COLORADO
Department of
Labor and Employment

Division of Workers' Compensation
633 17th Street, Suite 400
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303-318-8700

# June Case Law Update

**Presented by Judge Laura Broniak and Judge John Sandberg**

**This update covers ICAO and COA decisions issued between May 5, 2018 to June 12, 2018**

## Industrial Claims Appeals Office Decisions



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# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 3-840-625-04

IN THE MATTER OF THE CLAIM OF:

CHRISTEL SCHROEDER,

Claimant,

v.

FINAL ORDER

THORN EMI NORTH AMERICA,

Employer,

and

FEDERAL INSURANCE COMPANY,

Insurer,
Respondents.

The *pro se* claimant seeks review of an order of Administrative Law Judge Felter (ALJ) dated November 22, 2017, that denied and dismissed any and all of her claims for post maximum medical improvement (post-MMI) maintenance medical benefits after July 26, 2015. We modify the ALJ's order and, as modified, affirm.

This matter went to hearing on the sole issue of whether post-MMI maintenance medical benefits from July 26, 2015, and ongoing are reasonably necessary and causally related to the claimant's compensable injury of September 17, 1986. After the hearing, the ALJ found that the claimant sustained an industrial injury when she slipped on a waxed floor at work, falling on her buttocks and outstretched hands. She reported pain in her forearms and low back, and subsequently developed stiffness in her neck.

The respondents filed a general admission of liability. The claimant initially treated with authorized treating physician, Dr. Davis, who diagnosed the claimant with lumbar degenerative joint disease, mild fibrositis, and depression.

On September 6, 1989, the parties settled the indemnity claims. The claimant was paid a lump sum in cash, and an annuity was purchased by the claimant's former attorney with the remainder of the settlement proceeds. The stipulation appears to have been approved by an administrative law judge. Since this time, the claimant's claim has remained open for maintenance medical care only.

The claimant continued to undergo treatment with Dr. Davis as well as other physicians. The claimant underwent testing, psychiatric and psychological evaluations, surgery, hospitalizations, and was provided with medications, blocks, physical therapy, and injections. In particular, from October 7, 2002, through July 28, 2015, the claimant underwent 17 cervical epidural steroid injections and 32 lumbar steroid injections for her degenerative condition.

On March 6, 2016, Dr. Ogin performed an independent medical examination at the request of the respondents. Dr. Ogin opined that none of the claimant's current medical treatment was reasonably necessary, and/or causally related to the September 17, 1986, industrial accident.

Subsequently, on May 23, 2017, the claimant filed an application for hearing listing compensability, medical benefits, authorized provider, reasonably necessary, permanent total disability (PTD) benefits, death benefits, and penalties as issues to be considered. In response to the claimant's application for hearing, the respondents stated, in part, that compensability, PTD, and all issues are moot since they had been settled, except for the issue of medical benefits.

After the hearing, the ALJ entered his order ruling that "[a]ny and all claims for post maximum medical improvement medical maintenance benefits after July 26, 2015 are hereby denied and dismissed." He found that each and every medical provider was of the opinion that the claimant's present condition is not causally related to the September 17, 1986, industrial injury. In his order, the ALJ recognized that an insurer may contest future claims for medical treatment on the basis that such treatment is not causally related to the industrial injury. He determined that even though an admission is filed, the claimant bears the burden of proof to establish the right to specific medical benefits. The ALJ ultimately concluded that the claimant failed to sustain her burden of proving that her post-MMI medical maintenance care and treatment since July 26, 2015, was proximately and causally related to her industrial injury of September 17, 1986.

The claimant has timely filed a petition to review the ALJ's order.[1] However, the claimant did not file a brief in support of her petition. Consequently, the effectiveness of

[1] On February 12, 2018, the ALJ entered an Order dismissing the claimant's "construed" petition to review. He ruled that on February 6, 2018, the claimant filed a letter requesting another trial with a change of venue. He ruled that since the petition was not filed within 20 days of the certificate of mailing of his order of November 22, 2017, the claimant's petition was jurisdictionally barred. Section 8-43-301(2), C.R.S. However, the record on appeal demonstrates that the claimant's petition to review actually was filed on December 11, 2017, or

our review is limited. *See Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986). Additionally, the record contains no transcript of the hearing before the ALJ. Where, as here, the appealing party fails to procure a transcript of the hearing, we must presume the ALJ's findings of fact are supported by substantial evidence. *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988).

With regard to liability for ongoing medical benefits after MMI, an admission of liability for the payment of medical treatment does not amount to an admission that all subsequent medical treatment is causally related to the industrial injury, or that all subsequent treatment is reasonable and necessary. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). Even if the respondents are obligated by admission to pay ongoing medical benefits after MMI, they always remain free to challenge the cause of the need for continuing treatment and the reasonableness and necessity of specific treatments. *Cf. HLJ Management Group, Inc. v. Kim*, 804 P.2d 250 (Colo. App. 1990) (filing of admission does not vitiate respondents' right to litigate disputed issues on a prospective basis).

However, where the respondents attempt to modify an issue that previously has been determined by an admission, they bear the burden of proof for such modification. Section 8-43-201(1), C.R.S.; *see also Salisbury v. Prowers County School District RE2*, W.C. No. 4-750-735 (June 5, 2013); *Barker v. Poudre School District*, W.C. No. 4-750-735 (March 7, 2012). Additionally, at the time the parties entered into their stipulation, §8-51-108, C.R.S. (1985), the predecessor statute to §8-43-204, C.R.S., provided that a settlement could only be reopened or set aside on the grounds of fraud or mutual mistake of material fact. *See* Ch. 77, sec. 2, §8-53-105, 1985 Colo. Sess. Laws 355.

Here, the ALJ's order appears to terminate any and all post-MMI maintenance medical benefits from July 26, 2015, and ongoing. However, in the pleadings filed before the hearing, that was not identified as an issue to be decided by the ALJ. As detailed above, the claimant filed the application for hearing identifying medical benefits as one of the issues to be heard at the hearing. In response, the respondents did not identify as an issue to be heard the termination of all post-MMI maintenance medical benefits or the modification of an issue previously admitted, or the reopening of the 1989 stipulation on grounds of fraud or mutual mistake of fact. Further, in his order, the ALJ placed the burden on the claimant to prove that her post-MMI maintenance care since

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within 20 days from the date of the ALJ's order. Consequently, the claimant's petition to review was timely filed pursuant to §8-43-301(2), C.R.S. and is not jurisdictionally barred.

July 26, 2015, was proximately and causally related to her industrial injury and reasonably necessary. Order at 10-11 ¶¶45, c. If the respondents had attempted to terminate all post-MMI maintenance medical benefits or modify their admission, or reopen the 1989 stipulation based on fraud or mutual mistake of fact, then they would have had the burden to do so. Section 8-43-201(1), C.R.S.; *see also Salisbury v. Prowers County School District RE2*, *supra*; *Barker v. Poudre School District, supra*; §8-51-108, C.R.S.; Ex. 1. Consequently, we conclude it is necessary to modify the ALJ's order to provide that the claimant's claims for post-MMI maintenance medical benefits from July 26, 2015, up to the date of the hearing are denied and dismissed as not being causally related to the industrial injury of September 17, 1986.

We further conclude that substantial evidence supports the denial and dismissal of post-MMI maintenance medical benefits from July 26, 2015, up to the date of the hearing. Again, since the record on appeal contains no transcript of the hearing before the ALJ, we must presume the ALJ's findings of fact are supported by substantial evidence. *Nova v. Industrial Claim Appeals Office*, *supra*. Regardless, the ALJ credited Dr. Ogin's opinion that none of the claimant's current medical care and treatment is reasonably necessary, and/or causally related to the September 17, 1986, industrial accident. This was a reasonable reading of Dr. Ogin's report. Ex. A at 17. Section 8-43-301(8), C.R.S. Accordingly, we affirm the ALJ's order as modified.

**IT IS THEREFORE ORDERED** that the ALJ's order dated November 22, 2017, is modified and, as modified, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

5/7/18 by TT .

CHRISTEL A SCHROEDER, PO BOX 16, STILLWELL, KS, 66085 (Claimant)
RITSEMA & LYON PC, Attn: KRISTIN A CARUSO ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. Nos. 5-022-847-03 &
4-977-514-01

IN THE MATTER OF THE CLAIM OF:

BEN M. CAMARA,

Claimant,

v.

FINAL ORDER

ABM INDUSTRIES,

Employer,

and

INDEMNITY INSURANCE COMPANY OF NORTH AMERICA,

Insurer,
Respondents.

The respondents seek review of a supplemental order of Administrative Law Judge Turnbow (ALJ) dated February 20, 2018, that ordered the respondents to pay for surgery and other reasonable necessary medical benefits. We affirm the ALJ's order.

The claimant sustained an admitted injury to his low back on October 13, 2014, which is the subject of W.C. No. 4-977-514-01. The claimant sustained another admitted injury to his low back on March 23, 2016, which is the subject of W.C. No 5-022-847-03. The claims were consolidated for hearing on the issues of whether the recommended L4-5 lumbar decompression is reasonable and necessary and whether the need for the surgery was related to the October 13, 2014, or March 23, 2016, injury and reopening of the October 13, 2014, claim. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant was employed as a bus driver for the employer. The claimant's October 13, 2014, injury occurred when he slipped and fell on a wet bathroom floor injuring his low back and experiencing left leg pain. The claimant underwent an MRI on November 12, 2014, which showed a small broad-based disc protrusion at L4-5, resulting in mild central canal stenosis and moderate bilateral foraminal compromise but no exiting nerve root deformity Other disc levels were normal from T11-12 to L5-S1. The claimant was eventually referred to Dr. Ghiselli at the Denver Spine Surgeons. Dr. Ghiselli found that the claimant had minimal leg symptoms and no weakness and did not feel that surgery would be of benefit to the

claimant or that it was necessary. The claimant then underwent a steroid injection, after which he demonstrated improved range of motion and functional improvement.

The claimant was evaluated by Dr. Fall on February 9, 2015. Dr. Fall reported that the claimant was doing well, able to do his home exercise program and had no pain. Dr. Fall concluded that the claimant suffered from an asymptomatic L4-5 disc protrusion and discharged the claimant from care and released him to full duty with no impairment. Dr. Holmboe placed the claimant at maximum medical improvement (MMI) on May 13, 2015, for the 2014 work injury and released him from care.

The claimant was involved in a non-work-related motor vehicle accident (MVA) collision on February 26, 2015. The claimant was a restrained driver with no airbag deployment and the claimant's car was drivable after the collision. The emergency room physician noted that the claimant's only complaints were left lateral neck pain and headaches. At the emergency room the claimant was diagnosed with upper back pain and was given Motrin and discharged.

On March 4, 2015, the claimant consulted with Dr. Gray at the Lakewood Injury Treatment center and reported his chief complaints were headaches, neck pain and left low back pain with lower extremity symptoms. Dr. Gray ordered a repeat MRI of the low back to rule out a worsening of his pre-existing condition at L4-5. The second MRI revealed mild degenerative disc disease and a shallow broad-based posterior disc protrusion and annular fissure at L4-L5 which abuts the descending L5 nerve root, slightly greater on the left than the right. An addendum to the report stated that the broad based posterior disc protrusion at L4-L4 is slightly improved and decreased in size in the interval. Dr. Gray commented that there did not appear to be any significant changes. The claimant was referred to chiropractic care and advised to follow-up with Dr. Fall to discuss the possibility of a repeat steroid injection. The claimant continued to seek treatment and complain of left sided low back pain and left leg pain.

Dr. Wakeshima evaluated the claimant on May 19, 2015, and concluded that the current posterior neck pain and upper back pain were 100 percent related to the 2015 MVA. Dr. Wakeshima acknowledged the claimant's history of pre-existing low back injury and leg pain. Dr. Wakeshima noted no significant interval changes between the claimant's 2014 work-related injury and the 2015 MVA and attributed 60 percent of the claimant's ongoing low back pain to the MVA and 40 percent to the 2014 work-related injury. Dr. Wakeshima concluded that spine surgery was not indicated. A note from a July 21, 2015, visit with Dr. Wallace indicated that the claimant was getting better and

that his left leg pain was receding and not as intense but still had stiffness in his neck and low back.

The claimant underwent a Division Independent Medical Examination (DIME) for the 2014 work-related injury which was performed by Dr. Dillon on December 8, 2015. The DIME physician agreed that the claimant reached MMI for his 2014 low back and left leg conditions and determined that they were not ratable. Dr. Dillion attributed the claimant's current symptoms to the 2015 MVA.

The claimant was involved in a second MVA on March 23, 2016, while driving a bus for the employer. The claimant reported that he had increased low back pain with stabbing pain that radiated into both legs. The claimant underwent a third MRI on April 28, 2016, which showed moderate bilateral L4-5 neuroforaminal stenosis and mid central spinal canal stenosis at this level owing to a broad based protrusion, minor central disc bulge at L5-S1 and no interval change in comparison to the prior MRI of 2014.

The claimant returned to Dr. Fall on May 20, 2016, and she acknowledged that although there was no interval change between the 2014 MRI and the 2016 MRI, she found that the 2016 MRI, in contrast to the 2014 MRI, demonstrated moderate bilateral L4-5 neuro-foraminal stenosis and mid central spinal canal stenosis due to a broad based disc protrusion and also noted that the claimant was experiencing parasthesias down both legs. Dr. Fall recommended that the claimant undergo bilateral L4-5 transforaminal steroid injections.

After the claimant received steroid injections he returned to Dr. Fall and continued to report no changes in symptoms. After an electro diagnostic evaluation Dr. Fall recommended that the claimant undergo a left L5-S1 injection and also referred him to a spine surgeon for a surgical evaluation.

Spine surgeon, Dr. Castro, noted that the claimant's pain significantly increased after the March 2016 accident. After comparing the 2016 MRI to the 2014 MRI, Dr. Castro found that it highlighted some disc desiccation at L4-L5 with mild disc protrusion and annular tear.

The claimant underwent a L5-S1 transforaminal epidural steroid injection on September 14, 2016, and then returned to Dr. Fall reporting that he was worse. The claimant's pain had increased and he was having difficulty doing things around the house. The claimant was referred for additional pool therapy.

The claimant returned to Dr. Castro in November of 2016 and underwent another MRI. This MRI showed canal stenosis at L4-L5 with protrusion and annular tearing, L5-S1 with canal narrowing. Foraminal narrowing right greater than left. Dr. Fall reviewed the MRI and assessed that the claimant suffered from L4-5 and L5-S1 disc protrusions with bilateral lower extremity radiculitis with possible progression on a more recent study. Hoping to improve the claimant's symptoms, Dr. Castro recommended a one-level micro-discectomy decompression for decompression of the lateral recesses. Dr. Fall agreed with Dr. Castro's recommendations.

Dr. Burris performed an independent medical examination (IME) at the respondents' request. Dr. Burris agreed with Dr. Fall and Dr. Castro that the claimant suffered from low back pain with bilateral lower extremity radiculitis and that the 2016 work-related MVA was the proximate cause of the claimant's current symptoms and that the L4-5 lumbar decompression recommended by Dr. Castro is reasonable, necessary and related.

Dr. Riess performed a second IME for the respondents. In Dr. Reiss' opinion, the 2016 work related MVA did not change the claimant's pre-existing condition and the treatment recommendations were related to the pre-existing non-work-related condition.

The claimant underwent a third IME with Dr. Hughes on June 26, 2016. Dr. Hughes agreed that the surgical treatment proposed by Dr. Castro was reasonable and necessary but believed that the original 2014 work injury was the proximate cause of the claimant's current symptoms.

The ALJ credited the opinions of Dr. Burris, Dr. Castro and Dr. Fall to find that the March 2016 work-related MVA was the cause of the claimant's current symptoms and that the L4-5 lumbar decompression recommended by Dr. Castro is reasonable, necessary and related to the March 23, 2016, event. The ALJ specifically rejected the opinions of Dr. Reiss finding that Dr. Reiss' testimony was inconsistent with the other providers' opinions, the overwhelming medical records and the objective findings on the claimant's four separate MRI scans which documented that the claimant's initial lumbar strain was objectively worse after the March 2016 work-related MVA. The ALJ ordered the respondents to pay for the recommended surgery and other reasonable and necessary medical benefits.

On appeal the respondents contend that the ALJ's order should be scrutinized more critically because the ALJ adopted the claimant's proposed findings of fact and

order virtually verbatim. The respondents further contend that the order is not supported by substantial evidence nor is it a correct recitation of the issues submitted for hearing and the order fails to resolve the conflicts in the evidence. We are not persuaded the ALJ committed reversible error.

The courts have repeatedly declined to reverse orders merely because they were originally drafted by one of the parties. In *Ficor, Inc. v. McHugh*, 639 P.2d 385 (Colo. 1982), and *Uptime Corp. v. Colorado Research Corp.*, 161 Colo. 87, 420 P.2d 232 (1966), the court held that if the findings are otherwise sufficient, they are not weakened or discredited because they were originally drafted by one of the parties. The court in *Uptime* added that it is presumed on appeal that the fact finder "examined the proposed findings and agreed that they correctly stated the facts as he himself found them to be; otherwise, he would not have adopted them as his own." 420 P.2d at 235. We are unpersuaded that there is any basis to depart from these holdings.

Nevertheless, as argued by the respondents, where the order was drafted by one of the parties we must critically scrutinize the ALJ's findings. The ALJ's findings here adequately indicate the basis for the decision, and the findings support the award. Thus, we perceive no irregularity or impropriety. We also note that at the conclusion of the hearing on August 24, 2017, the parties agreed to submit proposed orders. Thus, the respondent waived any objection to the ALJ's consideration of the claimant's "proposed" order. Therefore, we decline to reverse the ALJ's order on this basis.

The ALJ determined that the claimant established, by a preponderance of the evidence, that his need for back surgery was proximately caused by the March 2016 work injury. *See Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997) (right to medical benefits arises only when claimant establishes by preponderance of evidence that need for treatment proximately caused by work injury). Questions of causation are generally factual in nature, to be resolved by the ALJ after weighing the competing evidence. *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). Because the question of the need for medical treatment is one of fact, we must defer to the ALJ's resolution of conflicts and inconsistencies in the record, and must uphold her findings if supported by substantial evidence. §8-43-301(8), C.R.S.; *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). The substantial evidence standard also requires that we view evidence in the light most favorable to the prevailing party. Thus, the overall scope of our review under the substantial evidence standard is "exceedingly narrow." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 2003). Although causation need not be proved by medical evidence, to the extent such evidence is offered, it is for the ALJ to assess its weight, credibility, and

probative effect. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). Furthermore, to the extent the testimony of a medical expert contained inconsistencies, or was subject to multiple interpretations, it was for the ALJ to resolve such conflicts, and we are bound by her resolution of conflicts in the medical evidence. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968).

Notwithstanding the respondents' contentions, substantial evidence supports the ALJ's determination that the March 2016 work-related MVA was sufficiently related to the claimant's subsequent medical condition to require medical treatment in the form of surgery. In this regard the ALJ expressly credited the claimant's testimony, together with the medical opinions of Dr. Burris, Dr. Castro and Dr. Fall. The claimant's testimony and the opinions of these doctors provide substantial evidence and valid support for the ALJ's conclusions.

The respondents specifically take issue with the ALJ's finding that Dr. Reiss' opinion was "inconsistent with every other provider's opinion, the overwhelming medical records and the objective findings on the claimant's four separate MRI scans documenting that the claimant's initial lumbar strain was objectively worsened after the March 23, 2016 work MVA." ALJ Order, Finding of Fact 65. The respondents assert that the MRIs did not document an objective worsening. In addition to other record evidence, however, Dr. Fall assessed the claimant's L4-5 and L5-S1 disc protrusion with bilateral lower extremity radiculitis with possible progression on the recent study. Claimant's Exhibit 2 at 67. It was reasonable for the ALJ to infer that this change demonstrated an objective worsening of the claimant's condition after the 2016 MVA. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003) (If two or more equally plausible inferences may be drawn, we may not substitute our judgment for that of the ALJ).

The respondents also contend that the ALJ failed to resolve the conflict between Dr. Dillon, Dr. Reiss, Dr. Gray and Dr. Wallace who attributed the claimant's symptoms to his non-work related accident based on the claimant's statement at the time of their examination and the opinions of Dr. Castro, Dr. Fall and Dr. Burris who attributed the claimant's symptoms to his 2016 injury. The ALJ did however resolve the conflict and determined that the opinions of Dr. Burris, Dr. Castro and Dr. Fall were more credible and persuasive than the other providers. Moreover, Dr. Dillon, Dr. Grey and Dr. Wallace did not evaluate the claimant after the 2016 work-related MVA. Those physicians did not have the opportunity to review the April, 2016, MRI, nor were they in a position to address the claimant's subjective complaints involving more profound symptoms of pain.

It is therefore plausible for the ALJ to discount their opinions. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000) (evidence not cited is implicitly rejected as unpersuasive).

We find no error in the ALJ's order. The ALJ's findings of fact are supported by the evidence. Those findings, in turn, support the conclusion that the claimant's current symptoms and need for surgery is related to the 2016 MVA accident and that the surgery is reasonable and necessary. We have no basis to disturb the order on review. §8-43-301(8), C.R.S.

**IT IS THEREFORE ORDERED** that the ALJ's order dated February 20, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

CERTIFICATE OF MAILING

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

5/8/18 by TT .

HOGGATT LAW OFFICE PC, Attn: CAMERON LUCKE ESQ, 123 NORTH COLLEGE DRIVE STE 160, FORT COLLINS, CO, 80524 (For Claimant)
RITSEMA & LYON PC, Attn: RICHARD A BOVARNICK ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-044-321-01

IN THE MATTER OF THE CLAIM OF:

HENRY EASTMAN,

Claimant,

v.

FINAL ORDER

UNITED PARCEL SERVICE,

Employer,

and

LIBERTY MUTUAL,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Turnbow (ALJ) dated November 22, 2017, that determined he did not sustain an injury arising out of and in the course and scope of his employment and denied and dismissed his claim for benefits. We affirm.

This matter went to hearing on whether the claimant sustained a compensable injury to his right shoulder on March 20, 2017, and, if so, whether rotator cuff surgery is reasonable, necessary, and related to the compensable injury. After the hearing, the ALJ found that the claimant has worked for the respondent employer for 12 years as a loader/unloader. His job duties involve unloading packages from the package car.

The claimant alleges that he suffered a work-related injury to his right shoulder on March 20, 2017. On this date, the claimant claims he was unloading a truck and attempted to remove a package from a stack. As he slid the package towards himself, he lost his grip causing his right arm to be pushed back. The claimant did not have any immediate pain or symptoms. The claimant continued working and completed his usual duties of moving additional boxes while pushing, pulling, and lifting boxes up to 50 to 60 pounds. After finishing his shift, the claimant went home without reporting a work injury to the respondent employer.

On the following day, March 21, 2017, the claimant experienced the onset of pain while operating the manual gearshift of his personal vehicle. The claimant characterized the onset of pain as severe. About one hour prior to the commencement of his shift, the claimant reported his injury to the employer's manager, Aaron Shafenberg. The claimant explained that he suffered a work injury during the evening shift on March 20, 2017, but his discomfort developed when he was shifting his car the next day. The employer's regional manager, Gary Penaflor, was present by speakerphone when the claimant reported the injury to Mr. Shafenberg. Mr. Penaflor ultimately reprimanded the claimant for failing to immediately report his injury on March 20, 2017.

On March 22, 2017, the claimant had his initial visit at Workwell Occupational Medicine. The claimant was evaluated and treated by William Ford, PA-C, who diagnosed the claimant with a work-related sprain of the right rotator cuff capsule. He placed the claimant on restricted duty with a two-pound lifting restriction. The claimant subsequently continued working light duty for the employer. Mr. Ford recommended physical therapy.

After participating in physical therapy, the claimant returned to Mr. Ford for a re-evaluation. Mr. Ford was highly suspicious of a rotator cuff tear, and he recommended the claimant undergo an MRI of his right shoulder.

A subsequent MRI showed a high-grade partial, near full-thickness tear of the anterior supraspinatus tendon, no full-thickness tear of the subscapularis tendon identified with tendinopathy and partial-thickness tear of the subscapularis tendon likely, osteoarthritis of the acromioclavicular joint, and labral degeneration.

Orthopedic surgeon, Dr. Fitzgibbons, diagnosed the claimant with a right shoulder rotator cuff tear and recommended right shoulder rotator cuff repair, decompression, and debridement.

On May 2, 2017, the claimant returned to Mr. Ford who noted that the claimant was awaiting authorization of surgery. Mr. Ford maintained the claimant's work restrictions and noted that the claimant's modified duty with the employer had expired. The claimant has remained off work since May 2, 2017.

On May 9, 2017, the respondents issued a letter to Dr. Fitzgibbons notifying him that the requested surgery was denied, pending a determination of compensability of the claim.

On July 21, 2017, Dr. Paz performed an independent medical examination at the request of the respondents. Dr. Paz took a history of the injury from the claimant with specific details regarding the alleged mechanism of injury and surrounding circumstances. The claimant described kneeling down and pulling the top box, on a stack of boxes three high, backwards with his right hand. The claimant stated his right hand lost grip, came free, and pulled backwards so the right hand movement ended at the level of the right shoulder. Dr. Paz opined that the claimant's described mechanism of injury was not consistent with a rotator cuff tear. He explained that the delayed onset of symptoms was not consistent with an acute rotator cuff tear. Dr. Paz explained that an acute rotator cuff tear instead would have immediate pain and symptoms. Dr. Paz opined it was not medically probable that there was any injury to the claimant's right shoulder on March 20, 2017.

The ALJ ultimately concluded that the claimant failed to establish he sustained a work-related injury on March 20, 2017. She found the claimant did not have any symptoms, including pain or discomfort, at the time he alleges he was injured. Crediting the opinions of Dr. Paz, the ALJ found that an acute rotator cuff tear would cause immediate and severe pain. The ALJ therefore denied and dismissed the claimant's request for workers' compensation benefits.

The claimant has petitioned to review the ALJ's order but has not raised any allegations of error. Further, the claimant did not file a brief in support of his petition to review. Accordingly, the scope of our review is extremely limited. *See Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986).

In order to prove a compensable injury the claimant bears the burden to establish that the injury arose out of and in the course of employment. Section 8-41-301(1), C.R.S.; *Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). The ALJ is charged with making pertinent factual determinations, including those concerning liability for benefits, under a preponderance of the evidence standard. Section 8-43-201, C.R.S. Proof by a preponderance of the evidence requires the proponent to establish that the existence of a contested fact is more probable than its nonexistence. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). Under this standard, the ALJ assesses the credibility of the witnesses, the weight of the evidence, and determines whether the burden of proof has been satisfied. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). It is solely for the trier of fact to determine the persuasive effect of the evidence and whether the burden of proof has been satisfied. *Id*.

Because the question of whether the claimant met his burden to prove compensability is factual in nature, we are bound by the ALJ's determinations in this regard if they are supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.

Here, we conclude that the ALJ's determination is supported by substantial evidence in the record. As noted above, the ALJ credited the opinions of Dr. Paz. During the hearing, Dr. Paz testified that someone who sustained an acute rotator cuff tear would experience immediate pain. He explained that the delay in the claimant's onset of pain is inconsistent with the natural history of an acute tear of the rotator cuff. Dr. Paz further testified that the mechanism of injury as described by the claimant was more of a rowing motion, or the pulling back of the hands towards the chest wall. Dr. Paz explained that this maneuver does not require use of the rotator cuff. Dr. Paz testified that in his opinion, the claimant did not suffer a work-related injury on March 20, 2017. Tr. at 57-59; Ex. B at 19-20. Section 8-43-301(8), C.R.S. Thus, we have no basis for disturbing the ALJ's determination that the claimant failed to establish he sustained a compensable injury.

**IT IS THEREFORE ORDERED** that the ALJ's order dated November 22, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

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

5/10/18 by TT .

HENRY EASTMAN, 3201 8TH ST, BOULDER, CO, 80304 (Claimant)
LEE & BROWN LLC, Attn: MATT B BOATWRIGHT ESQ, C/O: KATHERINE MARKHEIM LEE ESQ, 3801 EAST FLORIDA AVENUE SUITE 210, DENVER, CO, 80210 (For Respondents)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-937-329-03

IN THE MATTER OF THE CLAIM OF:

IRENE TORRES,

Claimant,

v.

FINAL ORDER

CITY AND COUNTY OF DENVER,

Employer,

and

SELF-INSURED,

Insurer,
Respondent.

The respondent seeks review of an order of Administrative Law Judge Felter (ALJ) dated October 6, 2017, that affirmed the decision of the Division sponsored Independent Medical Exam (DIME) physician finding the claimant was not at maximum medical improvement (MMI) and ordered the respondents liable for the cost of a cervical discectomy and fusion surgery. We modify the order in regard to medical treatment, and, as modified, affirm the ALJ's order.

The claimant worked for the respondent's Parks and Recreation Department on December 11, 2013. While driving a city vehicle on that date the claimant was injured in a traffic accident. She was taken to the emergency room and treated for neck and back pain. An MRI revealed a central disc bulge at the C3-4 and C4-5 level. The claimant was treated with facet joint injections that were of some help. The claimant was evaluated by Dr. Sabin who recommended surgery. The claimant was provided another surgical opinion by Dr. Castro. He was hesitant to suggest immediate surgery. Instead, the claimant treated with Dr. Kawasaki and underwent rhizotomies on both the left and the right sides of the cervical spine. These treatments led to considerable relief. Dr. Kawasaki placed the claimant at MMI on December 11, 2015, and assigned a 24% whole person impairment rating. The doctor suggested permanent restrictions of no more than 50 pounds lifting. The respondents filed a corresponding Final Admission of Liability on January 8, 2016.

The claimant requested a review of these findings by a DIME physician. Dr. Morreale completed the DIME review on May 6, 2016. The claimant reported by that date the beneficial effects of the rhizotomy had begun to wane. The claimant reported left upper extremity pain and weakness. Dr. Morreale concluded the claimant was not at MMI. He recommended the claimant undergo an anterior cervical discectomy and fusion at C3-4 and C4-5 before he would deem the claimant to have achieved MMI.

The claimant returned to see Dr. Kawasaki. He referred her again to Dr. Sabin for a surgical consult. Dr. Sabin evaluated the claimant on July 22, 2010. He observed the claimant was not complaining of radicular symptoms. The doctor resolved the claimant was not a good candidate for surgery as suggested by Dr. Morreale. Dr. Sabin believed the best treatment involved periodic injections and additional rhizotomies. Dr. Kawasaki repeated rhizotomies at two spinal levels on February 24 and March 17, 2017. Dr. Kawasaki also recommended a second surgical consult with Dr. Ghiselli. The respondent denied this request.

The respondent requested a hearing to overcome the determination of Dr. Morreale that MMI did not apply. A hearing was convened on May 23 and completed on August 21, 2017. The respondent presented the testimony of Dr. Reiss. Dr. Reiss testified the claimant was not a candidate for surgery and that she remained at MMI. Dr. Kawasaki testified the claimant had enjoyed significant recent improvement in her symptoms following her second round of rhizotomies. He acknowledged the benefits of a rhizotomy were limited in duration. Dr. Kawasaki affirmed that he believed a second surgical opinion with Dr. Ghiselli would be helpful. The claimant presented the second opinion testimony of Dr. Yamamoto. Dr. Yamamoto agreed the claimant was not at MMI. The doctor also thought it necessary for the claimant to receive a surgical opinion from Dr. Ghiselli.

In his order of October 6, 2017, the ALJ agreed with Dr. Morreale that the claimant was not at MMI. The ALJ found the recommendation for the discectomy and fusion surgery compelling. The respondent was directed by the ALJ to pay the cost of the surgery recommended by Dr. Morreale.

On appeal, the respondent argues that the issue of a particular treatment, including the recommended discectomy and fusion surgery, was not raised as an issue for the ALJ to determine. The respondent also contends the ALJ was without jurisdiction to order the provision of a medical therapy recommended only by an unauthorized physician.

We note the respondent did not arrange for the entirety of the two hearings to be transcribed for purposes of appeal. The record contains the testimony submitted on May 23, which was solely that of Dr. Kawasaki, and the testimony of Dr. Reiss given on August 21. The testimony of the claimant and of Dr. Yamamoto, also provided on August 21, was not ordered transcribed (as indicated by the parentheticals included by the transcriptionist). Consequently, in the absence of a transcript we must presume that the ALJ's factual determinations said to be supported by the testimony of the claimant or by Dr. Yamamoto are supported by substantial evidence in the record. *Nova v Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988).

I.

The respondent argues the issue of authorization for the discectomy and fusion surgery was not raised as an issue by the claimant. The decision, therefore, of the ALJ ordering liability for that surgery is asserted to have abridged the respondent's right to adequate notice and procedural due process. However, the record reveals this claim to be unavailing. The claimant's Response to Application for Hearing dated December 30, 2016, endorsed as an issue "Medical benefits recommended by Division IME." At the outset of the May 23 hearing the ALJ did specifically deny the claimant's counsel the ability to set forth the issues she sought to present. However, the respondent's attorney was asked to respond to the ALJ's inquiry as to what specifically the respondent aimed to overcome concerning the DIME's determinations. The reply stated "Both as to MMI and as to impairment. Part of the MMI is reasonableness of a recommended surgery." Tr. at 4. Most significant however, is the text of the respondent's post hearing Position Statement. The respondent begins by identifying the issues to include: "If this ALJ finds the Respondent has not overcome the Division Independent Medical Examination physician's determination regarding maximum medical improvement, whether claimant has proven, by a preponderance of the evidence, that the anterior cervical discectomy and fusion at C3-4 and C4-5 is reasonably necessary to treating her work injury." The position statement contains five paragraphs of proposed findings and analysis pertinent to the reasonableness of the specific surgery. Based on these statements in the record we are not persuaded the respondent was unaware that a request for a specific medical treatment represented by the discectomy and fusion surgery was an issue to be presented to the ALJ.

II.

The respondent contends the only medical opinion recommending a discectomy and fusion surgery originated with an unauthorized doctor. Dr. Morreale was a DIME

physician. Pursuant to Workers' Compensation Rule of Procedure 11-2(G), a DIME physician is not authorized to treat a claimant. Whereas Dr. Kawasaki, the authorized treating physician, advocated a surgical consult with Dr. Ghiselli; he did not endorse a particular category of surgery. Citing the decision in *Short v. Property Management of Telluride*, W.C. No. 3-100-726 (May 4, 1995), the respondent argues the ALJ is without jurisdiction to order an authorized physician to perform or direct a specific treatment suggested only by an unauthorized physician.

Section 8-42-404(5) specifies the employer has the ability to nominate the physician required to be paid to deliver medical treatment to the claimant through a list of four from whom the claimant may select. Treatment sought by the claimant apart from that performed by the selected physician and his referrals is not the liability of the respondents. *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999). The Director's Workers' Compensation Rule of Procedure 16 states a respondent may deny authorization or payment for a requested medical treatment solely on the basis the provider is not an 'authorized treating provider.' *See* Rules 16-9(E)(3), 16-12(B)(1) and 16-11(A). [1]

In this instance, the dispute does not involve the right of the respondent to insist that the discectomy and fusion surgery be completed by an authorized physician. Rather, it turns on the authority of the ALJ to authorize a treatment not recommended by a designated doctor. In *Short*, the respondents denied medical maintenance treatment following MMI. The treating doctor made post MMI treatment recommendations, as did two IME doctors. The ALJ determined not only that *Grover* meds were reasonable but also went so far as to order the respondents to pay for medications, a back brace and a TENS unit suggested only by one of the IME doctors. The Panel affirmed a general order for *Grover* medical benefits but set aside the liability for the specific treatments based as they were on the advice of an unauthorized physician. The Panel held that "the ALJ lacks jurisdiction to order an authorized treating physician to provide a particular form of treatment which has been prescribed by an unauthorized treating physician." *Id*. The implied basis for this result is the difficulty involved in an ALJ directing a medical

[1] In 2013 the statute was amended by the addition of § 8-42-101(6). That subsection provides the respondent is liable to reimburse a claimant for the claimant's payment for medical treatment in a compensable claim, if the treatment was determined to be reasonable and necessary, and the respondent failed to furnish that medical treatment. It is not required that the treatment be recommended and performed by authorized providers. *See Simms v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

professional to perform a treatment that the provider does not necessarily endorse.[2] Accordingly, the analysis described in *Short* applies equally in this case.

Similar to the holding in *Short*, we conclude the ALJ is without authority to order an authorized treating physician to provide a particular form of treatment, which has been prescribed only by a physician unauthorized to treat. The claimant here has been evaluated by two surgeons in the chain of referrals from Dr. Kawasaki. Neither has unreservedly advocated a discectomy and fusion surgery. Dr. Kawasaki appears to feel surgery may be appropriate, but he necessarily requires a surgeon to agree to perform the procedure. For that reason, he sought to have the claimant evaluated by Dr. Ghiselli. The respondent declined to authorize that evaluation.

The respondent has the right to insist it is liable only for treatment provided by authorized providers. An ALJ is unable to direct a medical professional to administer a treatment that professional does not believe is appropriate. That is not a matter arising under articles 40 to 47 of title 8 for which the ALJ is provided authority by § 8-43-201(1). While an ALJ does retain the authority to rule on the reasonableness of proposed or accomplished medical treatment, §§ 8-42-101(1)(a) and 8-43-207(1) and (o), in circumstances such as those present in this case the ALJ must necessarily ensure there is present authorized medical staff willing to implement the treatment ordered authorized by the ALJ. Here, the ALJ directed the respondent to "pay the cost of medical care … including the surgery recommended by Dr. Morreale." However, Dr. Morreale is disqualified from providing treatment by the DIME rules and no authorized physician has yet indicated a willingness to undertake the surgery. We therefore, modify the ALJ's order pursuant to § 8-43-303(8) to direct the respondent to pay for the cost of a surgical consult by Dr. Ghiselli as was requested by Dr. Kawasaki.

**IT IS THEREFORE ORDERED** that the ALJ's order issued October 6, 2017, is modified to order the respondents liable for the costs of a surgical consult by Dr. Ghiselli, and as modified, is affirmed.

[2] As in *Short*, a request to change physicians pertinent to an authorization for surgery was not before the ALJ. Neither § 8-43-404(5)(a)(VI) nor § 8-43-404(10) (b) are applicable. Accordingly, the analysis described in *Short* applies equally in this case.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

5/15/18 by TT .

ERICA WEST ESQ, 837 EAST 17TH AVENUE #102, DNEVER, CO, 80218 (For Claimant)
CITY ATTORNEYS OFFICE, Attn: MICHELLE SISK ESQ, 201 WEST COLFAX AVENUE DEPT 1108, DENVER, CO, 80202 (For Respondents)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-040-419-01

IN THE MATTER OF THE CLAIM OF:

MARIA VAZQUEZ CRUZ,

Claimant,

v.

FINAL ORDER

LANCELOT INC,

Employer,

and

TRUCK INSURANCE EXCHANGE,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Sidanycz (ALJ) dated September 8, 2017, that ordered the payment to the claimant of $5,000 for disfigurement benefits. We set aside the order of the ALJ.

On February 19, 2017, while cooking at work, the claimant was burned when hot grease splashed onto her face. The claimant received emergency treatment and missed six days from work. Her treating doctor deemed the claimant to have reached maximum medical improvement (MMI) on April 1, 2017, with no permanent impairment. The respondents filed a corresponding Final Admission of Liability (FAL) on April 13. Several months later the claimant secured counsel and submitted an application for a hearing concerning disfigurement benefits on July 10.

The respondents moved to strike the application for a hearing, contending the application was barred as it was filed more than 30 days subsequent to the FAL. The respondents relied on § 8-43-203(2)(b)(II), C.R.S. That section provides that if a claimant fails to contest an FAL and submit an application for hearing concerning any disputed issue within 30 days of the date of the FAL, the "case will be automatically closed." The claimant contended that Rule 10 of the Office of Administrative Courts Procedural Rules for Workers Compensation Hearings allows for an extended period within which a claimant may pursue an award for disfigurement benefits pursuant to § 8-42-108, C.R.S. Rule 10 states:

> A claimant may request a determination of additional compensation for disfigurement to areas of the claimant's body normally exposed to public view by filing an Application for Hearing – Disfigurement Only with the OAC office closest to the claimant's residence, unless a different venue is agreed upon by the parties and approved by a judge, or as otherwise ordered by a judge. Unless the parties agree otherwise, the date of the Application for Hearing must be at least six months from the date of injury except when the claimant has had surgery, in which case the Application for Hearing must be at least six months from the date of surgery. If a final admission of liability has been filed pursuant to Section 8-43-203(2)(b)(II)(a), C.R.S., a claimant may request a hearing on disfigurement regardless of the date of injury or surgery.

Prehearing ALJ Sandberg heard the argument and determined the direction in Rule 10 that an application for a hearing pertinent to disfigurement cannot be heard until six months have passed following the date of injury served to render the claimant's application timely. The PALJ denied the respondents' motion.

The respondents challenged the PALJ decision at the September 7, 2017, OAC disfigurement hearing. The ALJ noted that the six month interval referenced before a scar may be subject to disfigurement evaluation was a reasonable measure imposed to ensure the scar had sufficient time to resolve before it could be designated as permanent in appearance. The ALJ concluded the Rule allowed a scar to be evaluated for an award of disfigurement benefits "at any time" subsequent to the six months of rehabilitation regardless of the 30 day limit in § 8-43-203(2)(b)(II). Tr. at 15. The ALJ surmised that because the claimant's scars involved burns, she was not limited to the $4,975 benefit cap imposed by § 8-42-108(1). Instead, § 8-42-108(2)(a) or (b) applied. The ALJ awarded $5,000 in disfigurement benefits.

On appeal, the respondents argue Rule 10 does not, and may not, serve to amend § 8-43-203(2)(b)(II) to allow an award of disfigurement benefits following the 30 day closure of the claim. *Dyrkopp v. Industrial Claim Appeals Office*, 30 P.3d 821 (Colo. App. 2001). The respondents point out that the concluding sentence in Rule 10 establishes the Rule was not intended to conflict with the 30 day limit to request benefits once an FAL was filed. We agree with the respondents.

Section 8-43-203(2)(b)(II)(A), C.R.S. provides that after a FAL is filed with the Division, the case will be closed automatically as to the issues admitted in the FAL if the claimant does not, within 30 days after the date of the FAL, contest the FAL in writing and request a hearing on any disputed issues. *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261 (Colo. App. 2004). The automatic closure of issues raised in an uncontested FAL 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." *Leewaye v. Industrial Claim Appeals Office*, 178 P.3d 1254, 1256 (Colo. App. 2007) (citing *Dyrkopp v. Industrial Claim Appeals Office*, *supra.)* Once a case has automatically closed by operation of the statute, the issues resolved by the FAL are not subject to further litigation unless they are reopened pursuant to § 8-43-303, C.R.S. *Berg v. Industrial Claim Appeals Offic*e, 128 P.3d 270, 272 (Colo. App. 2005); *Coxen v. Laidlaw Transit, Inc*., W.C. No. 4-674-208 (April 10, 2012), *aff'd* 12CA0800 (Feb. 21, 2013).

The respondents' FAL in this matter specified the amount admitted for disfigurement was $0. Accordingly, the claimant, in order to dispute this denial of disfigurement benefits was obligated to submit an application for a hearing pertinent to that issue within 30 days of the April 13, 2017, FAL. The claimant's failure to do so in this case allowed the issue of disfigurement to automatically close. *Alamanza v. Terry Johnson*, W.C. No. 4-713-132-02 (Dec. 7, 2012).

The PALJ and the ALJ construed OAC Rule 10 to allow an application for a disfigurement award to be submitted at any time. This interpretation, however, requires Rule 10 to function as an exception to § 8-43-203(2)(b)(II). An administrative rule is not the equivalent of a statute. As such, rules promulgated by the Office of Administrative Courts may not expand, enlarge or modify the underlying statute the rule is intended to enforce. *See Cornerstone Partners v. Industrial Claim Appeals Office*, 830 P.2d 1148 (Colo. App. 1992). Thus, any regulation that is contrary to or inconsistent with the regulatory authorizing statute is void. *Monfort Transp. v. Industrial Claim Appeals Office*, 942 P.2d 1358 (Colo. App. 1997); *McCormick v. Exempla Healthcare*, W.C. No. 4-594-683 (Jan. 27, 2006); *Moore v. Nextel Communications*, W.C. No. 4-392-327 (Aug. 17, 2000), *see also Popke v. Industrial Claim Appeals Office*, 944 P.2d 677 (Colo. App. 1997)(we must, where possible, construe the rule consistent with the enabling statute). Were we to agree with the ALJ that OAC Rule 10 sanctioned requests for disfigurement benefits at any time beyond the 30 days allowed by statute, we essentially would be reading the Rule to be inconsistent with § 8-43-203(2)(b)(II). Instead, we conclude that

§8-43-203(2)(b)(II) sets forth the governing law regarding the time for filing an application for disfigurement benefits. *Lucero v. Wyndham Hotel*, W.C. No. 4-705-926-02 (August 30, 2016).

However, OAC Rule 10 should be read in a fashion compatible with § 8-43-203(2)(b)(II). The final sentence in the Rule provides: "If a final admission of liability has been filed pursuant to Section 8-43-203(2)(b)(II)(a) C.R.S. a claimant may request a hearing on disfigurement regardless of the date of injury or surgery." This clause is intended to provide that the six month time frame for filing an application for disfigurement benefits from the date of injury or from the date of surgery is inapplicable when an FAL has been filed. Therefore, this clause of Rule 10 requires a party to comply with the 30 day period to contest the FAL and request a hearing on any disputed issues that are ripe for hearing as set forth in § 8-43-203(2)(b)(II). Consequently, in this matter, the claimant's application for disfigurement benefits was untimely filed when measured by either OAC Rule 10 or by § 8-43-203(2)(b)(II). Accordingly, we are required to set aside the ALJ's order awarding those benefits.

**IT IS THEREFORE ORDERED** that the ALJ's order issued September 8, 2017 is set aside.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

5/17/18 by TT .

KAUFMAN & KAUFMAN LLC, Attn: MATHEW F KAUFMAN ESQ, 401 23RD STREET STE 302, GLENWOOD SPRINGS, CO, 81601 (For Claimant)
LAW OFFICE OF ROBERT B HUNTER, Attn: JOE M ESPINOSA ESQ, PO BOX 258829, OKLAHOMA CITY, OK, 73125-8829 (For Respondents)
LAW OFFICE OF ROBERT B HUNTER, Attn: JOE M ESPINOSA ESQ, 1801 BROADWAY SUITE 1300, DENVER, CO, 80202-3878 (Other Party)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-027-576-02

IN THE MATTER OF THE CLAIM OF:

ROBERTO HERNANDEZ,

Claimant,

v.

FINAL ORDER

ABC PRO PAINTING, LLC,

Employer,

and

NON-INSURED,

Respondent.

The respondent seeks review of an order and corrected order of Administrative Law Judge Lamphere (ALJ) dated November 16, 2017, and December 15, 2017, respectively, that determined the claimant was not an independent contractor, that determined the claimant sustained a compensable injury, that ordered the respondent liable for medical and temporary total disability (TTD) benefits, and that ordered the respondent liable for penalties for violating §§8-43-408(1), C.R.S., 8-43-103(1), C.R.S., and 8-43-203(2)(a), C.R.S. We affirm.

This matter went to hearing on whether the claimant was an independent contractor, whether the claimant suffered a compensable injury to his low back and hip on September 17, 2016, whether the claimant is entitled to medical benefits and TTD benefits, average weekly wage, penalties under §8-43-408(1), C.R.S. for the respondent's failure to carry workers' compensation insurance coverage, penalties under §8-43-103(1), C.R.S. for the respondent's failure to timely notify the Division of Workers' Compensation in writing of the claimant's asserted injury, and penalties under §8-43-203(2)(a), C.R.S. for the respondent's failure to timely admit or deny liability for the claimant's asserted injury.

After the hearing, the ALJ found that in mid-April 2016 the claimant responded to a flyer posted in a local restaurant by the respondent advertising job openings for painters. In response to the advertisement, the claimant contacted Jorge Aceves, the

owner/operator of ABC Pro Painting, LLC, and the claimant eventually was hired to work as a painter.

On September 17, 2016, the claimant and Mr. Aceves were painting a residential house. The claimant was injured when the ladder on which he was standing slipped off the side of the home to the ground. He fell to the ground landing on his buttocks and the ladder fell on his back.

The claimant yelled for Mr. Aceves who was painting on the opposite side of the house. Mr. Aceves asked the claimant if he wanted to see a doctor, but the claimant declined medical attention since he was not in much pain at the time. After resting, the claimant returned to work painting the outside trim of the home. However, as the work day wore on, the claimant began to experience worsening low back and hip pain. The claimant was able to finish the work day, but he told Mr. Aceves that his back was hurting. The claimant eventually returned home for the evening without seeking medical attention.

The claimant worked one more day for the respondent after suffering his low back injury. He painted a deck in Monument on September 18, 2016. The claimant was able to finish the job despite continued low back pain from his fall the day before.

Text messages between the claimant and Mr. Aceves confirm that the claimant was having back pain and requested to see a doctor. Accordingly, Mr. Aceves scheduled an appointment on September 20, 2016, for the claimant to see a chiropractor, Dr. Billings. Mr. Aceves transported the claimant to the office of Dr. Billings, and he also paid for the initial office visit.

The claimant saw Dr. Billings for additional treatment on September 22, 26, 28, and October 11 and 18, 2016, and March 13, 2017. The claimant paid for each of these visits. However, the claimant purportedly stopped treatment with Dr. Billings because he no longer could afford to pay. The claimant has had unrelenting low back pain through this time period and up through the date of the hearings on September 5 and 25, 2017.

Dr. Billings requested an MRI, but the claimant could not pay for it. Consequently, it never was performed. Nevertheless, Dr. Billings opined that the mechanism of injury, or falling off the ladder, was consistent with the findings on physical examination and the claimant's subjective complaints of low back, hip, and upper back pain. Dr. Billings took the claimant off work on September 20, 2016. Dr. Billings needed to review the results of an MRI prior to releasing the claimant to any type

of restricted work duty. He also explained that an MRI without contrast was necessary for further assessment of the claimant's condition due to his continued low back pain.

The ALJ ultimately determined that the claimant was an employee of the respondent and not an independent contractor. The ALJ found that the claimant was not free from the control and direction of Mr. Aceves with regard to his job duties and his daily work schedule. He found that the claimant was transported to and from job locations in vehicles owned and provided by Mr. Aceves as the owner of the respondent. Further, while at the job site, the claimant requested permission from Mr. Aceves to attend a dental appointment. Also, the ALJ found that Mr. Aceves paid the claimant by check or cash and was paid at an hourly rate. Checks always were made out to the claimant personally, rather than to an independent trade or business name. The ALJ further found that there was no written document between the claimant and the respondent indicating the terms of employment. Additionally, the claimant never purchased any tools, equipment, and materials to complete the jobs. Rather, all tools were purchased and provided by the respondent. The ALJ also concluded the claimant sustained a compensable industrial injury and ordered the respondent liable for medical and TTD benefits. The ALJ further found that the respondent did not carry workers' compensation insurance, did not timely notify the Division in writing of the claimant's asserted injury, and did not notify, in writing, the Division and the claimant whether it was admitting or denying the claimant's claim for benefits. The ALJ therefore assessed penalties against the respondent for violating §§8-43-408(1), C.R.S., 8-43-103(1), C.R.S., and 8-43-203(2)(a), C.R.S.

On December 15, 2017, the ALJ issued his Corrected Order. In his Corrected Order, the ALJ stated that he incorrectly had referenced the Workers' Compensation cash fund instead of the Colorado Uninsured Employer Fund as the partial recipient of the penalty assessment. The ALJ therefore corrected his original Order accordingly. Further, in his Corrected Order, the ALJ also stated that he inadvertently omitted the total amount of unpaid compensation to be deposited with the Division of Workers' Compensation (Division). Accordingly, the ALJ corrected his original Order to require the respondent to deposit $20,588.71 to the Division. *See Michalski v. Industrial Claim Appeals Office*, 757 P.2d 1146 (Colo. App. 1988)(failure to file petition to review a supplemental order is not a jurisdictional defect where supplemental order does not address any issue raised in party's petition to review); *see also Nozik v. JBS USA*, W.C. No. 4-874-669 (March 13, 2013).

The respondent has petitioned to review the ALJ's order, raising one argument on appeal. The respondent argues that substantial evidence in the record supports the

conclusion that the claimant was an independent contractor and not an employee. More specifically, the respondent contends that with regard to the nine factor test contained in §8-40-202(b)(II), C.R.S. for determining independent contractor status, it had proved the presence of four factors, the claimant had proved only the presence of three, and no evidence was presented for the remaining two factors. Thus, the respondent contends substantial evidence could only support a finding that the claimant was an independent contractor. We disagree.

Pursuant to §8-40-202(2)(a), C.R.S., "any individual who performs services for pay for another shall be deemed to be an employee . . . unless such individual is free from control and direction in the performance of the service, both under the contract for performance of service and in fact and such individual is customarily engaged in an independent trade, occupation, profession, or business related to the service performed." The putative employer may establish that the claimant was free from direction and control and engaged in an independent business or trade by proving the presence of some or all of the nine criteria set forth in §8-40-202(2)(b)(II), C.R.S. *See Nelson v. Industrial Claim Appeals Office*, 981 P.2d 210 (Colo. App. 1998).

The factors set forth in §8-40-202(2)(b)(II), C.R.S. indicating that an individual is not an independent contractor include the individual being paid a salary or hourly rate instead of a fixed contract rate and being paid individually rather than under a trade or business name. Conversely, independence may be shown if the person for whom the services are performed provides no more than minimal training to the individual, does not provide tools or benefits, does not dictate the time of performance, does not establish a quality standard for the individual's work, does not combine its business with the business of the individual, does not require the individual to work exclusively for a single person or company, and is not able to terminate the individual's employment without liability.

In *Industrial Claim Appeals Office v. Softrock Geological Services, Inc.*, 325 P.3d 560 (Colo. 2014), the Colorado Supreme Court addressed the analysis to be used in unemployment insurance cases when determining whether a claimant is an independent contractor or an employee. The *Softrock* analysis applies to workers' compensation cases as well since the pertinent statutes in unemployment and workers' compensation are identical. *See Pierce v. Pella Windows*, W.C. No. 4-950-181 (April 26, 2016)(explaining why analysis in *Softrock* applies in the workers' compensation context); §8-70-115(1)(b), C.R.S.; §8-40-202, C.R.S. In *Softrock*, the Court held that whether an individual is customarily engaged in an independent trade, occupation, profession, or business related to the service performed must be determined by applying a totality of circumstances test

that evaluates the dynamics of the relationship between the individual and the putative employer. The Court expressly disapproved of the notion that the lack of work by the claimant for someone other than the putative employer is dispositive proof of an employer-employee relationship. *See also Western Logistics, Inc. v. Industrial Claim Appeals Office*, 325 P.3d 550 (Colo. 2014).

Additionally, there is no precise number or combination of factors which are decisive in determining whether the claimant is an employee or an independent contractor. *Industrial Claim Appeals Office v. Softrock, supra; Rapouchova v. Frankie's Installation*, W. C. No. 4-630-152 (Aug. 17, 2005). Rather, the ALJ determines as a matter of fact whether or not particular factors are present, and ultimately, whether the claimant is an employee or independent contractor based on the totality of the evidence concerning the statutory factors. *Nelson v. Industrial Claim Appeals Office, supra*. Thus, to overcome the presumption of employment contained in §8-40-202(2)(a), C.R.S. and to establish independent contractor status, a balancing test is applied. *Nelson v. Industrial Claim Appeals Office, supra*. In *Softrock*, the Colorado Supreme Court warned against the use of "a rigid check-box type inspection." The question of whether the respondent has presented sufficient proof to overcome the presumption is one of fact for the ALJ. Accordingly, we are bound by the ALJ's determinations in this regard if supported by substantial evidence and plausible inferences drawn from the record. Section 8-43-301(8), C.R.S.; *F.R. Orr v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

Here, we have reviewed the record and the ALJ's order and we are not persuaded there is any reversible error. Essentially, the respondent requests that we reweigh the evidence to reach a result contrary to that of the ALJ. However, we have no authority to substitute our judgment for that of the ALJ concerning the sufficiency and probative weight of the evidence that was presented. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000); *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). The ALJ here applied the totality of the circumstances test and evaluated the dynamics of the relationship between the claimant and the respondent. The ALJ found that Mr. Aceves previously had signed an affidavit indicating the respondent was the claimant's sole employer on September 17, 2016, the date of the claimant's injury. While at the hearing Mr. Aceves testified he did not understand the contents of the affidavit he previously had signed, the ALJ found his testimony unpersuasive in this regard. Order at 6-7 ¶¶26-28; Ex. 22; Tr. at 58-66. We must defer to the ALJ's credibility determinations and his resolution of conflicts in the evidence. *Metro Moving and Storage, Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

Additionally, the ALJ entered the following findings regarding the factors set forth in §8-40-202(2)(b)(II), C.R.S., which are supported by substantial evidence in the record:

> (1) The respondent established a quality standard for the claimant. Mr. Aceves testified that he would check on the claimant's work to make sure the job was well done. He testified that a lot of times he would bring the claimant's attention "to fix some stuff that he would do." The claimant also testified that Mr. Aceves would check on the quality of his work. Tr. at 93, 122;
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> (2) The respondent paid at an hourly rate instead of at a fixed or contract rate. Mr. Aceves testified he paid the claimant at an hourly rate every 15 days. The claimant also testified Mr. Aceves paid him hourly. Tr. at 84-85, 90, 115-116;
>
> (3) The respondent provided tools to the claimant. Both the claimant and Mr. Aceves testified that the respondent employer provided all the tools and materials for the claimant to complete the work. Mr. Aceves specifically testified that all the tools were his and the claimant did not have to provide any tools or equipment. Tr. at 87, 101;
>
> (4) The respondent dictated the time of performance of the job. Mr. Aceves testified that he would transport the claimant to the jobsite 100% of the time. Tr. at 87-88. The claimant testified that during the time period he worked for the respondent, he was taken to the job site by Mr. Aceves. The claimant testified that Mr. Aceves would call him and tell him that he wanted him at his house at 7:00 and he would be there at that time and Mr. Aceves then would take him to the job site. Tr. at 121; and
>
> (5) The respondent paid the claimant personally instead of making checks payable to the trade or business name of the claimant. Checks that the respondent issued to the claimant for his painting were made out to him personally rather than to a trade or business owned or operated by the claimant. Ex. 2.

The ALJ also found that the respondent did not provide training to the claimant, that there was no written document between the claimant and the respondent regarding their work relationship, and that it was "equivocal" as to whether the claimant was required to work exclusively for the respondent. However, as explained above, there is

no precise number or combination of factors which are decisive in determining whether the claimant is an employee or an independent contractor. *Industrial Claim Appeals Office v. Softrock, supra; Rapouchova v. Frankie's Installation, supra.* Instead, the ALJ was persuaded that the evidence presented and his factual findings regarding the enumerated factors above demonstrated the claimant was not free from the control and direction of the respondent and was not engaged in an independent trade, occupation, profession, or business related to the service performed when he was injured on September 17, 2016. Since there is ample evidence in the record supporting the ALJ's determination that there was an employment relationship rather than an independent contractor relationship between the claimant and the respondent at the time the claimant sustained his injury, we have no basis to disturb the order. Section 8-43-301(8), C.R.S. That the ALJ might have reached a contrary conclusion, as argued by the respondent, is immaterial on review. *See Mountain Meadows Nursing Center v. Industrial Claim Appeals Office*, 990 P.2d 1090 (Colo. App. 1999).

Last, to the extent the respondent argues there is no evidence and the ALJ made no findings regarding the ninth factor, which is whether the business operations of the person for whom service is provided was combined in any way with the business operations of the service provider, we are not persuaded there is any error. A similar situation was addressed by the Colorado Court of Appeals in *Dana's Housekeeping v. Butterfield*, 807 P.2d 1218 (Colo. App 1990). In *Dana*, the employer arranged for house cleaning services for its clients and it provided the workers who had signed an independent contractor type agreement. The Court concluded that the nature of the employer's work and that of the worker were relatively the same and became intermingled in the provision of the services. The Court upheld the determination that the injured claimant in that case was an employee and not an independent contractor. Here, similar to *Dana*, the respondent's business was to provide painting services, and the claimant was a painter. The claimant was injured in the process of painting. These findings were all included in the ALJ's Order. The ALJ's findings in this regard support an employment relationship. Section 8-40-202(2)(b)(II), C.R.S.[1] Consequently, we have no basis to disturb the ALJ's order.

[1] We also note that in its appeal the respondent focuses solely on whether the claimant was free from control and direction in the performance of the service. The respondent does not address whether the record supports a conclusion the claimant was customarily engaged in an independent trade or business. However, to demonstrate that the claimant was an independent contractor, the respondent must also have shown that the claimant was engaged in an independent business or trade as set forth in §8-40-202(2)(b)(II), C.R.S. *See Long View Systems Corp. v. Industrial Claim Appeals Office*, 197 P.3d 295 (Colo. App. 2008).

**IT IS THEREFORE ORDERED** that the ALJ's order and corrected order dated November 16, 2017, and December 15, 2017, respectively, are affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

5/23/18 by TT .

ANDERSON & LOPEZ, Attn: RICK PAUL LOPEZ ESQ, 4905 NORTH UNION BLVD SUITE 302, COLORADO SPRINGS, CO, 80918 (For Claimant)
MACEAU LAW, Attn: RYAN C GILMAN ESQ, 1465 N UNION BLVD STE 100, COLORADO SPRINGS, CO, 80909 (For Respondents)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-973-089

IN THE MATTER OF THE CLAIM OF:

TAYLOR L. WATKINS,

Claimant,

v.

O'MEARA FORD CENTER,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

REMAND ORDER

The claimant seeks review of an order of Administrative Law Judge Cannici (ALJ) dated September 15, 2017, that struck the claimant's applications for hearing. We set aside the ALJ's order and remand for further proceedings.

The facts appear to be undisputed. The claimant has two workers' compensation claims: W.C. No. 4-973-089 is for a date of injury of September 17, 2014 and W.C. No. 4-973-090 is for a date of injury of January 12, 2015. The claimant was placed at maximum medical improvement (MMI) and a Division Independent Medical Examination (DIME) was requested on both claims. The DIME was performed by Dr. Fall who issued a report on January 10, 2017. The respondents filed a Final Admission of Liability for both claims on February 13, 2017. The claimant timely objected and filed an application for hearing on both claims on March 8, 2017. The applications for hearing endorsed the issues of overcoming the DIME, permanent partial and permanent total disability benefits. Hearings were scheduled for both claims on July 6, 2017. The claimant obtained a new attorney and the parties agreed to allow the claimant to withdraw his applications for hearing and to re-file to allow the new counsel time to prepare for hearing. On June 23, 2017, orders were entered on both claims memorializing this agreement. The order further stated, "Claimant must re-file his Application for Hearing within ten (10) days of the date of this Order." According to the order the claimant was

required to re-file the applications for hearing on or before July 3, 2017. The claimant re-filed the applications for hearing on both claims on August 30, 2017.

The respondents filed a motion to strike and dismiss the claimant's applications for hearing contending that by statute, the claimant's failure to comply with the extended timeline established by the order closed the issues admitted on the Final Admission of Liability and the ALJ no longer had jurisdiction over the issues endorsed by the claimant. The ALJ granted the respondents' motion and struck the applications for hearing in both claims in an order dated September 15, 2017.

The claimant filed a motion for reconsideration which was denied by the ALJ on September 26, 2017. The claimant filed a petition to review and a request for Specific Findings of Fact and Conclusions of Law and order, which was received by the Office of Administrative Courts on September 28, 2017. There is a handwritten note on the request stating "Denied, PJC, 10/4/17."

On appeal the claimant contends the ALJ erred as matter of law in striking the applications for hearing and that appellate review is not possible because the ALJ failed to issue findings of fact, conclusions of law and an order. We disagree with the claimant's contention that the ALJ's order is not sufficient to permit appellate review. We, however, agree with the claimant's contention that the ALJ erred as a matter of law in dismissing the applications for hearing and, therefore, set aside the ALJ's order and remand the matter for further proceedings.

Our authority to review the ALJ's order is defined in § 8-43-301(8), C.R.S. This statute precludes us from disturbing the ALJ's order unless the ALJ's findings of fact are insufficient to permit appellate review, the ALJ has not resolved conflicts in the evidence, the record does not support the ALJ's findings, the findings do not support the order, or the order is not supported by the applicable law.

We disagree with the claimant's contention that the ALJ's order is insufficient for review. Although the ALJ denied the claimant's request for Specific Findings of Fact and Conclusions of Law, the basis of the ALJ's conclusion is apparent from the ALJ's September 15, 2017, order, granting the respondents' motion to strike and dismissing the claimant's applications for hearing for failure to comply with the previously established filing deadlines. *Riddle v. Ampex Corp.*, 839 P.2d 489 (Colo. App. 1992); *Boice v. Industrial Claim Appeals Office*, 800 P.2d 1339 (Colo. App. 1990). We therefore address the merits of the appeal.

Section 8-43-203(2)(b)(II)(A), C.R.S., provides in pertinent part:

> An admission of liability for final payment of compensation must include a statement that this is the final admission by the workers' compensation insurance carrier in the case, that the claimant may contest this admission if the claimant feels entitled to more compensation to whom the claimant should provide written objection and notice to the claimant that the case will be automatically closed as to the issues admitted in the final admission if the claimant does not, within thirty days after the date of the final admission, contest the final admission in writing and request a hearing on any disputed issues that are ripe for hearing included in the selection of an independent medical examiner pursuant to section 8-42-107.2, C.R.S., if an independent medical examination has not already been conducted.

In *Del Ramirez v. ConAgra Beef Company*, W.C. No. 4-478-614 (April 12, 2004), the panel held that the statute only requires *filing* of the application for hearing within thirty days of the Final Admission of Liability and the failure to *set the hearing* in accordance with a rule of procedure did not amount to a jurisdictional defect. The panel further observed that §8-43-203(2)(b)(II) does not establish a time limit for setting a hearing to contest an final admission of liability and declined to read such a nonexistent provision into the jurisdictional requirements of the statute. *See Kraus v. Artcraft Sign* Co., 710 P.2d 480 (Colo. App. 1985)(statute is product of legislative action and court should not read nonexistent provisions into the Act).

Relying on this principle in *Gerchman v. Wal-Mart Stores, Inc.*, W. C. No. 4-525-960 (July 23, 2004), the panel held that there is nothing in the statute that states that once the claimant satisfies the requirement to file an application for hearing on a disputed issue ripe for hearing that "withdrawal" of the application and consequent "cancellation" of the scheduled hearing vitiates the effectiveness of the timely filed application for purposes of satisfying the jurisdictional requirements of § 8-43-203(2)(b)(II). *See Dalco Industries, Inc. v. Garcia*, 867 P.2d 156 (Colo. App. 1993)(provisions of § 8-43-203(2)(b)(II) create jurisdictional barrier to consideration of issues which have been closed by failure timely to contest FAL). Moreover the panel recognized that there is nothing in the statute or rules that suggests that by agreeing to cancel a hearing a party is admitting that an otherwise timely application for hearing will be treated as if it was never filed for purposes of § 8-43-203(2)(b)(II). Rather, as the panel stated in *Gerchman,* the withdrawal and cancellation of a hearing is a procedural matter and such procedural steps may occur for many reasons.

We are not persuaded by the respondents' contention that *Thomas v. Four Corners Health Care*, W.C. No. 4-484-220 (April 27, 2009), mandates a different result. *Thomas* is factually distinguishable from the present case in that the application for hearing in that case was not timely filed after a Final Admission of Liability, despite a pre-hearing order that stated failure to re-file would constitute a waiver of rights. Moreover, the panel specifically stated that the claimant in *Thomas* was only arguing about the effect of compliance with the pre-hearing order and did *not* contend that compliance with the terms of a pre-hearing order was unnecessary to preserve the issues. Consequently the *Thomas* order did not address the reasoning in *Del Ramirez* or *Gerchman*. To the extent the reasoning in *Thomas* conflicts with *Del Ramirez* or *Gerchman*, we decline to follow it.

We see no basis to depart from the panel's prior reasoning in *Del Ramirez* or *Gerchman*. The claimant here satisfied the requirement to file an application for hearing and, therefore, satisfied the jurisdictional requirements of §8-43-203(2)(b)(II), C.R.S. The order memorializing the procedural agreement to withdraw the application for hearing and cancel the scheduled hearing does not vitiate the effectiveness of the initial timely filed application for purposes of satisfying the jurisdictional requirements. *See also Morales v. Excel Corp.*, W.C. No. 4-408-889 (May 31, 2006). The ALJ's order striking the application for hearing is, therefore, a misapplication of the law. We set aside the order and remand the matter for further proceedings.

**IT IS THEREFORE ORDERED** that the ALJ's order dated September 15, 2017, is set aside and the matter is remanded for further proceedings.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

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

5/23/18 by TT .

PINNACOL ASSURANCE, Attn: HARVEY D FLEWELLING ESQ, 7501 EAST LOWRY BLVD, DENVER, CO, 80230 (Insurer)
KAPLAN MORRELL LLC, Attn: MICHAEL H KAPLAN ESQ, 6801 W 20TH STREET SUITE 201, DENVER, CO, 80634 (For Claimant)
RUEGSEGGER SIMONS SMITH & STERN LLC, Attn: DREW RZEPIENNIK ESQ, 1401 SEVENTEENTH ST SUITE 900, DENVER, CO, 80202 (For Respondents)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-973-090

IN THE MATTER OF THE CLAIM OF:

TAYLOR L. WATKINS,

Claimant,

v.

REMAND ORDER

O'MEARA FORD CENTER, INC.

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Cannici (ALJ) dated September 15, 2017, that struck the claimant's application for hearing. We set aside the ALJ's order and remand for further proceedings.

The facts appear to be undisputed. The claimant has two workers' compensation claims: W.C. No. 4-973-089 for a date of injury of September 17, 2014 and W.C. No. 4-973-090 for a date of injury of January 12, 2015. The claimant was placed at maximum medical improvement (MMI) and a Division Independent Medical Examination (DIME) was requested on both claims. The DIME was performed by Dr. Fall who issued a report on January 10, 2017. The respondents filed a Final Admission of Liability for both claims on February 13, 2017. The claimant timely objected and filed an application for hearing on both claims on March 8, 2017. The applications for hearing endorsed the issues of overcoming the DIME, permanent partial and permanent total disability. Hearings were scheduled for both claims on July 6, 2017. The claimant obtained a new attorney and the parties agreed to allow the claimant to withdraw his applications for hearing and to re-file to allow the new counsel time to prepare for hearing. On June 23, 2017, orders were entered on both claims memorializing this agreement. The order further stated, "Claimant must re-file his Application for Hearing within ten (10) days of the date of this Order." According to the order the claimant was required to re-file the

applications for hearing on or before July 3, 2017. The claimant re-filed the applications for hearing on both claims on August 30, 2017.

The respondents filed a motion to strike and dismiss the claimant's applications for hearing contending that by statute, the claimant's failure to comply with the extended timeline established by the order closed the issues admitted on the Final Admission of Liability and the ALJ no longer had jurisdiction over the issues endorsed by the claimant. The ALJ granted the respondents motion and struck the applications for hearing in both claims in an order dated September 15, 2017.

The claimant filed a motion for reconsideration which was denied by the ALJ on September 26, 2017. The claimant filed a petition to review and a request for Specific Findings of Fact and Conclusions of Law and order, which was received by the Office of Administrative Courts on September 28, 2017. There is a handwritten note on the request stating "Denied, PJC, 10/4/17."

On appeal the claimant contends the ALJ erred as matter of law in striking the applications for hearing and that appellate review is not possible because the ALJ failed to issue finding of fact, conclusions of law and an order. We disagree with the claimant's contention that the ALJ's order is not sufficient to permit appellate review. We, however, agree with the claimant's contention that the ALJ erred as a matter of law in dismissing the applications for hearing and, therefore, set aside the ALJ's order and remand the matter for further proceedings.

Our authority to review the ALJ's order is defined in § 8-43-301(8), C.R.S. This statute precludes us from disturbing the ALJ's order unless the ALJ's findings of fact are insufficient to permit appellate review, the ALJ has not resolved conflicts in the evidence, the record does not support the ALJ's findings, the findings do not support the order, or the order is not supported by the applicable law.

We disagree with the claimant's contention that the ALJ's order is insufficient for review. Although the ALJ denied the claimant's request for Specific Findings of Fact and Conclusions of Law, the basis of the ALJ's conclusion is apparent from the ALJ's September 15, 2017, order, granting the respondents' motion to strike and dismiss the claimant's applications for hearing for failure to comply with the previously established filing deadlines. *Riddle v. Ampex Corp.*, 839 P.2d 489 (Colo. App. 1992); *Boice v. Industrial Claim Appeals Office*, 800 P.2d 1339 (Colo. App. 1990). We therefore address the merits of the appeal.

Section 8-43-203(2)(b)(II)(A), C.R.S., provides in pertinent part:

> An admission of liability for final payment of compensation must include a statement that this is the final admission by the workers' compensation insurance carrier in the case, that the claimant may contest this admission if the claimant feels entitled to more compensation to whom the claimant should provide written objection and notice to the claimant that the case will be automatically closed as to the issues admitted in the final admission if the claimant does not, within thirty days after the date of the final admission, contest the final admission in writing and request a hearing on any disputed issues that are ripe for hearing included in the selection of an independent medical examiner pursuant to section 8-42-107.2, C.R.S., if an independent medical examination has not already been conducted.

In *Del Ramirez v. ConAgra Beef Company*, W.C. No. 4-478-614 (April 12, 2004), the panel held that the statute only requires *filing* of the application for hearing within thirty days of the Final Admission of Liability and the failure to *set the hearing* in accordance with a rule of procedure did not amount to a jurisdictional defect. The panel further observed that §8-43-203(2)(b)(II) does not establish a time limit for setting a hearing to contest an final admission of liability and declined to read such a nonexistent provision into the jurisdictional requirements of the statute. *See Kraus v. Artcraft Sign* Co., 710 P.2d 480 (Colo. App. 1985)(statute is product of legislative action and court should not read nonexistent provisions into the Act).

Relying on this principle in *Gerchman v. Wal-Mart Stores, Inc.*, W. C. No. 4-525-960 (July 23, 2004), the panel held that there is nothing in the statute that states that once the claimant satisfies the requirement to file an application for hearing on a disputed issue ripe for hearing that "withdrawal" of the application and consequent "cancellation" of the scheduled hearing vitiates the effectiveness of the timely filed application for purposes of satisfying the jurisdictional requirements of § 8-43-203(2)(b)(II). *See Dalco Industries, Inc. v. Garcia*, 867 P.2d 156 (Colo. App. 1993)(provisions of § 8-43-203(2)(b)(II) create jurisdictional barrier to consideration of issues which have been closed by failure timely to contest final admission of liability). Moreover the panel recognized that there is nothing in the statute or rules that suggests that by agreeing to cancel a hearing a party is admitting that an otherwise timely application for hearing will be treated as if it was never filed for purposes of § 8-43-203(2)(b)(II). Rather, as the panel stated in *Gerchman*, the withdrawal and cancellation of a hearing is a procedural matter and such procedural steps may occur for many reasons.

We are not persuaded by the respondents' contention that *Thomas v. Four Corners Health Care*, W.C. No. 4-484-220 (April 27, 2009), mandates a different result. *Thomas* is factually distinguishable from the present case in that the application for hearing in that case was not timely filed after a Final Admission of Liability, despite a pre-hearing order that stated re-filing was necessary to preserve the issues. Moreover, the panel specifically stated that the claimant in *Thomas* was only arguing about the effect of compliance with the pre-hearing order and did *not* contend that compliance with the terms of a pre-hearing order was unnecessary to preserve the issues. Consequently, the *Thomas* order did not address the reasoning in *Del Ramirez* or *Gerchman*. To the extent the reasoning in *Thomas* conflicts with *Del Ramirez* or *Gerchman*, we decline to follow it.

We see no basis to depart from the panel's prior reasoning in *Del Ramirez* or *Gerchman*. The claimant here satisfied the requirement to file an application for hearing and, therefore, satisfied the jurisdictional requirements of §8-43-203(2)(b)(II), C.R.S. The order memorializing the procedural agreement to withdraw the application for hearing and cancel the scheduled hearing does not vitiate the effectiveness of the initial timely filed application for purposes of satisfying the jurisdictional requirements. *See also Morales v. Excel Corp.*, W.C. No. 4-408-889 (May 31, 2006). The ALJ's order striking the application for hearing is, therefore, a misapplication of the law. We set aside the order and remand the matter for further proceedings.

**IT IS THEREFORE ORDERED** that the ALJ's order dated September 15, 2017, is set aside and the matter is remanded for further proceedings.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

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

5/23/18 by TT .

PINNACOL ASSURANCE, Attn: HARVEY D FLEWELLING ESQ, 7501 EAST LOWRY BLVD, DENVER, CO, 80230 (Insurer)
KAPLAN MORRELL LLC, Attn: MICHAEL H KAPLAN ESQ, 6801 W 20TH STREET SUITE 201, DENVER, CO, 80634 (For Claimant)
RUEGSEGGER SIMONS SMITH & STERN LLC, Attn: DREW RZEPIENNIK ESQ, 1401 SEVENTEENTH ST SUITE 900, DENVER, CO, 80202 (For Respondents)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-993-719-03

IN THE MATTER OF THE CLAIM OF:

TONY CORLEY,

Claimant,

v.

FINAL ORDER

BRIDGESTONE/FIRESTONE,

Employer,

and

OLD REPUBLIC INSURANCE CO.,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Turnbow (ALJ) dated January 25, 2018, that ordered the respondents to pay the claimant temporary disability benefits calculated by using an average weekly wage (AWW) of $508.31. We modify the AWW, and as modified, affirm the ALJ's order.

The claimant was injured on August 22, 2015, while working for the employer as an auto repair technician. The claimant has been assigned work restrictions at various points in his recovery, including a variety of limitations. The respondents admitted liability for the claimant's low back injury and calculated an AWW of $507.07. The respondents have paid temporary benefits based on that figure. The claimant asserted the AWW was miscalculated. A hearing pertinent to this dispute was convened on November 15, 2017.

Following the hearing, the ALJ found the claimant's method of earnings was modified on November 15, 2014, to reflect a rate of pay per task instead of through his previous hourly standard of payment. Relying on § 8-42-102(3) C,R.S., the ALJ deemed it more accurate and fair to compute the AWW by applying the claimant's category of payment beginning November 15, 2014, and relying on the resulting wages paid through the last pay check prior to his injury. That check included wages earned through August 15, 2015. The ALJ noted this period was comprised of 39 weeks. By consulting the pay records compiled by the respondent employer, the ALJ found the claimant was paid

$19,824.13 over the 39 weeks. When divided by 39, the ALJ concluded the AWW should be $508.31. The ALJ ordered the AWW increased to that amount and directed the respondents to pay temporary benefits accordingly.

On appeal, the claimant contends the ALJ incorrectly added the wages paid to the claimant throughout the 39 weeks. The claimant asserts he was paid $20,510.97 over those weeks and the AWW, instead, should be set at $525.92. The respondents reply by asserting the ALJ is allowed discretion in calculating the AWW. The respondents also argue the period involved is not 39 weeks. Rather, it is said to represent 39.142857 weeks.

Both parties submitted copies of the weekly paycheck stubs attributed to the claimant's wages. The claimant does not dispute the findings of the ALJ concerning the period to be included for calculation of the AWW. He is only concerned with the arithmetic applied by the ALJ. A review of the weekly pay records indicates the claimant was paid $20,510.97 through the 39 pay stubs presented by both parties. When divided by the 39 weeks involved, the weekly average is $525.92. It appears the ALJ overlooked the payment of $656.84 dated the week ending July 25, 2015. While maintaining the integrity of the ALJ's determinations, the relevant period for calculating the AWW consists of the 39 weekly pay periods between November 15, 2014, and August 15, 2015, we find there is not substantial evidence in the record to support the ALJ's calculation the claimant was paid $19,824.13 over that period. Instead, the record indicates the amount paid was $20,510.97. Accordingly, we modify the calculation of the AWW to be $525.92.

While it is correct to recognize the ALJ has discretion to establish the AWW, the respondents' characterization of an inadvertent error in mathematics as an exercise in ALJ discretion is a misnomer. The ALJ reasonably exercised her discretion in selecting the circumstances under which the AWW was to be calculated by initiating the period of calculation at the point the claimant most recently had his method of payment modified and by disputing the claimant's contentions that portions of that period were unrepresentative. However, we may, and necessarily must, take judicial notice that 2 + 2 still equals 4.

The respondents' contention that 39.142857 weeks are involved, as opposed to only 39, does not correspond to the evidence. The claimant received 39 weekly checks during the interval in question. Section 8-42-102(2)(b) provides that when an employee is being paid by the week the weekly remuneration shall be deemed the weekly wage. The ALJ's method of calculation therefore consistently required the total of payments made

over the dates involved be divided by the number of weekly pay checks represented. Accordingly, we find no compelling reason to attribute further error to the findings of the ALJ.

**IT IS THEREFORE ORDERED** that the ALJ's order issued January 25, 2018, is modified to state the AWW is $525.92, and, as modified is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

5/25/18 by TT .

IRWIN FRALEY PLLC, Attn: ROGER FRALEY JR ESQ, 6377 S REVERE PARKWAY SUITE 400, CENTENNIAL, CO, 80111 (For Claimant)
POLLART MILLER LLC, Attn: BRAD J MILLER ESQ, 5700 S QUEBEC STREET SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 5-042-673-01

IN THE MATTER OF THE CLAIM OF:

DENNIS DOWD,

Claimant,

v.

FINAL ORDER

AMAZON.COM DEN 5,

Employer,

and

ZURICH AMERICAN INS. CO.,

Insurer,
Respondents.

The *pro se* claimant seeks review of an order of Administrative Law Judge Nemechek (ALJ) dated January 11, 2018, that determined the claimant failed to prove he sustained a compensable injury and denied and dismissed the claimant's request for medical benefits. We affirm the ALJ's order.

This matter went to hearing on whether the claimant sustained a work-related injury to his lumbar spine on March 17, 2017, and his request for medical benefits. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The ALJ found that the claimant was previously diagnosed with degenerative disc disease in his lumbar spine. The claimant received treatment for this condition in 2012 in Florida. An MRI revealed multi-level chronic degenerative changes most prominent at L4-5 and mild broad based disc bulges at L2-3, L3-4 without significant canal stenosis. Dr. Burry assessed the claimant with thoracic or lumbar spondylosis with myelopathy, lumbar intervertebral disc without myelopathy, lumbago, thoracic or lumbar sacral neuritis or radiculitis, unspecified. The claimant received treatment for the lumbar spine though October of 2013. The claimant moved to Colorado in November of 2013.

In November of 2015, the claimant was evaluated by Dr. Hollander as a new patient. It was documented that the claimant reported that he had experienced low back pain for the past five years and an MRI showed arthritis. Dr. Hollander diagnosed

neuropathy with unclear etiology. The ALJ found that there was no evidence that the claimant was disabled as a result of his lumbar condition before he worked for the employer.

The claimant began working for the respondent employer in a package sorting facility on June 9, 2016. The claimant sorted packages and worked part-time Friday through Tuesday from 7:30 pm to 11:30 pm. The claimant was required to lift up to 49 pounds in this position. A fifteen minute break was mandated at 9:30 pm. The claimant testified that working on the line with the conveyor was a physically demanding job but that he had good attendance while working for the employer. The ALJ found that the claimant was a credible witness when describing his job duties and requirements while working for the employer.

The claimant testified that he experienced pain in his back after working on March 17, 2017. The claimant finished his shift and the next day felt pain that was so severe he could not get out of bed. The ALJ credited the claimant's testimony that he felt severe pain after working on March 17, 2017.

A series of emails was exchanged between the claimant and the employer on March 20, 2017. The claimant said he worked the T-line on Friday and hurt his back and spent all weekend in bed. On March 21, 2017, the claimant completed the employer's accident report. The report stated that claimant was working the "T Lane" as a scanner/pick-off and lifted heavy boxes all night. The date of the incident was listed as March 18, 2017, which differed from the earlier emails from the claimant.

The claimant received a designated provider list and selected Concentra Aurora Southeast. The claimant was evaluated by Dr. Solot on March 21, 2017. The claimant reported that he had left-sided hip and back pain and that it started after taking the job with the employer. The ALJ specifically found that the claimant did not report a discrete injury or significant increase in symptoms after working on March 17th.

On March 22, Nurse Practitioner Kara Marcinek at Concentra recommended Cyclobenzaprine, Flexeril and physical therapy.

An employer's first report was completed on March 22, 2017, listing the date of injury as March 18, 2017 at 11:00 pm.

The claimant underwent an MRI on April 14, 2017, which revealed L4-5 disc degeneration with broad-based disc bulge and moderate bilateral facet arthropathy and

ligamentum flavum hypertrophy. There was also an intraspinal left-sided synovial cyst causing moderate to severe left lateral recess stenosis with compression of the descending left L5 nerve root.

An independent medical examination was performed by Dr. Cebrian at the respondents' request. Dr. Cebrian assessed multi-level degenerative disc disease and L5 radiculopathy with acute and chronic findings. Dr. Cebrian concluded that these conditions were not related to the work activities performed at the employer on the date of the alleged injury or due to the cumulative effects of the claimant's job. Dr. Cebrian noted that there was no acute injury described or onset of acute symptoms, nor was there a mechanism of sufficient force over a long enough period of time to cause an injury. Dr. Cebrian further concluded that the synovial cyst was due to the underlying natural history of the claimant's degenerative disc disease.

Dr. Aschberger reviewed the claimant's medical record and concluded that the claimant previously suffered symptoms similar to the current issues and that his symptoms did not stem from only one incident.

Based on these findings the ALJ determined that the claimant failed to prove that he sustained a work related traumatic injury or aggravation on March 17, 2017, or that his job duties caused him to develop a synovial cyst or cause the cyst to become symptomatic. The ALJ, therefore, denied and dismissed the claimant's request for medical benefits.

The claimant appeals the order contending that the ALJ should have recused himself and disputing the ALJ's findings of fact and conclusions of law. We perceive no reversible error.

We initially disagree with the claimant's contention that the ALJ should have recused himself because prior to becoming an ALJ he worked for employers and insurance carriers. An ALJ is presumed to be competent and unbiased unless the contrary is shown. *Wecker v. TBL Excavating, Inc*., 908 P.2d 1186 (Colo. App. 1995). Recusal is not warranted unless the ALJ has a personal, financial, or official stake in the outcome of the case. *See Neoplan USA Corp v. Industrial Claim Appeals Office*, 778 P.2d 312 (Colo. App. 1989). The claimant has not alleged that the ALJ in this case has a personal, financial or official stake in the outcome of this case. Moreover, it does not appear from the record on review that the claimant ever previously made such a motion, either prior to or at the hearing. Under these circumstances, the claimant waived

the right to move the ALJ to recuse himself. *See Dalco Industries, Inc. v. Garcia*, 867 P.2d 156 (Colo. 1993).

Nor are we persuaded that there is any other basis to disturb the ALJ's order on review. Pursuant to §8-43-301(8), C.R.S., the panel has 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. These conditions do not exist in this case.

A claimant has the burden to prove that his injury was proximately caused by an injury arising out of and in the course of employment. Section 8-43-201, C.R.S.; § 8-41-301(1)(b), C.R.S.; *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000). Whether the claimant has met his burden of proof is a factual question for resolution by the ALJ, and his factual findings must be upheld if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.

Moreover, the respondents are liable if employment-related activities aggravate, accelerate, or combine with a pre-existing condition to cause a need for medical treatment. Section 8-41-301(1)(c), C.R.S.; *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). However, although pain may be a typical symptom from the aggravation of a pre-existing condition, a claimant is entitled to medical benefits for treatment of pain, only so long as the pain is proximately caused by the employment-related activities and not the underlying pre-existing condition. The mere onset of pain symptoms does not necessarily require a finding that the employment aggravated or accelerated the pre-existing condition. *See Miranda v. Best Western Rio Grande Inn*, W.C. No. 4-663-169 (April 11, 2007). Resolution of this issue is also one of fact for the ALJ, which must be upheld if supported by substantial evidence in the record. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). Substantial evidence is that quantum of probative evidence which a rational fact finder would accept as adequate to support a conclusion without regard to the existence of conflicting evidence. *See Id.*

Here, we conclude that the ALJ did not err, as a matter of law, in ruling that the claimant failed to prove by a preponderance of the evidence that he failed to prove he sustained a traumatic injury to or an aggravation of his lumbar spine on March 17, 2017. Rather, the ALJ cited to the correct law and definitions governing compensability, and the order demonstrates that his analysis of the compensability of the claimant's claim used this law and these definitions under the Act. *See Shafer Commercial Seating, Inc. v.*

*Industrial Claim Appeals Office*, 85 P.3d 619 (Colo. App. 2003) (ALJ presumed to have considered relevant legal principles when entering an order).

The claimant failed to procure a transcript. Under these circumstances, we must presume the ALJ's findings concerning the evidence presented at the hearing are supported by substantial evidence. *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988). In any event, the ALJ's findings are supported by the documentary evidence contained in the record. The ALJ relied on the opinions of Dr. Cebrian (Respondents' Exhibit C at 20) and Dr. Aschberger. (Respondents' Exhibit B at 2). Dr. Cebrian concluded that the claimant's primary problem was the synovial cyst that resulted in an L5 radiculopathy. Dr. Cebrian further stated that there is not a mechanism for his job at Amazon to aggravate or cause a synovial cyst and that no exogenous event was necessary to develop symptoms. According to Dr. Cebrian, the synovial cyst is due to the underlying natural history of the degenerative disc disease. Respondents' Exhibit C at 21. Dr. Aschberger similarly concluded that it was apparent that the claimant's current condition was due to a pre-existing abnormality. Respondents' Exhibit B at 2.

The claimant's arguments concerning the persuasiveness of these medical opinions notwithstanding, the relative weight and credibility to be assigned to expert medical opinions is in the sole province of the ALJ as fact finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). We have no authority to substitute our judgment by reweighing the evidence in an attempt to reach a result that is different from that of the ALJ. *Rockwell International v. Turnbull*, 802 P.2d 1185 (Colo. App. 1990). These opinions provide substantial evidence and valid support for the ALJ's determination that the claimant did not sustain a compensable injury. Consequently, we must uphold the ALJ's finding that the claimant failed to meet the burden of proof to establish a compensable injury. Section 8-43-301(8), C.R.S.

**IT IS THEREFORE ORDERED** that the ALJ's order dated January 11, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

CERTIFICATE OF MAILING

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

6/01/18 by TT .

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# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-041-216-01

IN THE MATTER OF THE CLAIM OF:

TYNNAE FISHER,

Claimant,

v.

FINAL ORDER

UNIVERSITY OF COLORADO HEALTH,

Employer,

and

TRAVELERS INSURANCE,

Insurer,
Respondents.

The respondents seek review of the supplemental order of Administrative Law Judge Felter (ALJ) dated February 13, 2018, that authorized the claimant to request a Division sponsored Independent Medical Examination (DIME). We dismiss the petition to review without prejudice.

The claimant was injured at work on February 16, 2017. The claimant worked at the employer's hospital as a medical assistant in the emergency room. While aiding other staff in the transport of an uncooperative patient in a wheelchair, her foot became caught under a wheel of the chair causing her to fall on her back. The claimant complained of pain in her cervicothoracic and lumbar regions. She was treated conservatively by her authorized treating physician (ATP), Dr. Roth. Dr. Roth noted the claimant had been prescribed medications to treat rheumatolgic disorders prior to the date of her injury. He recommended light duty restrictions and the claimant continued to work. After several sessions of physical and massage therapy the claimant reported a significant decrease in pain as of May 24, 2017. Dr. Roth determined the claimant had achieved maximum medical improvement (MMI) on that date. The doctor observed the claimant had no need for further maintenance medical care, had sustained no permanent impairment and would be released to regular duty. On June 15, the respondents filed a Final Admission of Liability (FAL). The FAL acknowledged no temporary benefits were owed and admitted for 0% permanent impairment.

The claimant disputed the FAL by filing a Notice and Proposal form requesting a DIME review on July 11, 2017. The respondents scheduled a prehearing conference at which they pursued a motion to strike the claimant's request for a DIME. Premised on the authority of the decision in *Trujillo v. Elwood Staffing*, W.C. No. 4-957-118-02 (June 22, 2017), Prehearing ALJ DeMarino ruled the request for a DIME was premature and struck the claimant's request. The *Trujillo* decision applied the Supreme Court's holding in *Harman-Bergstedt v. Loofbourrow*, 320 P.3d 327 (Colo. 2014). That holding observed the concept of 'MMI' has no statutory significance in the case of injuries that do not result in the loss of no more than three days or shifts of work or permanent disability. Because § 8-42-107.2 (2)(a)(I)(A) provides the time to request a DIME commences upon the filing of an FAL, which, in turn, is to be filed only upon an ATP's finding of MMI, (*see* § 8-43-203(2)(b)(II) and (3)(c)(VII), W.C. Rule of Procedure 5-5(D) and (E), 7 CCR 1101-3) *Trujillo* surmised there could be no statutorily significant finding of MMI or valid FAL in a medical only case such as in this matter.

The claimant scheduled a hearing to contest the order of the PALJ. Following a hearing on December 5, 2017, featuring the submission of documentary evidence but no testimony, the ALJ reversed the ruling of the PALJ and resolved the claimant is presently entitled to commence a DIME review. Following a review of the briefs submitted pertinent to the respondents' petition to review, the ALJ authored a supplemental order on February 13, 2018, arriving at the same conclusion. The ALJ determined the decision in *Loofbourrow* held only that a claimant need not petition to reopen a claim in order to seek further medical benefits after an ATP's determination of MMI when no indemnity benefits are payable. The ALJ reasoned the PALJ's decision effectively denied the claimant her substantive due process rights to workers' compensation benefits. The ALJ further noted the order being issued was purely procedural and interlocutory as it does not award any benefits.

The respondents have appealed the ALJ's order contending it is subject to review pursuant to § 8-43-301(2) and (4). Those sections allow for an appeal to the Panel in the case where the order in question requires any party to pay a penalty or benefits or denies payment of a benefit. The respondents argue that, through the ALJ's order allowing the claimant to proceed with a DIME review, the respondents will be obligated by § 8-42-107.2(b) and W.C. Rule 11-3(I)(J) and (K) to incur the cost of copying and transmitting to the DIME physician a set of all their accumulated medical records. The respondents point to W.C. Rule 18-6(C) as a requirement they pay at least $18.53 for the cost solely of the ATP's MMI report. It is noted the Panel had previously determined that an order directing a change in the authorized physician became subject to review pursuant to § 8-43-301(2) based on the fact that the respondents were required by the statute and Rule to

pay for a copy of the previous doctor's medical file to be made and delivered to the new physician. *Houston v. Allcable, Inc.* W.C. No. 4-997-535-01 (October 5, 2016). The respondents contend that same principal renders the ALJ's order here ripe for appellate review.

The respondents argument overlooks some significant distinctions between the costs referenced in *Houston* and those involved in this case. Rule 18-6(C) is the cost the respondents must pay the ATP to receive an initial copy of his MMI report. However, once the respondents have that report they need not pay the $18.53 again to send a copy to the DIME physician, to the claimant, or to attach it to a pleading. In point of fact, should the insurer's claims adjuster endeavor to assemble and deliver the medical file to the DIME, the respondent would not be liable for any additional cost outlays.

More importantly, however, *Houston* identified as obligations of the respondents costs for more than just copying. In addition, the purpose for those costs were implicated in the medical treatment of the claimant whereas costs required for a DIME review are not, and therefore do not qualify as a workers' compensation benefit. Section 8-43-404(5)(a)(IV)(B) specifies the original authorized physician is to supply the new physician with a copy of the physician's file. The respondents are not allowed to simply copy their own medical file. In that regard, W.C. Rule 18-6(B) requires the insurer to pay the original physician for the copying costs. Section 8-43-404(5)(a)(IV) and Rule 8-6(C) also ensure the claimant the right to have at least one appointment with the new physician within 30 days. Accordingly, an order to authorize a new physician necessarily obligates the respondents to pay, at a minimum, the cost of this first appointment as well as the claimant's mileage to attend.

Further, § 8-42-101 characterizes medical treatment as an injured worker's benefit. However, the DIME procedure is not for the purpose of treatment. Rather, it "serves an evidentiary function in the process of litigating disputes …". *Ince v. Southwest Memorial Hospital*, W.C. No. 4-535-488 (April 19, 2004). In *Ince* we held that an injury a claimant might sustain while attending a DIME evaluation will not qualify as a compensable injury through application of the quasi-course of employment doctrine. Such an injury would be compensable if incurred while attending an appointment with an authorized provider. Whereas the latter appointment is for the purpose of 'treatment', a DIME examination was described in *Ince* as a process other than "medical treatment which respondents are required to provide and the claimant is required to accept as part of the implied contractual arrangement created by the Act. Rather, much like the videotapes described in *Jarosinski v. ICAO*, 62 P.3d 1082 (Colo. App. 2002), the DIME is a function of the litigation process by which each side gathers and presents evidence in support of or

opposition to the claim." Consequently, any costs the respondents incur in facilitating a DIME review for the claimant may not be characterized as a requirement to pay a 'benefit' for the purpose of § 8-43-301(2).

The panel previously has issued numerous decisions holding that orders related to DIME requests are in the nature of evidentiary rulings and are therefore, interlocutory. *See, e.g., Heinz v. State Farm*, W.C. No. 4-991-171-05, (December 9, 2016) *aff'd*, *Heinz v. Industrial Claim Appeals Office*, 16CA2236 (Nov. 22, 2017)(not selected for publication)*; Alvarez v. JBS USA, LLC*, W.C. No. 4-783-538 (July 10, 2012)*; Maestas v. Wal Mart Stores, Inc.*, 4-717-132 (January 22, 2009); *Sander v. Summit Group, Inc.*, W.C. No. 4-369-777 (September 27, 2000); *Lozano v. Front Range Rebar Co., Inc.*, W.C. No. 4-285-320 (August 3, 1998). Accordingly, since the ALJ's order regarding the availability of the DIME process does not award or deny a benefit, it therefore is not final and subject to review pursuant to § 8-43-301(2). Rather, the ALJ's order is procedural. *See Ortiz v. Industrial Claim Appeals Office*, 81 P.3d 1110 (Colo. App. 2003) (order striking claimant's request for DIME and ordering Division to proceed with respondents' request for DIME not final and reviewable). Thus, the ALJ's order is not a final order for purposes of §8-43-301(2), and accordingly, we may not consider the issue at this time.

**IT IS THEREFORE ORDERED** the petition to review the ALJ's order of February 18, 2017, is dismissed without prejudice.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

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