy was cancelled. MDR's owner made the necessary payments and, although he knew Hernandez had been injured since the policy's cancellation, signed and submitted the no-loss letter. He did not inform Bradley of Hernandez's accident. That same day, upon receiving the payments and

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<sup>1</sup> This certificate is attached as an appendix ("Appendix") to this opinion. A certificate of insurance is "[a] document acknowledging that an insurance policy has been written, and setting forth in general terms what the policy covers." Certificate of Insurance, Black's Law Dictionary (10th ed. 2014).

no-loss letter, Pinnacol reinstated MDR's policy retroactively to the March 3 cancellation date.

¶11 On March 16, 2011, MDR's owner returned to Bradley's office to report Hernandez's March 10 injuries. Bradley contacted Pinnacol to advise it of the claim. Pinnacol contested the claim on coverage grounds and later cancelled the policy.

## **II. Procedural History**

¶12 After conducting a hearing on Hernandez's workers' compensation claim, an administrative law judge ("ALJ") determined that Pinnacol's March 3 cancellation of MDR's insurance policy was proper. The ALJ further determined that MDR's owner's failure to disclose Hernandez's injuries when he signed the no-loss letter was a material misrepresentation that rendered void the March 11 reinstatement of the policy. As a result, MDR had no workers' compensation coverage on March 10—the day of Hernandez's injuries—and Pinnacol could not be held liable on the claim.

¶13 The ALJ also concluded that, in addition to MDR, who was Hernandez's direct employer, Hoff and Alliance were Hernandez's statutory employers under sections 8-41-402 and 8-41-401 of the WCA, respectively. Finding that none of these three parties had a workers' compensation insurance policy in effect on March 10, 2011, the ALJ held them jointly liable for Hernandez's benefits.

¶14 On appeal to the Industrial Claim Appeals Office ("ICAO" or "the Panel"), Hoff argued that, under the doctrine of promissory estoppel, Pinnacol should be barred from denying coverage because the certificate of insurance required Pinnacol to notify Alliance that MDR's policy was being cancelled, she and Alliance relied on the

certificate as proof that MDR had insurance, and Pinnacol failed to notify Alliance of the policy's cancellation. The Panel rejected this argument and affirmed the ALJ's order.

¶15 Hoff then appealed the Panel's order to the court of appeals,<sup>2</sup> again asserting a claim of promissory estoppel. In Hoff v. Industrial Claim Appeals Office, 2014 COA 137M, \_\_ P.3d \_\_, a division of the court of appeals reversed, with each of the division's three judges writing separately. Although the division unanimously rejected the Panel's promissory estoppel analysis,<sup>3</sup> id. at ¶¶ 28-30; id. at ¶ 46 (Casebolt, J., concurring in part and dissenting in part); id. at ¶ 69 (Berger, J., concurring in part and dissenting in part), it disagreed as to how the estoppel claim should be resolved.

¶16 The majority (Judges Dailey and Berger) held that the certificate required Pinnacol to notify Alliance if MDR's insurance policy was cancelled and that any contrary disclaimer language<sup>4</sup> in the certificate was void; accordingly, this notice obligation satisfied the "promise" element of Hoff's promissory estoppel claim as a

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<sup>2</sup> Neither Alliance nor MDR joined in this appeal or filed an appeal of its own.

<sup>3</sup> The court also was unanimous in determining that Hoff had standing to bring a claim for promissory estoppel. Hoff, ¶¶ 2 & n.1, 14-24. The issue of Hoff's standing is not before us, and we therefore do not address it further.

<sup>4</sup> The following statement appears at the top of the certificate:

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT . . . AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE . . . DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

See Appendix. Later, the certificate also states: "THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES." See id.

matter of law. See id. at ¶¶ 2, 31–43 (majority opinion); id. at ¶ 70 (Berger, J., concurring in part and dissenting in part). Judge Casebolt dissented from this holding, instead finding that the certificate was ambiguous and that “the kind and nature of the promises and disclaimers contained in the certificate present[ed] factual issues that the ALJ should first decide” on remand. See id. at ¶ 51 (Casebolt, J., concurring in part and dissenting in part).

¶17 The majority (Judges Dailey and Casebolt) also held, however, that the question of whether the other elements of promissory estoppel were satisfied was a factual issue best resolved by the ALJ in the first instance and that remand was therefore necessary. Id. at ¶¶ 2, 44 (majority opinion); id. at ¶ 46 (Casebolt, J., concurring in part and dissenting in part). Judge Berger dissented from this holding. In his view, the facts relevant to all elements of Hoff’s promissory estoppel claim were undisputed, and the court therefore should have resolved the claim as a matter of law. Id. at ¶¶ 68–69 (Berger, J., concurring in part and dissenting in part). Applying the law to the facts, Judge Berger would have held that Pinnacol was estopped from denying coverage for Hernandez’s benefits. See id. at ¶¶ 69–76.

¶18 We granted Pinnacol’s petition for certiorari.<sup>5</sup>

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<sup>5</sup> We granted certiorari to review the following issues:

1. Whether the court of appeals erred in holding, contrary to Broderick Inv. Co. v. Strand Nordstrom, 794 P.2d 264 (Colo. App. 1990), and decisions by the Industrial Claim Appeal Office (ICAO) which follow Broderick, that a certificate of insurance evidencing the issuance of a workers’ compensation insurance policy required the insurer to inform the certificate holder of the cancellation of the policy, where the certificate states that notice of cancellation “will be delivered in

### III. Analysis

¶19 We begin our analysis by addressing the appropriate standard of review and rejecting Pinnacol's contention that we should defer to the ICAO's interpretation of the WCA. We then turn to Hoff's promissory estoppel claim and, after summarizing the applicable law, examine whether the court of appeals properly determined that the initial, promise element of Hoff's claim was established as a matter of law.

¶20 In doing so, we first consider the court of appeals' determination that the certificate of insurance promised that the insurer, Pinnacol, would notify the certificate holder, Alliance, of policy cancellation. We conclude that the unambiguous language of the certificate contains no such promise.

¶21 Next, we consider the court of appeals' holding that public policy expressed in sections 8-41-402 and 8-41-404 of the WCA required it to construe the certificate as promising notice to Alliance. We conclude that nothing in the WCA supports imposing such a promise either.

¶22 Pinnacol was therefore under no obligation to notify Alliance of policy cancellation. Because Pinnacol did not promise to provide such notice, Hoff's

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accordance with the policy provisions," and the policy only requires the insurer to provide notice of cancellation to the policy holder.

2. Whether the court of appeals erred in interpreting section 8-41-404, C.R.S. (2014), to create a public policy mandate that invalidates the "disclaimers and exculpatory language" in a certificate of insurance to require that notice of cancellation of a policy be provided to certificate holders where section 8-44-110, C.R.S. (2014), does not require such notice and the certificate of insurance form containing such language was approved by the commissioner of insurance pursuant to section 8-44-102, C.R.S. (2013).

promissory estoppel claim fails for lack of a necessary element. Accordingly, we reverse the judgment of the court of appeals.

### A. Standard of Review

¶23 Pinnacol argues the court of appeals erred in not deferring to the ICAO's interpretation of the WCA. Because the ICAO has not rendered a decision addressing the precise issues before us here, we disagree that deference is owed.

¶24 Judicial review of the Panel's disposition of a workers' compensation claim is governed by the WCA. See Fulton v. King Soopers, 823 P.2d 709, 712-13 (Colo. 1992). Section 8-43-307 allows dissatisfied parties to appeal a Panel order to the court of appeals, see § 8-43-307(1), and several subsequent sections circumscribe the nature and scope of that court's review, see §§ 8-43-308 to -310. Section 8-43-313, in turn, allows a still-dissatisfied party to seek review of the court of appeals' decision in this court. If we grant review, our inquiry is limited "to a summary review of questions of law." § 8-43-313. In evaluating a Panel order under these provisions, appellate courts defer to the agency's factual findings but review its conclusions of law de novo. See City of Brighton v. Rodriguez, 2014 CO 7, ¶¶ 11-12, 318 P.3d 496, 501; Kieckhafer v. Indus. Claim Appeals Office, 2012 COA 124, ¶¶ 8, 12, 284 P.3d 202, 205-06.

¶25 So, the presumptive standard of review is de novo for the questions of law central to this case—i.e., the proper construction of the certificate, the insurance policy, and certain provisions of the WCA. See Specialty Rests. Corp. v. Nelson, 231 P.3d 393, 397 (Colo. 2010) ("Statutory construction is a question of law . . . ."); Meier v. Denver

U.S. Nat'l Bank, 431 P.2d 1019, 1021 (Colo. 1967) (“The construction of a written instrument [is] a question of law . . .”).

¶26 But, as Pinnacol points out, this typically unfettered review is sometimes restricted when it comes to interpreting provisions of the WCA. Although appellate courts ultimately are not bound by the Panel’s legal interpretations, see Rodriguez, ¶ 12, 318 P.3d at 501, or by its earlier decisions, Kieckhafer, ¶ 8, 284 P.3d at 205, courts nonetheless traditionally give deference to the Panel’s reasonable interpretations of WCA provisions, see Specialty Rests., 231 P.3d at 397; Kieckhafer, ¶ 8, 284 P.3d at 205.

¶27 Pinnacol seizes on this deference principle, claiming that the court of appeals’ prior decision in Broderick Investment Co. v. Strand Nordstrom Stailey Parker, Inc., 794 P.2d 264, 266 (Colo. App. 1990), set forth a rule that certificates of insurance create no rights for a certificate holder and that, although Broderick did not involve workers’ compensation, the ICAO has long applied this rule in the workers’ compensation context. As support, Pinnacol cites four prior ICAO decisions, in addition to the Panel’s decision here, and asserts these decisions “implicitly interpret the Act as not creating any contractual duty for the benefit of a certificate holder where, as here, the certificate is specifically limited to an informational document only which is subject to the terms of the policy.” Accordingly, Pinnacol argues the ICAO has interpreted the WCA as not requiring notice to certificate holders, and the court of appeals erred in failing to accord deference to this interpretation.

¶28 None of these ICAO decisions, however, interpreted the statutory provisions on which the court of appeals relied in this case. The ICAO did not examine whether

public policy underlying sections 8-41-402 and 8-41-404 of the WCA required insurers to notify certificate holders about policy cancellations and rendered void any disclaimers that would prevent certificates from serving their intended purpose under the Act.

¶29 In fact, three of the four prior decisions, as well as the decision below, merely applied Broderick as controlling precedent without tying that case or its purported rule to any WCA provision at all. See Hernandez v. MDR Roofing, Inc., W.C. No. 4-850-627-03, 2013 WL 858028, at \*4 (Colo. ICAO Feb. 27, 2013); Lopez-Najera v. Black Roofing, Inc., W.C. No. 4-565-863, 2004 WL 2107582, at \*3 (Colo. ICAO Sept. 13, 2004); Gomez v. Gonzales, W.C. Nos. 4-447-171 & 4-449-330, 2004 WL 348737, at \*8 (Colo. ICAO Feb. 18, 2004); Wilson v. H & S Constr., W.C. No. 4-472-849, 2002 WL 2018806, at \*3 (Colo. ICAO Aug. 30, 2002). And the other prior decision squared Broderick with a statutory provision extraneous to the court of appeals' analysis here. See Suttles v. Sherman, W.C. No. 4-308-510, 1997 WL 730627, at \*4-6 (Colo. ICAO Oct. 31, 1997) (citing § 8-45-112, C.R.S. (1997)). It neither interpreted sections 8-41-402 and 8-41-404 nor considered what those provisions require of insurers vis-à-vis certificate holders. Id.

¶30 Thus, Pinnacol's argument suffers from the false premise that the ICAO has rendered an interpretation of the WCA provisions central to the case at hand. In other words, there is no interpretation to which we or the court of appeals could defer. We therefore apply traditional de novo review.

## **B. Promissory Estoppel Does Not Apply Because There Was No Promise**

¶31 We now turn to Hoff's claim that Pinnacol is estopped from denying coverage for Hernandez's workers' compensation benefits. In order to place the issues on which we granted certiorari in context, we first briefly summarize the law of promissory estoppel. We then consider whether there is a promise here, based on the certificate of insurance or the WCA. We conclude there is not.

### **1. Promissory Estoppel Generally**

¶32 Promissory estoppel is a quasi-contractual cause of action that, under certain circumstances, provides a remedy for a party who relied on a promise made by another party, even though the promise was not contained in an enforceable contract. See Wheat Ridge Urban Renewal Auth. v. Cornerstone Grp. XXII, L.L.C., 176 P.3d 737, 741 (Colo. 2007). A claim for promissory estoppel consists of four elements: (1) a promise; (2) that the promisor reasonably should have expected would induce action or forbearance by the promisee or a third party; (3) on which the promisee or third party reasonably and detrimentally relied; and (4) that must be enforced in order to prevent injustice. See, e.g., Cherokee Metro. Dist. v. Simpson, 148 P.3d 142, 151 (Colo. 2006). Where these elements are present, a promise becomes binding and may be enforced through the normal remedies available under contract law. Bd. of Cty. Comm'rs v. DeLozier, 917 P.2d 714, 716 (Colo. 1996).

¶33 Here, the court of appeals concluded that Hoff qualified as a third party beneficiary of the alleged promise made to Alliance and thus could bring a claim based

on that alleged promise. Hoff, ¶¶ 2 & n.1, 22-24. The court also concluded that, although Bradley issued the certificate, Bradley was acting as Pinnacol's agent when it did so and therefore was an entity legally indistinguishable from Pinnacol for purposes of analyzing Hoff's claim. See id. at ¶¶ 29 & n.5, 38 n.6. Pinnacol does not challenge these conclusions, and we accept them as true for purposes of this appeal.

¶34 In addition, the court of appeals majority declined to decide whether Hoff had established all the elements of a claim for promissory estoppel. Id. at ¶¶ 2, 44. Rather, as to all but the promise element, the majority determined that factual issues remained and therefore remanded the case to the ALJ to address those issues in the first instance. See id. at ¶¶ 2 & nn.2-3, 44. Pinnacol does not challenge this remand decision either. Instead, Pinnacol focuses only on the court's disposition of the promise element.

¶35 The question for us, then, is whether the court of appeals properly determined that the promise element of Hoff's claim was satisfied as a matter of law. We turn to that question now.

## 2. Application

¶36 Based on both the language of the certificate's cancellation provision and perceived public policy underlying certain provisions of the WCA, the majority below construed the certificate as promising that Pinnacol would notify Alliance if MDR's workers' compensation policy was cancelled. See id. at ¶¶ 2, 31-43. The majority also concluded that the same public policy considerations voided the certificate's disclaimers. See id. at ¶¶ 31, 39-43.

¶37 We disagree. Considering each of the majority’s dual rationales in turn, we conclude that Pinnacol was under no obligation to notify Alliance of policy cancellation. We also find it unnecessary to address the validity of the certificate’s disclaimers.<sup>6</sup> Even assuming that, despite the disclaimers, the certificate could have contained enforceable promises, we still would conclude that a promise to give notice of policy cancellation to Alliance was not one of them. It follows that, regardless of the disclaimers’ validity, Hoff’s promissory estoppel claim fails for lack of a promise.

**a. Nothing in the Language of the Certificate Promised  
Notice to Alliance**

¶38 The certificate’s notice provision is unambiguous, and it did not promise notice to Alliance.

¶39 In construing a document, we look to its terms and apply them as written unless they are ambiguous. See USI Props. E., Inc. v. Simpson, 938 P.2d 168, 173 (Colo. 1997). To determine whether an ambiguity exists, we ask whether the document’s plain

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<sup>6</sup> As a result, we need not consider the broader issue of the legal status of certificates of insurance that contain such disclaimers, or the parties’ related contentions concerning Broderick, 794 P.2d 264. We note that courts in other jurisdictions have reached divergent conclusions on the question of whether—and if so, under what circumstances—such certificates can give rise to legal rights, compare, e.g., Criterion Leasing Grp. v. Gulf Coast Plastering & Drywall, 582 So.2d 799, 800–01 (Fla. Dist. Ct. App. 1991) (per curiam) (certificate gave rise to legal rights), Bucon, Inc. v. Pa. Mfg. Ass’n Ins. Co., 547 N.Y.S.2d 925, 927 (N.Y. App. Div. 1989) (same), and Marlin v. Wetzel Cty. Bd. of Educ., 569 S.E.2d 462, 469–73 (W. Va. 2002) (same), with T.H.E. Ins. Co. v. City of Alton, 227 F.3d 802, 805–06 (7th Cir. 2000) (certificate did not give rise to legal rights), W. Am. Ins. Co. v. Meridian Mut. Ins. Co., 583 N.W.2d 548, 550–51 (Mich. Ct. App. 1998) (per curiam) (same), and Bradley Real Estate Tr. v. Plummer & Rowe Ins. Agency, Inc., 609 A.2d 1233, 1234–35 (N.H. 1992) (same), and that Broderick belongs to the latter camp, see 794 P.2d at 265–67. We have not yet weighed in on this larger question, and because this case does not require it, we decline to do so today.

language “is reasonably susceptible on its face to more than one interpretation.” See Allen v. Pacheco, 71 P.3d 375, 378 (Colo. 2003). If the document is unambiguous, we will “neither rewrite [it] nor limit its effect by a strained construction.” Id.

¶40 The certificate here lists MDR as the “insured” and Pinnacol as an “insurer affording coverage.” See Appendix. Below this information, and within a box entitled “coverages,” the certificate lists two types of insurance policies: “general liability” and “workers compensation and employers liability.” Id. Several details, such as the policy number and dates of coverage, are included for each of the policies. Id. Further below still, and within a box entitled “certificate holder,” the certificate lists Alliance. Id. Finally, in a separate, adjacent box entitled “cancellation,” the certificate includes the statement central to this case:

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE  
CANCELLED BEFORE THE EXPIRATION THEREOF, NOTICE WILL BE  
DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

Id.

¶41 We conclude this language is reasonably subject to only one interpretation and is therefore unambiguous. In its first clause, the provision refers to the cancellation of “ANY OF THE ABOVE DESCRIBED POLICIES.” This language clearly refers to the general liability and workers’ compensation liability policies referenced within the “coverages” box on the certificate. In its second clause, the provision states that, if one of those policies is cancelled, “NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.” Beginning at the end, “the policy,” when read

together with the first clause, refers to whichever of the two above-referenced policies has been cancelled, and “provisions” refers to the provisions of that policy.

¶42 This leaves us with the word “notice.” Again, we find no ambiguity. Aside from specifying that policy cancellation is the event for which notice will be given, the language of the cancellation provision leaves the word “notice” unqualified. Thus, while we agree with the majority’s observation that “[t]he cancellation provision does not specify to whom notice of cancellation must be given by Pinnacol,” Hoff, ¶ 35, we conclude that the parties consigned the entire question of notice, including to whom it must be given, to the provisions of the policy being cancelled.

¶43 Unlike the court of appeals, we do not believe that, “because Pinnacol was already required, by the terms of the policy, to give notice of termination to MDR,” our construction fails to “give reasonable meaning to . . . the certificate.” See id. at ¶ 37. This reasoning simply begs the question: to conclude that the certificate duplicates a notice obligation contained in the policy, one must necessarily assume that the certificate imposes a notice obligation that exists independent of the policy to begin with. We reject the premise and thus reject the conclusion. Likewise, we discern no tacit meaning from the proximity of the box identifying Alliance as the certificate holder to the box containing the cancellation provision.

¶44 Looking to the two “above described” policies available, the one whose cancellation is at issue in this case is MDR’s workers’ compensation policy. The relevant provisions of that policy, in turn, oblige Pinnacol to give notice of cancellation to MDR and stipulate that such notice must comply with certain timing and delivery

specifications. Nothing in these provisions states that notice will be provided to anyone other than MDR.

¶45 Because the plain language of the certificate promises only that notice will be delivered in accordance with the provisions of MDR's insurance policy, and because the provisions of that policy contain no promise to give notice to certificate holders, we conclude that Pinnacol was under no contractual obligation to notify Alliance when it cancelled MDR's policy.

¶46 We next consider whether, as the court of appeals majority determined, the WCA requires us to impose such an obligation anyway.

**b. Nothing in the WCA Requires Insurers to Provide Notice of Policy Cancellation to Certificate Holders**

¶47 No provision or public policy contained in the WCA required Pinnacol to notify Alliance if MDR's insurance policy was cancelled.

¶48 Our primary task in construing a statute is to effectuate the intent and purpose of the legislature. See Pulsifer v. Pueblo Prof'l Contractors, Inc., 161 P.3d 656, 658 (Colo. 2007). "We determine legislative intent primarily from the plain language of the statute." Id. We also look to statutory language to determine whether public policy affects our construction of an insurance provision. See Bailey v. Lincoln Gen. Ins. Co., 255 P.3d 1039, 1045 (Colo. 2011); see also Rocky Mountain Hosp. & Med. Serv. v. Mariani, 916 P.2d 519, 525 (Colo. 1996) ("Statutes by their nature are the most reasonable and common sources for defining public policy."). In interpreting the WCA, we construe its language "so as to give effect and meaning to all its parts." Pulsifer,

161 P.3d at 658. If the statutory language is clear, we apply it as written. See Specialty Rests., 231 P.3d at 397. We construe the legislature’s failure to include particular language not as an oversight, but as a deliberate omission reflecting legislative intent. See id.

¶49 Applying these principles here, we note first that no WCA provision expressly requires that an insurer provide notice to certificate holders when the underlying insurance policy is cancelled. The only WCA provision that addresses notice of cancellation—section 8-44-110—states that a carrier of workers’ compensation insurance “shall notify any employer insured by the carrier . . . and any agent or representative of such employer, if applicable, by certified mail of any cancellation of such employer’s insurance coverage.” § 8-44-110. The provision does not mention certificates of insurance or certificate holders. Id.

¶50 The ALJ determined, the Panel agreed, and Hoff essentially concedes that the terms of section 8-44-110 required only that Pinnacol notify MDR and Bradley when it cancelled MDR’s policy, and that Pinnacol did so. Hoff does not contend that Alliance was an “employer insured by the carrier,” and for good reason. Even if the term “employer” as used in section 8-44-110 included statutory employers like Alliance, neither applicable law nor the certificate rendered Alliance an “insured” for purposes of that section: Alliance never contracted with Pinnacol for insurance coverage, and neither Hoff nor the court of appeals goes so far as to assert that the certificate itself amounted to an insurance policy or contract of insurance. Cf. Certificate of Insurance,

Black's Law Dictionary (10th ed. 2014) (stating that a certificate of insurance is “a document acknowledging that an insurance policy has been written”).

¶51 Nonetheless, the majority below looked to other provisions of the WCA—namely, sections 8-41-402 and 8-41-404—and concluded based on these provisions that “by legislative mandate, certificates of insurance play a critical role in the workers’ compensation system” and that this role “would be wholly undermined if . . . notices of termination need not be provided to certificate holders.” Hoff, ¶ 40. Consequently, the majority reasoned that “Colorado’s public policy, as described in the Act, requires that courts give effect to the reasonable meaning and purpose of certificates,” which, to the majority, meant that it “must . . . construe the certificate as requiring notice to the certificate holder of termination of coverage.” Id. at ¶ 41.

¶52 We respectfully disagree. Examining sections 8-41-402 and 8-41-404 in the context of the WCA’s insurance and liability scheme, we find nothing that warrants imposing the notice requirement that the court of appeals imposed here. A brief journey through these provisions bears this out.

¶53 The “comprehensive insurance scheme” set forth in the WCA is designed to protect injured workers by ensuring the quick and efficient payment of benefits. See Kelly v. Mile Hi Single Ply, Inc., 890 P.2d 1161, 1163 (Colo. 1995); see also § 8-40-102(1). To that end, any “employer” subject to the Act must “secure compensation for all employees” by maintaining workers’ compensation insurance. § 8-44-101(1)(a)–(d). The WCA embraces a broad conception of the term “employer,” see Finlay v. Storage Tech. Corp., 764 P.2d 62, 64 (Colo. 1988); see also § 8-40-203 (defining “employer”), and

“contains several provisions rendering certain entities who are not ‘direct’ employers of injured persons ‘statutory employers’ within the meaning of the Act,” Krol v. CF&I Steel, 2013 COA 32, ¶ 25, 307 P.3d 1116, 1121.

¶54 Section 8-41-402 is one of these provisions. Section 8-41-402 governs repairs to real property and states that every owner of real property who contracts out work done on that property to “any contractor, subcontractor, or person who hires or uses employees in the doing of such work shall be deemed to be an employer under the [WCA].” § 8-41-402(1). Hoff is Hernandez’s statutory employer under this provision.

¶55 Section 8-41-402(1) further provides that such owner-employers “shall be liable” for workers’ compensation claims resulting from work-related injuries on their property and “shall insure and keep insured all liability” for workers’ compensation imposed under the Act. Id. To offset this financial responsibility, subsection (1) gives such owner-employers the affirmative right to recover the cost of workers’ compensation insurance from the “contractor, subcontractor, or person” that they hire. Id.<sup>7</sup>

¶56 But, as the majority recognized, see Hoff, ¶ 40, section 8-41-402(2) imposes a conditional limitation on such owner-employers’ obligation to pay compensation benefits. Specifically, it provides that, if the “contractor, subcontractor, or person doing

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<sup>7</sup> It is worth noting that this subsection also says the WCA does not apply to “the owner or occupant, or both, of residential real property which meets the definition of a ‘qualified residence’ under [the Internal Revenue Code], who contracts out any work done to the property . . . .” § 8-41-402(1). The applicable section of the Code, in turn, defines “qualified residence” as including a taxpayer’s principal residence. See 26 U.S.C. § 163(h)(4)(A)(i)(I) (2012). Thus, the qualified-residence exception effectively shields an ordinary homeowner from workers’ compensation liability arising from work done to the home in which he or she lives. This exception does not apply here because Hoff uses the house where Hernandez’s injuries occurred as a rental property.

or undertaking to do any work for an [owner-employer] . . . is also an employer in the doing of such work and . . . insures and keeps insured all liability for compensation,” then “neither said contractor, subcontractor, or person nor any employees or insurers thereof shall have any right of contribution or action of any kind” against the owner-employer. § 8-41-402(2) (emphases added).

¶57 Separately, section 8-41-404 addresses workers’ compensation insurance in the specific context of construction work. Section 8-41-404 states in part that “a person who contracts for the performance of construction work on a construction site shall either provide . . . workers’ compensation coverage for, or require proof of workers’ compensation coverage from, every person with whom he or she has a direct contract to perform construction work on the construction site.” § 8-41-404(1)(a) (emphases added). Hoff is “a person who contracts for the performance of construction work on a construction site” for purposes of this provision. See § 8-41-404(5)(a)-(b) (providing broad definitions of “construction site,” in paragraph (a), and “construction work,” in paragraph (b), that encompass the roofing work done at Hoff’s rental house).<sup>8</sup> Critical to the majority’s decision here, the provision defines “proof of workers’ compensation coverage” as including a certificate of insurance. See § 8-41-404(5)(c).

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<sup>8</sup> Like section 8-41-402, section 8-41-404 includes a “qualified residence” exception and therefore does not apply to a homeowner contracting to have work done to the home in which he or she lives. See § 8-41-404(1)(a), (4)(a)(I). But, as noted above, Hoff does not qualify for this exception. Moreover, section 8-41-404 also does not apply to an owner of real property who hires someone “specifically to do routine repair and maintenance” on that property. § 8-41-404(4)(a)(II). Here, the ALJ found that this exception does not apply to Hoff because the roof repair job was not “routine.” Hoff does not challenge this determination, and we therefore accept it for purposes of this appeal.

¶58 Unlike section 8-41-402, section 8-41-404 does not render the persons to whom it applies statutory employers or impose liability for injured workers' benefits. Compare § 8-41-402(1), with § 8-41-404. Rather, persons who fail to provide or obtain proof of insurance as required by section 8-41-404 may be subjected to the administrative fine provisions of section 8-43-409(1)(b) of the WCA. See § 8-41-404(3) ("A violation of subsection (1) of this section is punishable by an administrative fine imposed pursuant to section 8-43-409(1)(b).").<sup>9</sup>

¶59 Reading sections 8-41-402 and 8-41-404 together, the majority below determined that "the Act specifically recognizes certificates of insurance as a mechanism to protect an owner from precisely the types of liabilities [i.e., liability for workers' compensation benefits] imposed on Hoff in this case." Hoff, ¶ 42 (citing §§ 8-41-402, 8-41-404(5)(c)). But we see nothing in the Act that supports this statement.

¶60 Sections 8-41-402 and 8-41-404, though related, impose separate and distinct liabilities: the former imposes liability for workers' compensation benefits, § 8-41-402(1), and the latter imposes liability for administrative fines, § 8-41-404(3). It is only within the framework of section 8-41-404, however, that the legislature has carved out a role for certificates of insurance. As noted above, section 8-41-404 requires that the persons to whom it applies either provide, or obtain proof of, workers' compensation insurance, see § 8-41-404(1)(a), and specifies that a certificate qualifies as such proof, see

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<sup>9</sup> Section 8-43-409(1)(b) imposes fines of either a maximum of \$250, for an initial violation, or a minimum of \$250 and a maximum of \$500, for any subsequent violation, "[f]or every day that the employer fails or has failed to insure or to keep the insurance required by [the WCA]." See § 8-43-409(1)(b)(I)-(II).

§ 8-41-404(5)(c). It then immunizes persons who obtain proof of insurance from liability under its administrative fine provision. See § 8-41-404(1)(c).

¶61 By contrast, section 8-41-402 does not mention certificates or any other proof of insurance. Unlike section 8-41-404, section 8-41-402 does not offer the entities to which it applies the option of obtaining proof of insurance in lieu of supplying insurance. See § 8-41-402(1). Nor does it provide any safe harbor equivalent to section 8-41-404(1)(c). See § 8-41-402. Although it does immunize an owner-employer from contribution and other lawsuits when the entity it employs is insured “and keeps insured,” § 8-41-402(2) (emphasis added), nothing in the statute indicates that this other insurance negates the owner-employer’s independent obligation to secure insurance for itself or that any proof of this other insurance can insulate the owner-employer from liability in the event the other insurance lapses, see § 8-41-402.<sup>10</sup>

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<sup>10</sup> Although this interpretation could, in theory, lead some owner-employers to conclude that their safest bet would be to secure workers’ compensation insurance of their own, we do not see such a result as inevitable. For example, an owner-employer might instead choose to be more proactive in verifying that the coverage identified in a certificate remains in effect on the date work is to be performed. This the owner-employer can do with no trouble at all: at the legislature’s behest, the Division of Workers’ Compensation has created a searchable online database through which anyone can confirm that a given employer has insurance in effect on the date the search is conducted. See Colo. Dep’t of Labor & Emp’t, Insurance Coverage, <https://perma.cc/6FUK-RK22>; see also § 8-47-111(2) (“[T]he division shall develop a procedure for verifying whether or not all employers doing business in . . . Colorado comply with the [insurance] requirements of [the WCA].”). And even where an owner-employer opts to acquire insurance, section 8-41-402 expressly allows it to recover the cost of that insurance from the entity it hires. See § 8-41-402(1). Moreover, to the extent there may be circumstances in which both the owner-employer and its hired entity obtain insurance, we note that this consequence fully comports with the fundamental goal of the WCA: “to assure the quick and efficient delivery of . . . benefits to injured workers at a reasonable cost to employers, without the necessity of any

¶62 Thus, contrary to the court of appeals' conclusion, nothing in section 8-41-402 or section 8-41-404 states, or even suggests, that the legislature intended for certificates of insurance to shield owner-employers from liability for workers' compensation benefits. Because the clear language of these provisions, including the absence, in section 8-41-402, of any exception to an owner-employer's statutory obligations, refutes the majority's interpretation of them, we reject that interpretation. See Specialty Rests., 231 P.3d at 397.

¶63 Moreover, the role certificates play within section 8-41-404 is not undermined if insurers of the policies evidenced by the certificates do not notify certificate holders in the event those policies are cancelled. Section 8-41-404(1)(c) provides that, if a person who must secure or require proof of workers' compensation insurance under section 8-41-404(1)(a) "exercises due diligence by . . . requiring proof of workers' compensation insurance as required by this section," then that person "shall not be liable" for the administrative fines imposed under section 8-41-404(3). § 8-41-404(1)(c). By its terms, this safe-harbor provision requires only that a person exercise due diligence by obtaining a certificate. See id. Nothing in the provision ties the availability of its

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litigation." § 8-40-102(1). Not only does encouraging both statutory and direct employers to maintain coverage more adequately protect injured workers, it also ensures that those employers receive the primary benefit that the WCA is designed to give them—namely, immunity from common-law tort liability. See Curtiss v. GSX Corp. of Colo., 774 P.2d 873, 874–75 (Colo. 1989). Indeed, the legislature has expressly declared its belief that "it is in the best interests of the public to assure that all employers who fall under the provisions of [the WCA] have in effect current policies of insurance or self-insurance for workers' compensation liability." § 8-47-111(1) (emphasis added).

protections to the continued validity of the insurance policy underlying that certificate.  
Id.

¶64 In sum, we disagree with the majority below regarding the role certificates play under the WCA and find no support for its conclusion that “Colorado’s public policy, as described in the Act,” required it to construe the certificate here as mandating notice of policy cancellation to the certificate holder. Because no provision of the Act expressly imposes this requirement either, we conclude that the WCA did not require Pinnacol to notify Alliance when it cancelled MDR’s policy.

¶65 Requiring notice to all certificate holders may be sensible, but it is not our place to legislate what we perceive as a more sensible result. We cannot simply rewrite the statute. See Dove Valley Bus. Park Assocs., Ltd. v. Bd. of Cty. Comm’rs, 945 P.2d 395, 403 (Colo. 1997).

\* \* \*

¶66 Pinnacol was under no obligation to notify Alliance in the event MDR’s workers’ compensation insurance policy was cancelled. Because Pinnacol did not promise to provide notice, Hoff cannot establish the initial, promise element of her promissory estoppel claim, and her claim must fail. The court of appeals erred in concluding otherwise.

#### **IV. Conclusion**

¶67 Neither the terms of the certificate of insurance nor any provision or public policy contained in the WCA required Pinnacol to notify Alliance in the event MDR’s insurance policy was cancelled. Pinnacol therefore did not “promise” to provide such

notice, and Hoff's claim for promissory estoppel must fail for lack of the requisite promise element. For these reasons, we reverse the judgment of the court of appeals.

**JUSTICE GABRIEL** concurs.

**JUSTICE COATS** dissents, and **CHIEF JUSTICE RICE** and **JUSTICE EID** join in the dissent.

APPENDIX

CP 10, 11

**ACORD** **CERTIFICATE OF LIABILITY INSURANCE**

POLICY NUMBER  
10420740

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S) AUTHORIZED REPRESENTATIVE OR PRODUCER AND THE CERTIFICATE HOLDER. DATE TITLED: January 29, 2015 2:31 PM

**IMPORTANT:** If the certificate holder is an ADDITIONAL ASSURED, the policy(ies) must be endorsed. If SUBSCRIPTION IS WAIVED, subject to the printed conditions of the policy(ies), the policy may require an endorsement. A statement on this certificate does not confer rights in the certificate holder(s) (in/n) with endorsement(s).

Insurer Bradley Insurance Group 3401 W. 48th Avenue Denver, CO 80221 Christopher J. DiDonato	Agency 303-493-3000 303-493-8657
Insured NDR Reading Inc. 6250 N. Federal Blvd. 601 Denver, CO 80221	Insured Atlanta Casualty Company Phoenix Assurance 11130

**COVERAGES** CERTIFICATE NUMBER: 10420740

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES, LIMITS AND RATES HAVE BEEN PROVIDED BY THE POLICIES.

TYPE	TYPE OF INSURANCE	CLASSIFICATION	POLICY NUMBER	POLICY PERIOD	COVERAGE	LIMIT
A	GENERAL LIABILITY		10420740	01/29/15	LIABILITY	\$1,000,000
	COMMERCE/INDUSTRY				LIABILITY	\$100,000
B	PRODUCT LIABILITY		10420740	01/29/15	LIABILITY	\$1,000,000
	COMMERCE/INDUSTRY				LIABILITY	\$1,000,000

**CERTIFICATE HOLDER** **CANCELLATION**

A Blank Constellation 1525 Market St., Ste 202 Denver, CO 80202	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE PROVIDED IN ACCORDANCE WITH THE POLICY PROVISIONS.
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EXHIBIT

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JUSTICE GABRIEL, concurring.

¶168 Because I believe that the majority has correctly set forth the applicable law and has reached the result dictated by that law, I concur in the majority's opinion. I write separately, however, to express my view that the result that I believe the law dictates here is arguably inequitable and warrants legislative action to clarify the purpose and effect of a certificate of insurance, as well as the rights and obligations of those who provide and those who obtain such certificates.

### I. Applicable Statutes

¶169 Like the majority, see maj. op. ¶¶ 47-64, I cannot say that the applicable statutes impose a duty on insurers to give notice of a policy's cancellation to certificate holders.

¶170 Section 8-44-110, C.R.S. (2015), requires every insurance carrier authorized to transact business in Colorado, including Pinnacol Assurance, to notify "any employer insured by the carrier or Pinnacol Assurance, and any agent or representative of such employer, if applicable, by certified mail of any cancellation of such employer's insurance coverage." I see nothing in the applicable definitions of "employer" to suggest to me that the term "employer" as used in this section includes a statutory employer like Hoff here. See § 8-40-203, C.R.S. (2015) (defining the term "employer" for purposes of the Workers' Compensation Act (the "Act")); see also § 8-40-302, C.R.S. (2015) (delineating the scope of the term "employer" under the Act).

¶171 Even if the term "employer" as used in section 8-44-110 did include statutory employers, however, neither applicable law nor the certificate of insurance at issue renders such an employer an "insured" for purposes of that section. The certificate of

insurance is not itself an insurance policy or contract of insurance. Rather, it is “[a] document acknowledging that an insurance policy has been written, and setting forth in general terms what the policy covers.” Certificate of Insurance, Black’s Law Dictionary (10th ed. 2014).

¶72 Accordingly, in my view, the applicable statutes did not require that notice of cancellation be provided to the certificate holder in this case.

¶73 I am not persuaded otherwise by section 8-41-404, C.R.S. (2015). Subject to certain exceptions not pertinent here, section 8-41-404(1)(a) requires a person who contracts for the performance of construction work on a construction site either to provide workers’ compensation coverage for, or to require proof of workers’ compensation coverage from, every person with whom he or she has directly contracted to perform the construction work. Section 8-41-404(1)(c) then provides that any person who contracts for the performance of such work and who exercises due diligence by either providing workers’ compensation coverage or requiring proof of such coverage from every person with whom he or she has a direct contract “shall not be liable under subsection (3) of this section.” Section 8-41-404(3), in turn, provides for an administrative fine for violating subsection (1).

¶74 I see nothing in section 8-41-404 that renders a certificate holder an insured for purposes of the Act generally or section 8-44-110 in particular. To the contrary, section 8-41-404, on its face, makes clear that a certificate constitutes proof that someone else has obtained workers’ compensation coverage.

¶75 Notwithstanding the foregoing, I acknowledge that section 8-41-404 suggests the importance of certificates of insurance in this context, particularly given that those who contract for the performance of construction work often rely on such certificates and on the insurance coverage reflected thereon. As a result, it may well be sound public policy to require insurers to provide notice of an insurance policy's cancellation to those holding certificates of insurance concerning the subject insurance policy. Such a public policy decision, however, is for the legislature and not the courts to make.

¶76 Accordingly, I would respectfully encourage our General Assembly to consider the public policies implicated by this case, particularly with respect to the purpose and effect of a certificate of insurance and the rights and obligations of those who provide and those who obtain such certificates.

## **II. Certificate of Insurance**

¶77 Having determined that the applicable statutes did not require that notice of cancellation be provided to the certificate holder in this case, I must next consider whether the certificate itself required such notice. This question, in turn, requires me to assess first whether the disclaimers and exculpatory language contained in the certificate are void as against public policy and second whether the certificate is ambiguous.

¶78 The certificate at issue contains a disclaimer that states:

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF

INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S)' AUTHORIZED REPRESENTATIVE OR PRODUCER AND THE CERTIFICATE HOLDER.

¶79 The certificate further states, “NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES.”

¶80 Because I perceive nothing in the applicable statutes that imposes a duty on insurers to give notice of a policy’s cancellation to certificate holders, I cannot say that those statutes render the above-quoted provisions, which merely explain the limits of the certificate, void as against public policy. Accordingly, I proceed to address whether the certificate at issue is ambiguous.

¶81 Whether a written contract is ambiguous is a question of law that we review de novo. Pub. Serv. Co. v. Meadow Island Ditch Co., 132 P.3d 333, 339 (Colo. 2006). “A contract is ambiguous when it is reasonably susceptible to more than one meaning.” Id.

¶82 To determine whether a contractual provision is ambiguous, we examine the provision’s language and construe that language in harmony with the plain and generally accepted meaning of the words employed. Ad Two, Inc. v. City & Cty. of Denver, 9 P.3d 373, 376 (Colo. 2000). We may also consider “extrinsic evidence regarding the meaning of the written terms, including evidence of local usage and of the circumstances surrounding the making of the contract,” but in determining whether

a contract term is ambiguous, we may not consider “the parties’ extrinsic expressions of intent.” Pub. Serv. Co., 132 P.3d at 339.

¶83 Here, Hoff contends that the certificate is ambiguous because the language concerning the notice of cancellation is encompassed in a box including the identity of the certificate holder. She argues that the clear import of the location and language of the notice provision is that it is a message to the certificate holder directly. Her argument may be correct insofar as it goes, but it does not establish any ambiguity as to whether and when notice to the certificate holder is required, which is the issue before us.

¶84 Specifically, although I agree with Hoff that the juxtaposition of the identity of the certificate holder with the notice provision suggests that the notice referred to is notice due the certificate holder, nothing in the juxtaposition of these provisions suggests to me that notice must always be given to the certificate holder. To the contrary, the notice provision states that notice will be delivered “in accordance with the policy provisions,” and Hoff does not suggest any ambiguity as to the meaning of that phrase.

¶85 Accordingly, Hoff has not established that the certificate at issue is ambiguous.

### **III. Conclusion**

¶86 For these reasons, I respectfully concur in the majority’s opinion and the judgment of the court.

JUSTICE COATS, dissenting.

¶187 Because I disagree with the majority's construction of the controlling statutes and would, instead, largely affirm the judgment of the court of appeals, I respectfully dissent. Quite apart from the outcome of this particular case, however, I fear that the majority's myopic, and at various points in the analysis questionable, construction is likely to have unintended, and substantially deleterious, consequences for the protection of both workers and employers. I write separately, therefore, to identify what I consider to be the central flaw in the majority's reasoning and to emphasize the magnitude of its departure from the underlying philosophy of the workers' compensation scheme.

¶188 Unlike the majority, I believe the court of appeals was entirely correct in its assessment that "[t]he Act expressly contemplates that a person or entity in the chain of contract or work on a construction contract may obtain a certificate of workers' compensation insurance to protect itself from the types of liabilities at issue here." However, unlike the court of appeals, which clearly considered its hands tied by our half-century-old opinion in Chevron Oil Co. v. Industrial Commission, 456 P.2d 735 (Colo. 1969), and the structuring of Hoff's assignment of error to circumvent its subsequent interpretation by other panels of that court, and therefore felt compelled to articulate its holding in a roundabout way, in terms of a combination of promissory estoppel principles and the public policy expressed in the Act, I believe this court should cut through the circuitry and simply hold that the certificate issued by Pinnacle made Alliance an insured employer within the contemplation of section 8-44-110, C.R.S.

(2015), and that Pinnacol's failure to provide notice to Alliance as required by that statute therefore resulted in Pinnacol's continued coverage of the injured worker. I think it a relatively straightforward task to distinguish Chevron, which concerned a dispute among three different insurance companies over which would be liable to compensate for a worker's death and, as relevant here, merely stood for two peripheral propositions: first, that an administrative rule of the Industrial Commission could not modify the statutory scheme by adding a requirement to give prior notice of a cancellation to the Commission itself, and second, that in any event, the insurer was not a proper party to complain about non-compliance with that administrative rule, the purpose of which was for the protection of the claimant entitled to compensation. In light of its subsequent broad interpretation by the intermediate appellate court, see First Comp Ins. v. Indus. Claim Appeals Office, 252 P.3d 1221 (Colo. App. 2011), I consider it the duty of this court to clarify this holding of Chevron by express limitation.

¶89 As an aside, I applaud the majority for concluding, at least with regard to the workers' compensation statutes at issue here, that this court is not limited by any prior interpretation of the ICAO. I consider it counterproductive, however, to continue to mouth, as does the majority, confusing (if not deceptive) language to the effect that "courts nonetheless traditionally give deference to the Panel's reasonable interpretations of WCA provisions." Maj. op. ¶ 26. While no great harm can come of our showing deference, in the sense of a respectful consideration for the Commission's views, deference to the Panel's "reasonable interpretations" of WCA provisions implies actual acceptance of the Commission's choice among multiple reasonable

interpretations of ambiguous WCA statutes, more in the vein of modern federal administrative jurisprudence. See generally John H. Reese, Bursting the Chevron Bubble: Clarifying the Scope of Judicial Review in Troubled Times, 73 Fordham L. Rev. 1103 (2004). As we have indicated elsewhere, we have never adopted the federal administrative model, and it remains the obligation of the judiciary to interpret the statutes of this jurisdiction. Mile High Cab, Inc. v. Colo. Pub. Utilities Comm'n, 2013 CO 26, ¶ 12, 302 P.3d 241, 245-46.

¶90 The court of appeals' emphasis on the role given by the General Assembly to certificates of insurance in the workers' compensation scheme derives not only from the Act's specific provision for such certificates in the context of construction work but, more generally, from the fundamental compromise upon which workers' compensation was predicated. The statutory scheme was designed to grant an injured employee compensation from his or her employer without regard to negligence, and in return, the responsible employer would be granted immunity from common-law negligence liability. Frank M. Hall & Co. v. Newsom, 125 P.3d 444, 446 (Colo. 2005) (citing Finlay v. Storage Tech. Corp., 764 P.2d 62, 63 (Colo. 1988)). Our statutory scheme has also long provided an extra layer of protection for the employees of subcontractors by imposing, with some exceptions, employer liability not only on the subcontractors by whom these employees are directly employed, but also on the property owners or companies contracting out work to those subcontractors. Id. (citing San Isabel Elec. Ass'n, Inc. v. Bramer, 510 P.2d 438, 440 (Colo. 1973)). The central mechanism through which this

swift and certain compensation would become possible was to be statutorily required insurance, covering the liability statutorily imposed on each of these employers.

¶191 The scheme therefore imposes a duty on such “statutory employers” to insure and keep insured this broad statutorily created liability, permitting them even to recover the costs of such insurance from their subcontracting employers. By the same token, however, the scheme makes clear that neither subcontractors with employees of their own, who maintain insurance coverage for their employees as required by statute, nor their employees themselves have a right of contribution against their statutory employers. Unless the scheme intends the enrichment of workers’ compensation carriers by requiring that premiums be paid by statutory employers, notwithstanding existing adequate coverage by their subcontracting employers, and forcing subcontracting employers to bear not only the cost of their own coverage but also that of their statutory employers, it necessarily contemplates some means of establishing definitively whether the liability of persons or entities contracting or subcontracting with statutory employers remains adequately covered.

¶192 With regard to construction work in particular, where the phenomenon of subcontracting employers is virtually universal, the statutory scheme actually imposes an administrative fine upon any person who contracts for the performance of construction work and fails to either provide coverage himself or require proof of coverage by every person with whom he has a direct contract. Because the statute expressly exonerates from this administrative fine any person who contracts for the performance of construction work and requires proof of coverage by those with whom

he directly contracts, the majority concludes that proof of coverage has significance only in the context of administrative fines and plays no broader role with regard to the liability of statutory employers. By contrast, I believe proof of coverage provided by an insurance carrier to a statutory employer – a company or property owner who would be liable for injury or death to the employees of its contractors or subcontractors but for adequate coverage by those entities themselves – actually defines the scope of the carrier’s statutory obligation to provide notice before cancelling an insurance policy upon which that statutory employer’s liability is contingent.

¶93 Because the effectiveness of the Workers Compensation Act depends on the maintenance of adequate insurance coverage against the liability of employers for injuries to their employees, the statute requires notice to “any employer insured by the carrier or Pinnacol Assurance” before it will be permitted to cancel that employer’s coverage. See § 8-44-110. The majority accepts without reflection that in order to be an “employer insured by the carrier,” an employer must actually be in privity of contract with the carrier, but this gloss is certainly not implied by the term “insured” itself, and there is every reason to believe it was not intended by the legislature. The statutory phrase “any employer insured by” clearly refers to any employer whose liability for injury to his employees is insured against, rather than simply an employer who has insured his personal well-being. Where the statutory scheme creates multiple levels of liability, in the form of statutorily designated employers, all of whose liability for subcontractor employee injury is statutorily insured against by the policy of any subcontracting employer, the better reading of the phrase “any employer insured by the

carrier or Pinnacol Assurance” includes all of those statutory employers to whom the insurer has certified coverage against their statutorily imposed liability.

¶94 Apart from the majority’s failure to give any serious consideration to the meaning of the notice of cancellation provision, much less to examine it in light of the policy expressed by the scheme as a whole, I believe the majority’s cramped reading of the role that certificates or other proof of insurance play in the workers’ compensation scheme derives in part from its misunderstanding of the relationship between sections 8-41-402 and 404, C.R.S. (2015). Sections 401 and 402 treat of persons, companies, or corporations that lease or contract out any part of the work of their business, or that own any real property or improvements thereon and contract out any work done on that property. Section 404 deals with contracting for a particular kind of work—work on construction sites. Because a person who contracts for the performance of construction work on a construction site can (and almost certainly will) be a person, company, or corporation governed by section 401 or 402, the majority’s suggestion that the administrative fine imposed by section 404 is somehow unrelated to the liability imposed on statutory employers by section 402 is not simply too mechanical, but in fact untenable.

¶95 From section 404’s provision for a fine in the construction site context, and its express exoneration from that fine upon obtaining proof of coverage by a direct employer, the majority concludes not only that proof of coverage serves no purpose other than the exoneration of an employer from administrative fines, but also that the statutory scheme intends for separate coverage to be required of statutory employers,

even in the face of proof of adequate existing coverage by the direct employer. Not only does this interpretation (or more accurately imputation) imply a legislative intent to bestow a windfall on insurance carriers, in the form of double premiums for single coverage, but in addition, it effectively thwarts the fundamental goal of the scheme – to ensure coverage for all injured employees, in lieu of obliging them to seek recovery from uninsured employers. To construe the phrase in section 8-44-110, “shall notify any employer insured by the carrier or Pinnacol Assurance,” as including every employer to whom the insurer has provided proof that the employer’s statutory liability is insured against, would guarantee that each such statutory employer is given an opportunity to exercise its statutory right to renew coverage and pass on the cost, if it chooses, to the contractor, subcontractor, or person with whom it contracts.

¶96 Because our opinion in Chevron actually involved the impact of an administrative rule on the statutory scheme rather than construction of a cancellation provision of the Act, first appearing in 1989, see ch. 69, sec. 1, § 8-44-114, 1989 Colo. Sess. Laws 417, 418, I do not believe our holding in that case presents any impediment to this construction. To the extent it could be read to adversely affect the standing of a statutory employer to challenge the cancellation of a policy upon which its liability is contingent, I would expressly limit or overturn it. To construe the Workers Compensation Act so narrowly as to relieve Pinnacol of any obligation to notify Alliance of its intent to cancel, after certifying to Alliance sufficient coverage to protect it from claims of injury by its statutory employees, flies in the face of the fundamental compromise upon which the Act was predicated. While I therefore agree with the court

of appeals' understanding of the policy supporting the Act, because I believe that in the absence of notice to Alliance, the coverage by Pinnacol remained in existence, I see no need for a remand concerning reliance by Hoff.

¶97 I therefore respectfully dissent.

I am authorized to state that CHIEF JUSTICE RICE and JUSTICE EID join in this dissent.