

BROWN BAG SEMINAR

Thursday, May 15, 2014

(third Thursday of each month)

Noon - 1 p.m.

633 17th Street

12th Floor Conference Room

Note New Location This Month Only

1 CLE (including .4 ethics)

Presented by

Craig Eley

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

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Free

This outline covers ICAP and appellate decisions issued from

April 12, 2014 through May 9, 2014

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-879-066-01

IN THE MATTER OF THE CLAIM OF

LARRY JOHNSTON,

Claimant,

v.

HUNTER DOUGLAS, INC.,

Employer,

and

LIBERTY MUTUAL INSURANCE
COMPANY,

Insurer,
Respondents.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Jones (ALJ) dated November 5, 2013, that granted the respondents' request to suspend benefits pursuant to §8-43-404(3), C.R.S., and determined that Dr. Orent remained the claimant's authorized treating physician. The claimant also appeals the ALJ's June 26, 2013, order which held the Division Independent Medical Examination (DIME) proceedings in abeyance and the ALJ's July 17, 2013, order denying the claimant's request for specific findings of fact for the June 26, 2013, order as interlocutory. We dismiss, without prejudice, that portion of the appeal holding the DIME proceedings in abeyance and denying the claimant's request for specific findings of fact as interlocutory, and otherwise affirm the order.

A hearing was held on the issues of authorized treating provider, reasonable necessary medical benefits and suspension of benefits for violation of a Pre-hearing ALJ (PALJ) order to attend a medical examination with the treating physician. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant sustained an admitted injury on December 19, 2011, when he tripped on a piece of wood on the floor at work. Dr. Orent was selected as the authorized treating physician. Dr. Orent initially noted that the claimant was experiencing pain with his right knee and right shoulder. The claimant was eventually diagnosed with rotator cuff and bicep tendon tears for which the claimant underwent surgery. After surgery the claimant continued to complain of forearm pain. Dr. Orent made a referral to Dr. Conyers for consultation and possible injections.

An MRI of the claimant's knee did not show any tears. Dr. Orent recommended physical therapy to treat the knee and noted that surgery was not indicated. After attending some physical therapy the claimant continued to complain of pain in his knee and eventually cancelled all further physical therapy sessions for his knee. The claimant sent letters to Dr. Orent expressing his dissatisfaction with his treatment plan and stating that he continued to experience pain. Dr. Orent planned to refer the claimant to a pain specialist, Dr. Sorenson. In the meantime, however, the claimant sought treatment outside the workers' compensation system with Dr. Schneider, alleging that he had also sustained an injury to his hip and back as part of the work related injury. According to Dr. Orent, the hip and back were not causally related to the December 2011 injury. The claimant also underwent knee surgery outside of the workers' compensation system to remove a Baker's Cyst. This caused a delay in Dr. Orent's referral to Dr. Sorenson because the claimant was taking narcotics in connection with the unauthorized knee surgery.

The claimant also saw Dr. Bennett upon a referral from his attorney. Dr. Bennett diagnosed the claimant with CRPS, sympathetic maintained pain and S/P radial nerve entrapment. Among other things, Dr. Bennett recommended a stellate ganglion block, which the claimant underwent on December 26, 2012.

The claimant reported to Dr. Sorenson on December 18, 2012. Dr. Sorenson noted that the claimant's major concern was managing his Oxycontin use. Dr. Sorenson found no evidence of CRPS and a discussion took place concerning the necessity for the claimant to sign a narcotic agreement prior to continuing treatment. The claimant refused to sign the agreement. Dr. Orent noted that a signed narcotic agreement was a requirement mandated by the Chronic Pain Treatment Guidelines, Workers' Compensation Rules of Procedure (WCRP) 17 Ex. 9 H(6), and the claimant's refusal to sign the agreement prevented Dr. Sorenson from being able to treat the claimant. Dr. Orent eventually placed the claimant at maximum medical improvement (MMI) stating that he had done everything and put him through every treatment that he could and that the claimant was not cooperating with the plan for chronic pain management. June 10, 2013 Tr. at 49 and 126-127.

The claimant returned to work and on January 7, 2013, notified the employer that he was addicted to pain medications. The employer met with the claimant and advised him that Dr. Orent's office was willing to see him the next day. The claimant ended up cancelling the appointment. The insurance adjuster set a demand appointment with Dr. Orent to take place on Monday, January 14, 2013, with an alternative option of seeing his partner, Dr. Kistler, on Friday, January 18, 2013. On January 16, 2013, a PALJ issued an order compelling the claimant to attend an appointment with Dr. Kistler on January 18, 2013, "per §8-43-404 (3), C.R.S."

The claimant appeared at Dr. Kistler's office on January 18, 2013, but stated that he would not proceed with the examination because Dr. Kistler did not provide the claimant with an IME advisement form. Dr. Kistler noted in his report that the claimant also requested that the exam be recorded, which Dr. Kistler allowed. Dr. Kistler also stated that the claimant remained at MMI and that he could return for maintenance care should the claimant decide that he is able to proceed.

The ALJ found the testimony of Dr. Orent to be more credible than that of the claimant concerning the course of the claimant's treatment. Based upon these findings the ALJ determined that Dr. Orent remained the authorized treating physician, rejecting the claimant's contention that the right of selection passed to the claimant when Dr. Orent placed the claimant at MMI. The ALJ specifically noted that the claimant never made a request to change physicians and, therefore, Dr. Schneider and Dr. Bennett and their subsequent referrals were determined to be unauthorized providers.

The ALJ further found that the claimant's benefits should be suspended and barred for the claimant's violation of the PALJ's January 16, 2013, order. The ALJ found that the claimant refused to participate, or at the very least failed to cooperate and obstructed the appointment, with Dr. Kistler, an authorized treating provider, in violation of the PALJ's January 16, 2013, order. The ALJ concluded that the claimant's actions operated as a bar to his right to indemnity benefits after January 18, 2013, until such date as the claimant re-appears at Dr. Kistler's or Dr. Orent's office for such court ordered examination.

On appeal the claimant argues that "deauthorization was not an issue properly before the ALJ," and that the ALJ erred in finding that the claimant refused to cooperate with medical care. We are not persuaded the ALJ committed reversible error.

I.

In his petition to review, the claimant argues that the issues were unclear and that the ALJ erred in refusing to allow additional discovery. We disagree with the claimant that there was any ambiguity in the issues listed in the application for hearing. Contrary to the claimant's characterization of the issues, the ALJ's order does not "deauthorize" a provider. The issue of authorized treating provider was clearly listed as an issue for hearing. It follows that the ALJ would make a determination of who was authorized and who was not an authorized provider, which she did here. Consequently, we perceive no due process violation and no error in the ALJ's determination to proceed with the hearing despite the claimant's motion to compel discovery and to continue the hearing. See *Hendricks v. Industrial Claim Appeals Office*, 809 P.2d 1076, 1077 (Colo. App. 1990)(no

due process violation where parties are apprised of the evidence and afforded a reasonable opportunity to present evidence and argument in support of their positions).

“Authorization” refers to the physician's legal status to treat the injury at the respondents' expense. *Popke v. Industrial Claim Appeals Office*, 944 P.2d 677 (Colo. App. 1997). A physician who commences treatment upon a referral made in the “normal progression of authorized treatment” becomes an authorized treating physician. *Bestway Concrete v. Industrial Claim Appeals Office*, 984 P.2d. 680 (Colo. App. 1999); *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). The determination of whether there has been a referral in the “normal progression of authorized treatment” is a question of fact for resolution by the ALJ. *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997); *Suetrack USA v. Industrial Claim Appeals Office*, 902 P.2d 854 (Colo. App. 1995). We are bound by the ALJ's determinations if supported by substantial evidence and plausible inferences drawn from the record. Section 8-43-301(8), C.R.S. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003).

Here, the ALJ found, with ample record support, that the claimant sought treatment from Dr. Schneider and Dr. Bennett outside the chain of referral and such treatment was not authorized. The fact that the claimant contends that he was receiving relief from these providers is not a basis to set aside the ALJ's determination. Even assuming, as the claimant alleges, that the treatment by these providers was reasonable, necessary and related, if the treatment is unauthorized, the respondents are not required to pay for it. Section 8-43-404(7), C.R.S.; *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999); *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). Consequently, we perceive no basis to disturb the ALJ's order on this basis.

II.

The claimant also alleges that the ALJ erred in suspending benefits pursuant to §8-43-404(3), C.R.S. We, again, are not persuaded the ALJ erred.

Insofar as pertinent, §8-43-404(3), C.R.S., provides that compensation shall be suspended, “[s]o long as the employee, after written request by the employer or insurer, refuses to submit to medical examination or vocational evaluation or in any way obstructs the same.” The statute further provides that the right to benefits shall be barred if the employee refuses to submit to such examination after direction by the director or any agent, referee or administrative law judge...or in any way obstructs the same. See *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000); *Matthews v. United Parcel Service*, W.C. No. 4-325-652 (December 15, 1997); *Maryott v. J & N Properties*, W.C. No. 4-157-363 (April 28, 1997). The panel

previously has ruled that the terms “refuse” and “obstruct” contemplate intentional conduct rising above the level of mere negligence. *Ramos v. Wal-Mart Stores* W.C. No. 4-163-653 (December 18, 1995); *Ming v. Amalgamated Sugar Company*, W.C. No. 4-147-613, (September 8, 1993); *Johnson v. General Electric Environmental Co.*, W. C. No. 3-9310393, (May 24, 1995); *Sue v. Ingersoll Rand*, W.C. No. 3-803- 429 & 3-890-05 (April 26, 1994).

It is undisputed that the claimant here was ordered to attend the appointment with authorized treating physician, Dr. Kistler. We agree with the ALJ’s findings that the claimant’s refusal to participate or his obstruction of the appointment was intentional. The claimant testified that it was his understanding that the examination could not take place as certain regulations governed how it was to proceed and that the examination had to be tape recorded. August 26, 2013 Tr. at 34-35. Dr. Kistler further documented his exchange with the claimant, noting that the claimant was “so inflamed that I did not want to confront him about this.” August 26, 2013 Tr. at 45-46. The record supports the ALJ’s finding that the claimant was able to exercise control or to make a voluntary choice in whether to participate in the examination.

As we understand the claimant’s argument on appeal, the claimant contends he was justified in his obstruction of the appointment because the claimant was ordered to attend the examination pursuant to §8-43-404 (3), C.R.S., and according to the claimant, Dr. Kistler was required to comply with the requirements for independent medical examinations set forth in §8-43-404(2), C.R.S. and Workers’ Compensation Rules of Procedure (WCRP) 8-8 through 8-13. Specifically, WCRP 8-9 states that the examination shall not take place unless the injured worker has signed the independent medical examination form. We disagree with the claimant’s overly broad reading of the statute and conclude that Dr. Kistler, as an authorized treating physician, was not subject to the provisions governing independent medical examinations in §8-43-404(2), C.R.S. and WCRP 8-8 through 8-13.

In its’ entirety, §8-43-404, C.R.S. is an all encompassing statute addressing many different aspects of medical providers in the workers’ compensation system. Some sections apply only to Independent Medical Examinations. *See* 8-43-404, (1)(a) and (b), C.R.S., while other sections apply only to the selection of the authorized treating physician. *See* 8-43-404(5), C.R.S.

At issue here is §8-43-404(2), C.R.S. which was amended in 2009 by SB 09-168. This amendment required that all Independent Medical Examinations requested by the employer, be reduced to writing and audio-recorded in their entirety. The amendment also required the Director to promulgate rules that included provisions for the protection and privacy of the information contained in the recordings. *See Colorado Division of*

Workers' Compensation 2009 Legislative Advisory. The language of §8-43-404(2), C.R.S. also makes a distinction between the reports of an “examining” physician and a physician chosen to “treat” the claimant, both of which are required to send reports to parties at the same time and under the same terms and conditions.

Moreover, WCRP 8-8 through 8-13 which were promulgated by the Director in 2009 to implement the provisions in §8-43-404(2), C.R.S. are specifically entitled “Independent Medical Examinations.” The rules require that a form be provided to the claimant prior to the Independent Medical Examination. The form is explicitly titled, “IME Advisement.” Division of Workers’ Compensation Form #36-A; WCRP 8-9 (A). This form also provides detailed information regarding the Independent Medical Examination and states that the physician conducting the examination will not provide treatment or care and that no doctor/patient relationship will be established.

In contrast, the provisions for a demand appointment and the consequences for refusing to attend or obstructing a demand appointment in §8-43-404(3), C.R.S., appear to apply to requests for an examination by an authorized treating physician or to a request for an Independent Medical Examination. *See Twiggs v. Hoffman Structures*, W.C. No. 4-430-471 (December 11, 2001) (no language in §8-43-404 indicates the statute is inapplicable to requests for the claimant to undergo an examination by an authorized treating physician).

Because words in statutes are to be given their plain and ordinary meaning, we decline to interpret §8-43-404(2) in a manner suggested by the claimant as there is no textual support. *Weld County School District RE-12 vs. Bymer*, 955 P.2d 550 (Colo. App. 1998); *Kraus v. Artcraft Sign Co.*, 710 P.2d 480 (Colo. 1985) (court may not read non-existent provisions into the Act). Consequently, in our view, the plain language of §8-43-404(2), C.R.S. and the requirement to provide an IME Advisement Form and to record the examination, only apply to Independent Medical Examinations and not to demand appointments with the authorized treating physician.

Therefore, the claimant’s contention that the exam could not proceed because Dr. Kistler did not comply with the requirements for an Independent Medical Examination in §8-43-404(2) and WCRP 8-8 through 8-13, is without merit. There is no dispute that Dr. Kistler was an authorized treating provider within the chain of referral. Dr. Kistler was not merely an examining physician for purposes of an Independent Medical Examination. Thus, Dr. Kistler was not subject to the form and audio-recording requirements of §8-43-404 (2), C.R.S. and WCRP 8-8 thorough 8-13. The fact that the claimant was mistaken in his application of these rules does not change the intentional nature of the claimant’s conduct with regard to his obstruction of the appointment. Because the ALJ’s order in this regard is supported by substantial evidence and applicable law, we have no basis to

disturb the order on review. Section 8-43-301(8), C.R.S.

III.

The claimant also appeals the ALJ's June 26, 2013, order which held the DIME proceedings in abeyance and the ALJ's July 17, 2013, order denying the claimant's request for specific findings of fact for the June 26, 2013, order as interlocutory. We dismiss this portion of the appeal without prejudice for lack of a final order.

On June 26, 2013, the ALJ issued an order holding the DIME process in abeyance "until such time as this ALJ has issued an Order with respect to the issues listed on Respondent's January 11, 2013, Application for Hearing, and those Added by way of Pre-hearing Conference Orders and set forth at the onset of the April 3, 2013 Hearing." *See* WCRP 11-3(O). The claimant filed a request for specific findings of fact which was denied on July 17, 2013, as interlocutory. The claimant filed an untimely petition to review this order which was stricken by the ALJ. The claimant again renews his arguments that the DIME process should not be held in abeyance and that the ALJ erred in her determination that the order was interlocutory. We perceive no error.

Under §8-43-301(2), C.R.S., a party dissatisfied with an order "which requires any party to pay a penalty or benefits or denies a claimant a benefit or penalty," may file a petition to review. Orders which do not require the payment of benefits or penalties, or deny the claimant benefits or penalties are interlocutory and not subject to review. *Ortiz v. Industrial Claim Appeals Office*, 81 P.3d 1110 (Colo. App. 2003). Generally orders involving discovery and the presentation of evidence are interlocutory because they do not involve an award or denial of benefits or penalties. *See Reed v. Industrial Claim Appeals Office*, 13 P.3d 810 (Colo. App. 2000); *American Express v. Industrial Commission*, 712 P.2d 1132 (Colo. App. 1985).

In view of these principles, the panel has issued numerous decisions holding that orders related to DIME requests are interlocutory. *Bath v. Adams County*, W. C. No. 4-584-461 (September 20, 2005); *Sander v. Summit Group, Inc.*, W.C. No. 4-369-777 (September 27, 2000); *Leos v. Kurt Group, Inc.*, W.C. No. 4-231-009 (November 15, 1996); *Adams v. Sunburst Properties and Financial Corp.*, W.C. No. 4-261-472 (September 24, 1996). Accordingly, the ALJ's orders concerning holding the DIME in abeyance are interlocutory and not currently reviewable. *Oxford Chemicals, Inc. v. Richardson*, 782 P.2d 843, 846 (Colo. App. 1989) (order may be partially final and reviewable and partially interlocutory). Thus, we need not consider the issue at this time.

IV.

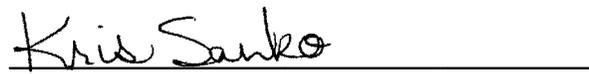
To the extent the claimant raises other issues in the petition to review which he seeks to incorporate in his brief in support, we have considered these arguments and reject them.

The only independent issue raised by the claimant's petition to review that was not incorporated by our disposition of the other issues, appears to be the claimant's assertion that his due process rights were violated because the ALJ adopted the respondents' proposed order. The courts repeatedly have declined to reverse orders merely because they were originally drafted by one of the parties. *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) (if the ALJ's findings are otherwise sufficient, they are not weakened or discredited because they were originally drafted by one of the parties). It is presumed that the ALJ examined the proposed findings and agreed that they correctly stated the facts as she found them to be; otherwise, she would not have adopted them as her own. *Id.* The claimant has not offered a basis to disregard that presumption here. Furthermore, the ALJ did not adopt the proposed order verbatim. Therefore, the order presumably reflects the independent determinations of the ALJ. *Id.*

IT IS THEREFORE ORDERED that the ALJ's order dated November 5, 2013, is affirmed. The claimant's appeal of the ALJ's June 26, 2013, and July 17, 2013, orders is dismissed without prejudice.

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

_____ 4/29/2014 _____ by _____ KG _____ .

LARRY JOHNSTON, 536 BIRCH AVE, DACONO, CO, 80514 (Claimant)
HUNTER DOUGLAS, INC., C/O: GINI MCMAHAN, ONE DUETTE WAY, BROOMFIELD,
CO, 80020 (Employer)
LIBERTY MUTUAL INSURANCE COMPANY, C/O: MICHAEL KETTER, PO BOX 168208,
IRVING, TX, 75016 (Insurer)
INGOLD LAW, LLC., C/O: CHRIS L. INGOLD, ESQ., 340 SOUTH LEMON AVE #7213,
WALNUT, CA, 91789 (For Claimant)
THE KITCH LAW FIRM, C/O: MARSHA A KITCH, ESQ., 3064 WHITMAN DRIVE STE
200, EVERGREEN, CO, 80439 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-897-030-02

IN THE MATTER OF THE CLAIM OF

MISTY KEEL, dependent of JOHN ERIC KEEL,

Claimant,

v.

ORDER OF REMAND

TRANSPORTATION TECHNOLOGY SERVICES,

Employer,

and

ACE AMERICAN INSURANCE COMPANY
CARRIER NO 494C186588-6,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Allegretti (ALJ) dated November 13, 2013, that granted the respondents' cross-motion for summary judgment and determined the respondents correctly calculated interest due and owing to the claimant on past due death benefits, and correctly calculated the Social Security offset. We set aside that portion of the ALJ's order regarding the amount of interest due and owing the claimant, and remand for further findings and a new order on this issue. In all other regards, we affirm the ALJ's order.

It is undisputed that at the time the deceased employee was killed on October 27, 2010, in a Colorado industrial accident, he and his wife and son were residents of Mississippi. A claim for workers' compensation benefits initially was brought in the state of Mississippi for the decedent's death. The respondents admitted the claim under Mississippi's workers' compensation act, and began paying benefits commencing on October 28, 2010. The respondents admitted for a compensation rate of \$337.58.

The claimants, the wife and son of the deceased, later made a claim for death benefits under Colorado's workers' compensation system. A hearing ultimately was held before ALJ Friend on the claimants' claim. On April 3, 2013, ALJ Friend determined that Colorado had jurisdiction over the claimants' claim. ALJ Friend, however, did not determine the decedent's average weekly wage under Colorado law, the equitable division of death benefits between the claimants, or offsets for the receipt of Social Security benefits or for workers' compensation benefits paid under the Mississippi claim.

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On September 3, 2013, the respondents filed a Fatal Case - General Admission in Colorado. The respondents admitted for the maximum temporary total disability rate of \$1,216.00 for a weekly compensation rate of \$810.67. On September 20, 2013, the respondents filed a Fatal Case - Amended General Admission, admitting for death benefits under Colorado's workers' compensation system totaling \$66,822.00 from October 28, 2010, to August 28, 2013, and death benefits from August 29, 2013, and ongoing at a weekly rate of \$620.29 for the son and wife of the deceased. The Amended General Admission asserted the respondents were entitled to take a Social Security offset in the amount of \$190.38 per week since the date of the incident forward. This offset was computed based on each claimant receiving Social Security benefits totaling \$825.00 per month.

It is undisputed that between the day after the decedent's death and the respondents' filing of their General Admission in Colorado, the respondents paid the claimant a total of \$49,961.84 under Mississippi's workers' compensation system. The respondents also paid 8% interest on \$16,860.16, or the difference between the workers' compensation benefits that actually were paid to the claimant under Mississippi's workers' compensation system (\$49,961.84), and the workers' compensation benefits that they assert should have been paid under Colorado's workers' compensation system (\$66,822.00).

Thereafter, the claimant, the wife of the deceased, filed an application for hearing listing the following as issues to be heard: amount of Colorado death benefits for which the insurer is liable, offsets of Social Security Survivor benefits and Mississippi workers' compensation death benefits.

Prior to the hearing, the claimants filed a summary judgment motion, arguing that the respondents miscalculated past-due and ongoing death benefits, miscalculated the amount of interest due and owing on past-due death benefits, and miscalculated the Social Security offset by using 52 weeks rather than 52.14 weeks for the number of weeks in a year. The respondents filed a cross-motion for summary judgment, arguing that they corrected the Social Security offset, and they filed an Amended General Admission reflecting the correct offset. The respondents further argued they correctly calculated death benefits and interest.

The ALJ subsequently granted the respondents' cross-motion for summary judgment, determining that the respondents correctly calculated the amount of interest due and owing to the claimant on the past-due death benefits. The ALJ found that between the day after the decedent's death and the respondents' filing of their General Admission in Colorado, the respondents paid the claimant \$49,961.84 under Mississippi's workers' compensation system. The ALJ found that since the claimant would have received \$66,822 for the same time period under Colorado's workers' compensation system, the claimant lost use of \$16,860.16. The ALJ further found that the respondents paid the claimant 8% interest on the \$16,860.16. The ALJ also

determined the respondents correctly calculated the Social Security offset as being \$190.38 per week. The ALJ specifically rejected the claimant's argument that since there are 52.14 weeks in a year, it was improper to use 52 weeks for calculating the Social Security offset.

I.

The claimant has appealed the ALJ's order granting the respondents' cross-motion for summary judgment.

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

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

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

A.

On review, the claimant appears to argue that she is entitled to recover concurrent death benefits under both Mississippi's and Colorado's workers' compensation systems for the total combined amount of \$116,783.84. The respondents contend that the claimant's argument is raised for the first time on review and, therefore, we should summarily disregard it. We disagree with both arguments.

Neither Mississippi law nor Colorado law allow a claimant to collect duplicate workers' compensation benefits. Mississippi law allows for a 100% offset of benefits paid to a claimant, when that claimant receives workers' compensation benefits under another state's laws. *See Southland Supply Co, Inc. v. Patrick*, 397 So.2d 77 (Miss. 1981)(claimant, who received workers' compensation benefits under Mississippi law, was not precluded from seeking workers' compensation benefits under Louisiana law, and the trial court correctly awarded such benefits subject to full credit for any amounts previously paid under Mississippi's Workers' Compensation Act).

Further, §8-42-114, C.R.S., the statutory provision governing offsets for death benefits paid to dependents of a deceased worker under Colorado's Workers' Compensation Act, provides as follows:

In case of death, the dependents of the deceased entitled thereto shall receive as compensation or death benefits sixty-six and two-thirds percent of the deceased employee's average weekly wages, not to exceed a maximum of ninety-one percent of the state average weekly wage per week for accidents occurring on or after July 1, 1989, and not less than a minimum of twenty-five percent of the applicable maximum per week. *In cases where it is determined that periodic death benefits granted by the federal old age, survivors, and disability insurance act or a workers' compensation act of another state or of the federal government are payable to an individual and the individual's dependents, the aggregate benefits payable for death pursuant to this section shall be reduced, but not below zero, by an amount equal to fifty percent of such periodic benefits.* (emphasis added)

In interpreting statutes, we must give effect to the intent of the General Assembly, and if the statutory language is clear and unambiguous, we must give the words their ordinary meaning and apply the statute as written. *See Cochran v. West Glenwood Springs Sanitation Dist.*, 223 P.3d 123, 125-26 (Colo. App. 2009). In doing so, we must read and consider the statute as a whole and interpret it in a manner giving consistent, harmonious, and sensible effect to all of its parts. *Lujan v. Life Care Centers*, 222 P.3d 970, 973 (Colo. App. 2009). We should not interpret the statute so as to render any part of it either meaningless or absurd. *Id.* Additionally, nonexistent provisions should not be read into the workers' compensation act. *Kraus v. Artcraft Sign Co.*, 710 P.2d 480, 482 (Colo. 1985).

Initially, we reject the respondents' contention that the claimant's argument for concurrent workers' compensation benefits under both Mississippi and Colorado law is raised for the first time on appeal and, therefore, we must summarily disregard it. In her application for benefits, the claimant listed Mississippi workers' compensation death benefits as an issue to be heard. Further, in her summary judgment motion, the claimant raised the issue of entitlement to workers' compensation benefits under §8-42-114,

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C.R.S., which addresses death benefits payable under the workers' compensation act of another state.

Additionally, the respondents have provided documents in support of their brief in opposition that were not presented to the ALJ for her consideration. As the respondents correctly note in their brief, we may not consider such documents on appeal. *See City of Boulder v. Dinsmore*, 902 P.2d 925 (Colo. App. 1995) (Panel's review restricted to evidence before ALJ).

Here, under either Mississippi law or Colorado law, the claimant is not entitled to recover the aggregate amount of workers' compensation benefits under the laws of both states. Rather, Mississippi law allows for a complete offset of workers' compensation benefits paid when a claimant recovers workers' compensation benefits under another state's laws. Further, the plain language of §8-42-114, C.R.S. provides that if a claimant is entitled to recover death benefits under Colorado's workers' compensation system, Colorado law provides that the aggregate of death benefits payable in Colorado shall be reduced, but not below zero, by an amount equal to fifty percent of the periodic benefits awarded under Social Security and under another state's workers' compensation act. Colorado law does not allow for the claimant to collect the full aggregate amount of workers' compensation benefits from two applicable states. As such, we disagree with the claimant's argument that she is entitled to recover of \$116,783.84, or the full aggregate of death benefits under both Mississippi's and Colorado's workers' compensation laws. Section 8-42-114, C.R.S.

B.

The claimant further argues that the Social Security offset taken by the ALJ is in error because it is based on an imprecise mathematical formula. The claimant reasons the Social Security offset calculation should be divided by 52.14 weeks rather than by 52 weeks. The claimant argues that using 52 weeks is both inaccurate and amounts to a deprivation of benefits. We are not persuaded to disturb the ALJ's order on this ground.

Both the General Assembly and the Division of Workers' Compensation consistently have used 52 weeks, rather than 52.14 weeks, when computing wages and offsets. Section 8-42-102(2)(a), C.R.S. provides that in computing average weekly wage at the time of injury, 52 weeks is used:

(2) Average weekly wages for the purpose of computing benefits provided in articles 40 to 47 of this title, except as provided in this section, shall be calculated upon the monthly, weekly, daily, hourly, or other remuneration which the injured or deceased employee was receiving at the time of the injury, and in the following manner. . . :

(a) Where the employee is being paid by the month for services under a contract of hire, *the weekly wage shall be determined by multiplying the monthly wage or salary at the time of the accident by twelve and dividing by fifty-two.* (emphasis added)

Similarly, in instructing insurance adjusters on how to calculate statutory offsets, the Division of Workers' Compensation (Division) also has used 52 weeks rather than 52.14 weeks. The Division has published the Adjuster's guide which instructs on using the following formula when calculating Social Security offset:

Initial monthly (SSDI award x 12) ÷ 52 x 50% = Amount of offset per week

Weekly TTD, PPD, or PTD Benefit – Amount of offset = Weekly benefit rate

Thus, we conclude that the ALJ properly calculated the Social Security offset using 52 weeks as opposed to 52.14 weeks. Consequently, we will not disturb the ALJ's order on this ground.

C.

Last, the claimant argues that the ALJ erred in determining she is entitled to recover interest for the loss of use of only \$16,860.16, which is the difference between the death benefits due and owing under Colorado law and the death benefits paid under Mississippi law. The claimant asserts she is instead entitled to recover 8% interest on the full amount of \$66,822.00, or the total sum she was due from October 28, 2010, through August 28, 2013, under Colorado's workers' compensation Act. Conversely, the respondent argues the ALJ correctly determined that the claimant is entitled to recover only 8% interest on \$16,860.16. We conclude that the ALJ's order regarding the amount of interest due and owing is in error. As such, we necessarily remand the matter for new findings and a new order with regard to the amount of interest due and owing to the claimant.

Section 8-43-410(2), C.R.S. provides as follows regarding interest on an award of workers' compensation benefits:

Every employer or insurance carrier of an employer shall pay interest at the rate of eight percent per annum upon all sums not paid upon the date fixed by the award of the director or administrative law judge for the payment thereof or the date the employer or insurance carrier became aware of an injury, whichever date is later. Upon application and satisfactory showing to the director or administrative law judge of the valid reasons therefor, said director or administrative law judge, upon such terms or conditions as the director or administrative law judge may determine, may relieve such

employer or insurer from the payment of interest after the date of the order therefor; and proof that payment of the amount fixed has been offered or tendered to the person designated by the award shall be such sufficient valid reason.

Interest is a statutory right and applies automatically on the date payment is due. *Beatrice Foods Co., Inc. v. Padilla*, 747 P.2d 685 (Colo. App. 1987). The date payment is due is the date on which the claimant becomes entitled to the benefits, and not necessarily the date of the ALJ's order. *Subsequent Injury Fund v. Industrial Claim Appeals Office*, 899 P.2d 220 (Colo. App. 1994).

Here, the ALJ found that the claimant timely received \$49,961.84 in Mississippi workers' compensation death benefits for the period of October 28, 2010, through August 28, 2013. Further, the ALJ found that the death benefits that were due and owing under Colorado Workers' Compensation Act for the time period of October 28, 2010, through August 28, 2013, totaled \$66,822.00 for 148 weeks. This amount was calculated using the 50% offset for receipt of Mississippi workers' compensation benefits, and the 50% offset for Social Security as follows:

Deceased's Colorado weekly compensation rate:	\$810.67
50% of Mississippi's workers' compensation benefit:	<u>-\$168.79</u>
	\$641.88
50% of Social Security offset:	<u>-\$190.38</u>
	\$451.50 x 148 weeks
Total Colorado death benefits:	=\$66,822

ALJ Friend found, however, that Colorado had jurisdiction over this matter. Consequently, the Mississippi workers' compensation death benefits that the respondents timely paid for the period of October 28, 2010, through August 28, 2013, actually were subsumed by or converted to Colorado workers' compensation benefits. It was as if, therefore, the Mississippi workers' compensation death benefits never were paid and it was not necessary to pay them due to the 100% offset of benefits paid through the Colorado claim. As such, the respondents are precluded from taking the 50% offset for receipt of another state's workers' compensation benefits under §8-42-114, C.R.S. Thus, the 8% interest in §8-43-410(2), C.R.S. should be applied to the amount of Colorado death benefits that were due and owing to the claimant and not paid by the respondents. Using the ALJ's findings, this amount totals \$41,841.08, and is calculated as follows:

Colorado death benefits: \$620.29 per week x 148 weeks =	\$91,802.92
Mississippi benefits paid:	<u>-\$49,961.84</u>

Total Colorado benefits on which to pay 8% interest: =\$41,841.08

As mentioned above, the ALJ found that the respondents were instead required to pay 8% interest on \$16,860.16, or the difference between the amount of workers' compensation death benefits due and owing under Colorado's workers' compensation law (\$66,822.00) and that amount of workers' compensation death benefits paid under Mississippi law (\$49,961.84). This is in error. Instead, under §8-43-410(2), C.R.S., the claimant is entitled to recover 8% interest on \$41,841.08. Consequently, we necessarily remand the matter for the ALJ to calculate the correct amount of interest due and owing to the claimant on the full amount of \$41,841.08. The Division has published a Benefits Calculator Program and interest calculator to assist parties in accurately calculating the interest due and owing at <http://www.coworkforce.com/benefits/>.

IT IS THEREFORE ORDERED that portion of the ALJ's order dated November 13, 2013, and regarding the amount of interest due and owing to the claimant, is set aside and remanded for further findings and a new order on this issue;

IT IS FURTHER ORDERED that in all other respects, the ALJ's order is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

MISTY KEEL

W. C. No. 4-897-030-02

Page 9

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

_____ 4/1/2014 _____ by _____ KG _____ .

MISTY KEEL, Attn: DEPENDENT OF JOHN ERIC KEEL, 143A PRE EDDY ROAD,
LUCEDALE, MS, 39452 (Claimant)

TRANSPORTATION TECHNOLOGY SERVICES, 175 WESTWOOD STE 100,
SOUTHLAKE, TX, 76092 (Employer)

ACE AMERICAN INSURANCE COMPANY, Attn: ESIS HOUSTON WC CLAIMS OFFICE,
C/O: CARRIER NO 494C186588-6, PO BOX 31108, TAMPA, FL, 33631 (Insurer)

KILLIAN, DAVIS, RICHTER & MAYLE P.C., Attn: ERIN C. BURKE ESQ, C/O: J. KEITH
KILIAN ESQ, PO BOX 4859, GRAND JUNCTION, CO, 81502 (For Claimant)

THOMAS POLLART & MILLER, LLC., Attn: ERIC POLLART, ESQ., C/O: FORREST V.
PLESKO, ESQ., 5600 QUEBEC ST, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-915-708-01

IN THE MATTER OF THE CLAIM OF

GLORIA LESSO,

Claimant,

v.

FINAL ORDER

MCDONALDS,

Employer,

and

GALLAGHER BASSETT,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Stuber (ALJ) dated December 5, 2013, that affirmed the claimant's choice of Dr. Hall to be her authorized treating physician. We reverse the order of the ALJ.

A hearing was convened in the claim on November 19, 2013, before the ALJ in regard to the issues of compensability, medical benefits, temporary benefits and the request by the claimant to have Dr. Timothy Hall authorized as a treating physician. The ALJ found the claim compensable, ordered the payment of several medical bills and ordered payment for periods of temporary partial and temporary total benefits. On appeal, the respondents question only the designation of Dr. Hall as a treating doctor.

The claimant testified she began her shift at the employer's fast food restaurant on March 19, 2013, when the soft drink conveyor went on the blink. This required the claimant to repeatedly bend over to retrieve cups and to verify the extent the soft drink dispenser was successfully filling the cups. After continually bending at work for several hours the claimant's back became increasingly sore until she finally experienced an event of extreme pain in her low back. The claimant informed her supervisor and was allowed to switch to just working at the front counter. Her request to go home was denied. After the completion of her shift, she returned home and then eventually went to the emergency room at Penrose hospital. The emergency room doctor recommended she remain off work for several days. When the claimant returned to work she presented the emergency room report to her manager. The claimant testified she requested a referral for medical treatment from her manager. The employer however, declined to provide her any choice of physician or to provide her any medical referral at all.

The claimant then elected to treat at the Peak Vista Community Health Center. She was seen at Peak Vista on March 22, and was prescribed pain medications of Lidoderm and Zanaflex. The claimant was directed to return to the clinic if her symptoms worsened or did not improve. The claimant did return to Peak Vista on several occasions. Many of the visits were pertinent to other injuries not related to work.

Claimant's counsel advised the ALJ in her closing comments in the hearing that it was her understanding Peak Vista would not treat the claimant if she had a work related injury. As a result, the claimant wished to treat with Dr. Hall. The respondents objected to the authorization of Dr. Hall because the claimant had heretofore not treated with that physician. The medical records submitted from Peak Vista do not contain any statements confirming that the claimant would not be seen for medical care or that the work nature of her injury would prove a barrier to further treatment. At hearing the claimant testified:

Q: What treatment have you received through Peak Vista?

A: I've received back patches, the pain medication. I've even had him try to see if I can get a different kind. I am allergic to Ibuprofen. ... And, he wanted to do therapy, but he will not touch it because of the fact that it was a work related injury. So, he's trying to go around it.

Q: Are you still seeing a doctor at Peak Vista for this?

A: I am.

Q: When was your last appointment?

A: I would say maybe a month ago, because he sent me to a specialist for injections to my back.

Q: And, have you done those injections, as of yet?

A: No.

Q: Are those scheduled?

A: They are. ... You send it to, I guess, a pager. And then, he calls you back. He works out of Penrose Hospital.

Q: Do you recall his name?

A: Not on hand, I have it written down at home. He said it would be between four to six injections in my back, the lower back. But, it would not go directly into the spine. (tr. pg. 30-31).

In his December 5, 2013, conclusions of law the ALJ found the claimant had notified her employer that she claimed a work related injury to her low back on March 19 and again shortly thereafter. The employer however, did not offer the claimant a choice of physician. As a result, the ALJ determined the right to select a physician passed to the claimant pursuant to § 8-43-404(5)(a)(I)(A) C.R.S. The ALJ observed the claimant selected Peak Vista to be the authorized treater. The ALJ then resolved "the Peak Vista

providers ultimately were unwilling to treat claimant's work injury." Accordingly, the ALJ ruled "she was then authorized to select Dr. Timothy Hall as her authorized treating physician." Conclusions of Law, ¶ 3.

We acknowledge that it has long been held in Colorado that the right of selection passes to the claimant if the employer or insurer fails to tender care "at the time of the injury." *Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565 (Colo. App. 1987). Moreover, it is still provided in 8-43-404 (5) (a) (I) (A) that if the services of a physician are not tendered at the time of injury, the employee shall have the right to select a physician or chiropractor. However, in our view even if the employer initially waived the right pursuant to § 8-43-404 (5)(a)(I)(A) in the "first instance" to choose the treating physicians by failing to provide a list of two physicians, such waiver does not preclude it from having any right to object to or participate in subsequent changes of physician. *See, Miller v. Rescare*, W.C. No. 4-793-307 (June 18, 2010); *Tournier v. City and County of Denver*, W. C. No. 3-892-574, 3-894-603, 3-921-234 (April 30, 1997).

However, § 8-43-404(5)(a) implicitly contemplates that the respondent will designate a physician who is willing to provide treatment. *See Ruybal v. University Health Sciences Center*, 768 P.2d 1259 (Colo. App. 1988); *Tellez v. Teledyne Waterpik*, W.C. No. 3-990-062, (March 24, 1992), *affd*, *Teledyne Water Pic v. Industrial Claim Appeals Office*, (Colo. App. 92CA0643, December 24, 1992) (not selected for publication). This would also be the case when the right of selection passes to the claimant. Should the physician selected by the claimant decline to treat, the claimant is again without a designated doctor. Therefore, if the physician selected by the claimant refuses to treat the claimant for non-medical reasons, and the respondents fail to appoint a new treating physician, the right of selection passes again to the claimant, and the physician selected by the claimant is authorized. *See Ruybal v. University Health Sciences Center, supra; Teledyne Water Pic v. Industrial Claim Appeals Office, supra; Buhrmann v. University of Colorado Health Sciences Center*, W.C. No. 4-253-689 (November 4, 1996); *Ragan v Dominion Services, Inc.*, W.C. No. 4-127-475, (September 3, 1993).

Whether the authorized treating physician refused to treat the claimant for non-medical reasons, is a question of fact for resolution by the ALJ. *See Lutz v. Industrial Claim Appeals Office*, 24 P.3d 29 (Colo. App. 2000); *Ruybal v. University Health Sciences Center, supra; Medina v. La Jar a Potato Growers*, W.C. No. 4-128-326 (June 1, 1998). Because this question 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. 38-43-304(8), C.R.S. 2009; *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App.

1997). Substantial evidence is probative evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding, without regard to the existence of contradictory testimony or contrary inferences. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). The substantial evidence standard requires that we view evidence in the light most favorable to the prevailing party, and defer to the ALJ's assessment of the sufficiency and probative weight of the evidence. Thus, the scope of our review is "exceedingly narrow." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 2003).

The record in this matter does not constitute substantial evidence to support the finding of the ALJ that Peak Vista has refused to treat the claimant. The statement by claimant's counsel in closing argument does not constitute admissible evidence. The medical records contain no statement or indication that Peak Vista has, or will, refuse to treat the claimant for her low back injury. The only evidence in the record that addresses the issue is the above quoted testimony from the claimant. That testimony however, asserts the claimant is being treated through a referral made specifically by Peak Vista physicians. That referral is described by the claimant as contemplating injections into her low back to treat her symptoms from her work injury. This evidence establishes that Peak Vista is providing the claimant treatment for her work injury. It does not reasonably support a contrary conclusion that treatment is being refused. Accordingly, the ALJ's basis for approving the change of physician to Dr. Hall as an authorized treater (*i.e.* a refusal to treat by Peak Vista) is not supported by substantial evidence in the record. The order of the ALJ, insofar as it authorizes Dr. Hall is reversed. Peak Vista remains as the authorized medical provider in this claim including those treaters in the authorized chain of referrals from Peak Vista.

IT IS THEREFORE ORDERED that the ALJ's order issued December 5, 2013, is reversed to the extent it authorized Dr. Timothy Hall as a treating physician.

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

_____ 4/21/2014 _____ by _____ KG _____ .

GLORIA LESSO, 3303 NORTH HANCOCK ST LOT 13, COLORADO SPRINGS, CO, 80907
(Claimant)

MCDONALDS, 324 E FILLMORE ST, COLORADO SPRINGS, CO, 80907 (Employer)

GALLAGHER BASSETT, C/O: ALIXE LANDRY, PO BOX 4068, ENGLEWOOD, CO, 80155
(Insurer)

MCDIVITT LAW FIRM, C/O: CHARLOTTE ANN VEAUX, ESQ., 19 EAST CIMARRON,
COLORADO SPRINGS, CO, 80903 (For Claimant)

TREECE ALFREY MUSAT PC, C/O: JAMES B FAIRBANKS, 999 18TH ST STE 1600,
DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-906-748-04

IN THE MATTER OF THE CLAIM OF

RODOLFO MORIN,

Claimant,

v.

FINAL ORDER

ACE HARDWARE,

Employer,

and

FIDELITY & GUARANTY INSURANCE
COMPANY,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Stuber (ALJ) dated January 15, 2014, that authorized an ankle screw removal and replacement surgery. We affirm the order.

The respondents contend the ALJ was in error when he deemed their prior payment for a previous surgery in this case to be an admission of liability. They also assert the ALJ incorrectly deemed the doctor that performed the recent surgery to be authorized, retroactively applied a statute which required them to reimburse another health insurance carrier and mistakenly weighed the evidence. The claimant argues the ALJ's order is not final or subject to review for the reason that the ALJ did not order a specific payment of a medical bill.

The claimant sustained a work related injury in this claim on December 13, 2012, when he jumped off his truck to avoid being hit by some unstable wooden pallets. The claimant injured his right ankle. The claimant had an extensive history of prior injuries and treatment to that ankle. In 1997, he had fallen off a 30 foot high water tank and fractured both ankles and a low back vertebrae. The claimant had been in a wheelchair for a year following that fall. In 2010, the claimant came under the care of Dr. William Montross. Dr. Montross diagnosed arthritis in the claimant's right ankle and a nonunion of the claimant's subtalar joint. After initiating treatment with Dr. Montross, the claimant injured his right ankle again on February 16, 2012, when he fell down the stairs at home. The claimant further injured the right ankle on May 24, 2012, when he was involved in an auto accident. Dr. Montross performed a surgery on the right ankle on July 10, 2012.

On that date the doctor removed previous hardware and inserted new screws to generate a fusion in the subtalar joint and to repair torn tendons. The claimant had his ankle casted and was restricted to nonweight bearing activity. In August, 2012, the claimant returned to work as a driver with the respondent employer. This activity caused increased pain and swelling of the ankle. In December, 2012, the claimant reported increased pain and scheduled a return appointment with Dr. Montross. The claimant suffered his work injury on December 13, 2012. The employer referred the claimant to the Concentra Clinic. Concentra made a referral to Dr. Montross due to his existing treatment relationship with the claimant.

Dr. Montross examined the claimant on January 2, 2013. At that exam the doctor observed the claimant's ankle was worse. He obtained an X ray which he read as showing one of the screws previously inserted in the ankle had become loose. He noted the claimant had also torn some tendons. An MRI completed on January 9 showed no union had formed as a result of the July 10, 2012, fusion surgery. Dr. Montross concluded the loose screw was actually holding the surfaces of the bones apart. He recommended surgery to install new hardware. The respondents authorized the surgery. The procedure was performed on February 1, 2013. The surgery featured the removal of the previous hardware and the installation of new screws to achieve a fusion of the subtalar joint. In subsequent examinations, Dr. Montross discerned the newly installed screws had migrated. The doctor surmised the claimant may have been returned to too active a status sooner than was advisable. On May 22, 2013, Dr. Montross recommended removing the screw in the ankle. The request by Dr. Montross to the respondent insurer to preauthorize the surgery was twice denied. On July 1, 2013, Dr. Montross surmised the screw was pushing into the joint. This made removal of the screw more urgent. The Respondents obtained a medical review of the surgery request from Dr. Timothy O'Brien. The conclusion of Dr. O'Brien was that the surgery was necessary but that it was not made necessary by the December 13, 2012, work injury. Dr. O'Brien reasoned the surgery was required due to the claimant's preexisting condition and injuries. Because the claimant felt it necessary to his health to complete the recommended surgery, he endeavored to have it paid for by his private insurance. Dr. Montross referred the claimant to Dr. Simpson to perform the surgery because Dr. Simpson would accept the claimant's personal health insurance for payment. The claimant had a surgical procedure performed by Dr. Simpson on November 26, 2013. No medical records from Dr. Simpson were available for the December 10, 2013, hearing before the ALJ.

The ALJ found the surgery recommended by Dr. Montross, a "right ankle screw removal and replacement surgery," to be reasonable and necessary. The ALJ also disagreed with the conclusion of Dr. O'Brien that the surgery was not related to the December 13, 2012, work incident. The ALJ noted two reasons for this finding. Imaging studies, represented by a January 9, 2013, MRI, revealed the screw in the joint

was holding the bones apart thereby preventing a fusion. Dr. Montross felt this was a consequence of the December 13 work injury. In addition, the ALJ observed that the respondent insurer had admitted liability for the February 1, 2013, fusion revision surgery. It was the unraveling of that surgery that led to the need for the surgery recommendation now being considered. The ALJ also found Dr. Simpson to have been a referral from Dr. Montross and was therefore in the authorized chain of treating physicians. Because there was no surgical note available from Dr. Simpson, the ALJ was unable to make a finding as to the nature of the November 26, 2013, surgery actually completed by Dr. Simpson. As a result, the ALJ did not enter an order specifically pertinent to that surgery. Instead, the ALJ ordered the insurer “liable for the expenses of a right ankle screw removal and replacement surgery.” These expenses were held to include reimbursement to the claimant of any copay he made and reimbursement to the private health insurer pursuant to the medical fee schedule. The ALJ concluded by decreeing: “This decision of the administrative law judge does not grant or deny a benefit or a penalty and may not be subject to a Petition to Review.”

On appeal, the respondents argue the ALJ’s opinion notwithstanding; the order is final and subject to appeal. The respondents contend the evidence shows the need for the surgery is due to preexisting injuries and not the December 13, 2012, work injury. They argue the ALJ is mistaken in finding the respondents authorized the recommended surgery because they had previously paid for the February 1, 2013, revision surgery. Finally, they assert the referral to Dr. Simpson by Dr. Montross was made for a reason not related to the provision of medical care. As a result, they state Dr. Simpson cannot be considered to be an authorized treating physician. While we agree with some of the respondents’ contentions, we ultimately find the ALJ’s order must be affirmed.

I.

The claimant, and by inference the ALJ, point to § 8-43-301(2), C.R.S., as allowing appellate review only when an order “requires a party to pay a penalty or benefits ...” The claimant argues the need to “pay” was not part of the ALJ’s order. We find this construction of the ALJ’s order unavailing. The ALJ ordered the respondents “liable for the expenses of a right ankle screw removal and replacement surgery.” It is not necessary that the ALJ’s order reference a specific medical bill or dollar amount when a medical benefit is ordered. We have held that a “general award of medical benefits are interlocutory,” and may not be reviewed pursuant to § 8-43-301(2), *Harley v. Life Care Centers*, W.C. No. 4-810-998 (May 20, 2011); *Gonzales v. Public Service Co. of Colorado*, W.C. No. 4-131-978 (May 14, 1996). However, that is not the case when the record reveals that specific medical benefits were at issue. In *Country Squire Kennels v. Tarshis*, 899 P.2d 362 (Colo. App. 1995), for example, the court reviewed the ALJ’s

determination that the respondents were liable for the costs of home cleaning without an order specifying the amounts or rates of payment.

In *Cheney v. Coco Cola and Blue Bell Creameries*, W.C. Nos. 4-854-583 and 4-873-873 (July 9, 2012), two orders of an ALJ were reviewed. The first was an order of compensability with only a general award of medical benefits. That order was held not subject to review because it did not actually require a party to pay a penalty or benefits. Because a party may still contest the reasonableness or relationship of any particular medical procedure, notwithstanding an order to provide medical benefits generally, such an order cannot be construed as one which actually requires payment for a medical benefit. The second order considered in *Cheney* was a denial of a request for a “recommended surgery to decompress the ulnar nerve at the elbow.” Because that issue involved a specific medical benefit, it was found subject to review and was resolved on its merits. The medical request ordered here, “the expenses of a right ankle screw removal and replacement surgery,” is equally specific and definite as was the ulnar nerve surgery in *Cheney*. The ALJ’s order then, reaching as it does a specific medical benefit, is final and reviewable despite the absence of a particular dollar amount or medical bill. See, *Burritt v. Kaiser Permanente*, W.C. No. 4-857-558 (February 13, 2014), (decision reviewing “a proposed rib resection”).

II.

The respondents complain the ALJ erroneously found the recommended surgery compensable because he concluded the respondents had admitted liability for the procedure. The ALJ found in ¶ 40 of his findings of fact:

“The insurer admitted liability for the February 1 fusion revision surgery. ... The problems found after the February 1, 2013, surgery are the unfortunate consequences of that surgery, not the earlier July 2012 surgery. The insurer accepted responsibility for the [prior] fusion revision surgery by Dr. Montross, even if the insurer conceivably had a defense against liability for that February 1 surgery.”

Noting that a respondent paid for a prior medical procedure does not allow for a finding that the respondent has admitted that in the future that same treatment is either reasonable treatment or that it is related to the work injury. It would not be necessarily seen as reasonable because the claimant’s condition may have changed in the intervening period, or the treatment may simply not have been successful when it was initially

provided. In addition, the respondents may become advised by subsequent medical documentation that the symptoms being treated were not actually caused by work conditions. That being the case, a finding that the original surgery was so unsuccessful that a subsequent surgery is required to alleviate the side effects of the original surgery, does not render the second surgery compensable. It may still be shown the original surgery itself was indeed not directed at relieving the effects of the work injury. In *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), the respondents had been paying for treatment for the claimant's lung condition for seven months upon the assumption the condition was caused by his work as a firefighter for the employer. The claimant developed complications after undergoing a lung biopsy. The employer however, declined to provide further medical treatment for the lung symptoms based on new medical reports stating the lung condition was not caused by work. At hearing, the claimant argued that the respondents, through their admission of liability and provision of medical treatment for that particular body part, were unable to deny further treatment for his lung symptoms except on the ground of reasonableness. The Court did not agree.

We decline to so limit the ability to dispute a claimant's entitlement to continued medical benefits where, as here, medical information obtained subsequent to an admission of liability brings into question the compensability of the claimant's injury. ... Therefore, in a dispute over medical benefits that arises after the filing of a general admission of liability, an employer generally can assert, based on subsequent medical reports, that the claimant did not establish the threshold requirement of a direct causal relationship between the on-the-job injury and the need for medical treatment. *Snyder*, 942 P.2d at 1338.

As applied in this case, the above finding by the ALJ is in error. The payment by the respondents for the February 1, 2013, ankle revision surgery does not constitute an admission that the ankle symptoms being targeted by that surgery are work related conditions. Where, as here, the respondents submitted newly obtained evidence, as in Dr. O'Brien's report, to question the relatedness of that surgery, and future recommended surgeries, they may do so.

However, the ALJ articulated a second basis for authorizing the proposed ankle revision surgery. The same ¶ 40 finding of fact specifies that after the work injury

“claimant’s condition clearly worsened.” The ALJ referenced “imaging studies confirmed the protrusion of the screw and nonunion of the bone.” The ALJ also noted the opinion of Dr. Montross that the proposed revision surgery was necessary to relieve the effects of the work injury. Where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove a causal relationship between the work injury and the condition for which benefits are sought. *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999). Whether the claimant sustained his burden of proof is a factual question for resolution by the ALJ. *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). Because these questions are 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). We conclude the evidence cited by the ALJ constitutes substantial evidence which supports his finding the proposed ankle revision surgery is made necessary by the claimant’s work injury. Therefore, on that basis we affirm the order of the ALJ that the respondents are liable to provide the surgery as a medical benefit.

III.

The claimant testified Dr. Montross referred the claimant to Dr. Simpson to have the ankle revision surgery performed. He stated he underwent this surgery with Dr. Simpson on November 26, 2013. The ALJ ordered the respondents liable for surgery to remove and replace the ankle hardware and to reimburse the private health insurer that had paid Dr. Simpson for the surgery. The respondents argue Dr. Simpson is an unauthorized provider. Accordingly, if he did perform the surgery, the respondents contend they are not liable for payment to an unauthorized physician. The ALJ determined the referral from Dr. Montross to Dr. Simpson was made because Dr. Simpson would accept claimant’s private health insurance while Dr. Montross would not. The respondents argue a referral made for such a reason does not place Dr. Simpson within the authorized chain of referral. They assert a referral made for personal reasons of the claimant does not constitute a legitimate medical referral.

A referral in the normal progression of authorized treatment allows for the authorized treatment provided by the doctor accepting the referral. *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). When the referral reveals it is based on the independent medical judgment of the referring doctor, it may be construed as an authorized referral. *City of Durango v. Dunagan*, 939 P.2d 496, 500 (Colo. App. 1997). The July 1, 2013, report of Dr. Montross contains the doctor’s notation that the ankle revision surgery is necessary and haste in completing the surgery “is becoming very important and urgent ...” Reflecting that urgency, the claimant testified he inquired of Dr. Montross as to his options when the respondent insurer denied authorization for the surgery. Dr. Montross, he testified, made the referral to Dr. Simpson due to this urgency.

The claimant was not familiar with Dr. Simpson prior to the referral and did not suggest his name to Dr. Montross. The ALJ resolved that the referral reflected “a reasonable medical justification.”

The circumstances in this case support the ALJ’s determination that the referral to Dr. Simpson renders the doctor as authorized. In *Roberts v. Starpak*, W.C. No. 4-268-198 (November 26, 1996), the respondents referred the claimant to Dr. Charbonneau despite denying the compensability of the claim. Acknowledging the denial of medical benefits by the insurer, Dr. Charbonneau informed the claimant she was “certainly free to seek medical care from whomever she sees fit to see as it is coming out of her personal insurance benefits.” The claimant then chose to treat with Dr. Oligmueller. The ALJ and the panel agreed that Dr. Oligmueller had become authorized to treat. “Dr. Oligmueller became authorized either because of Dr. Charbonneau’s general referral, or because Dr. Charbonneau declined to treat the claimant for non medical reasons and advised the claimant to seek treatment elsewhere.” The present case presents a parallel situation. The respondents have denied treatment by refusing to authorize the proposed ankle revision surgery. In order to secure the treatment, Dr. Montross made the referral to Dr. Simpson. The claimant also chose to treat with Dr. Simpson after the referral. When a designated physician refuses to treat for non medical reasons, the respondents must either designate a new physician or else the ability to choose an authorized treating doctor passes to the claimant. *Ruybal v. University of Colorado Health Sciences Center*, 768 P.2d 1259 (Colo. App. 1988). The claimant then, either chose Dr. Simpson as an authorized physician due to the refusal of Dr. Montross to treat for non-medical reasons, or because the referral was generated by the medical need to have the surgery completed in the near future. The result in this case is identical to that adopted in *Roberts*. The ALJ did not commit error in finding Dr. Simpson to be an authorized referral.

IV.

The respondents contend the ALJ is without authority to order them liable for the expenses of the ankle revision surgery which includes “reimbursement in full to claimant and reimbursement to the health insurer according to the Colorado fee schedule.” They assert the ALJ’s authority to require such reimbursement is derived from a recently enacted amendment to the statute. It is argued the revision to § 8-42-101(6) made by Senate Bill 13-285 may not be applied retroactively to this claim. The section added by S.B. 13-285 states:

(6) (a) If an employer receives notice of injury and the employer or, if insured, the employer's insurance carrier, after notice of the injury, fails to furnish reasonable and necessary

medical treatment to the injured worker for a claim that is admitted or found to be compensable, the employer or carrier shall reimburse the claimant, or any insurer or governmental program that pays for related medical treatment, for the costs of reasonable and necessary treatment that was provided. ...

(b) If a claimant has paid for medical treatment that is admitted or found to be compensable and that costs more than the amount specified in the workers' compensation fee schedule, the employer or, if insured, the employer's insurance carrier, shall reimburse the claimant for the full amount paid. ...

The respondents contend the ALJ's order that they reimburse the claimant's private health insurance carrier for the cost of Dr. Simpson's surgery and the claimant for his \$150 insurance copay, is illegitimately based on this change in the statute because the claimant's date of injury predates this amendment.

The General Assembly declared that these changes to the statute were procedural and also explicitly stated, "This act takes effect July 1, 2013, and applies to claims in existence on or after said date." While substantive rights and liabilities of the parties are determined by the law in effect at the time of the claimant's injury, procedural changes become effective during the pendency of a claim. *Specialty Restaurants Corp. v. Nelson*, 231 P.3d 393 (Colo. 2010). Because the 2013 amendments to §8-42-101(6), C.R.S. only changed the identity of the party that may receive the medical payment, but did not impose any additional liability for the payment of medical costs, it is consistent with a procedural change and may be applied retroactively. *Specialty Restaurants Corp v. Nelson, supra*. (procedural statute relates only to remedies or modes of procedure to enforce existing substantive rights or liabilities, and may be applied retroactively without invoking constitutional considerations.) We have previously held that S.B. 13-285 may be applied to a claim pending at the time of its enactment. *Barrera v. ABM Industries*, W.C. No. 4-865-048 (March 28, 2014).

Even if the General Assembly had not provided for the amendment's application to pending cases, the amendment was not necessary to justify the ALJ's order for reimbursement. Subsection (b) of the amendment only codifies W.C. Rule of Procedure 16-11 (G), 7 Code Colo. Reg. 1101-3. That section of the Rules had been extant prior to the date of the injury in this case. Additionally, in *Oxford Chemicals v. Richardson*, 782 P.2d 843 (Colo. App. 1989), the Court approved the reimbursement by the respondent

carrier to another insurance carrier of temporary benefit amounts awarded the claimant but paid by the second carrier. In *Martin v. Hyams*, W.C. No. 4-781-144 (May 11, 2010), we affirmed the ALJ's order that the respondent employer reimburse the private health insurer the amounts the health insurer had paid to treat the claimant's work injury, subject to the fee schedule. The authority then, of an ALJ to order reimbursement to another health insurance carrier had been recognized prior to the date of injury in this claim. We do not find reason to overturn this aspect of the ALJ's order.

Accordingly, we find no reason to set aside the ALJ's order to provide and reimburse payment for the ankle revision surgery.

IT IS THEREFORE ORDERED that the ALJ's order issued January 15, 2014, 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

_____ 5/6/2014 _____ by _____ KG _____ .

RODOLFO MORIN, 6097 PIONEER MESA DRIVE, COLORADO SPRINGS, CO, 80923
(Claimant)

ACE HARDWARE, 5520 ASTROZON, COLORADO SPRINGS, CO, 80916 (Employer)

FIDELITY & GUARANTY INSURANCE COMPANY, Attn: ELLEN SAPP, C/O:

GALLAGHER BASSETT, PO BOX 4068, ENGLEWOOD, CO, 80155 (Insurer)

MCDIVITT LAW FIRM, Attn: TINA R, OESTREICH, ESQ., C/O: ELIZABETH A

MCCLINTOCK, ESQ., 19 E CIMARRON ST, COLORADO SPRINGS, CO, 80903 (For
Claimant)

TREECE ALFREY MUSAT, P.C., C/O: KAREN G. TREECE, ESQ., 999 18TH STREET STE
1600, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-919-557-01

IN THE MATTER OF THE CLAIM OF

ALICE NORMAN,

Claimant,

v.

FINAL ORDER

LAW OFFICES OF FRANK MOYA,

Employer,

and

THE HARTFORD INSURANCE CO
OF MIDWEST,

Insurer,
Respondents.

The respondent insurer seeks review of an order of Administrative Law Judge Allegretti (ALJ) dated December 10, 2013, that ordered the claim compensable and ordered the respondent to pay for the claimant's medical care provided by the Kaiser Permanente clinic. We affirm the order.

The respondent insurer contends the claimant was injured while commuting to work. Because injuries sustained while a claimant is traveling to or from work are not considered to arise out of employment, the respondent argues the ALJ committed error in finding the claim compensable.

The claimant worked for the respondent employer as an attorney. The employer has a contract with the City and County of Denver to provide criminal defense representation to indigent defendants. The claimant was employed to provide those services and to supervise the employer's office regarding public defender services in the municipal courts. Her position required her to travel between the employer's office at 1724 Ogden Street, in Denver, to the court house at 520 West Colfax Street, the jails and various other miscellaneous locations.

On May 20, 2013, the claimant left her home west of Denver to travel to the court house for the purpose of a court appearance at 8:30 a.m. The claimant did not plan to go to her office first, but instead, to travel directly to the court house. The claimant was involved in an auto accident while driving to the court house, on 6th Avenue near C-470. She suffered several injuries in the accident and was transported by ambulance to the

hospital. At that point in the journey, the claimant would have taken the same route to arrive at either the court house or at her office on Ogden Street.

The ALJ determined the claimant's injuries from the auto accident were compensable. Relying upon the Supreme Court's analysis in *Madden v. Mountain West Fabricators*, 977 P. 2d 861 (Colo. 1999), the ALJ found that travel to and from the employer's office to the court house was contemplated by the contract of hire. Because that travel was an integral part of the requirement of the employer to fulfill its contract with the City and County of Denver, the ALJ noted the claimant's travel by car on the morning of May 20 was a special benefit to the employer beyond that of simply having the claimant show up for work. As such, the ALJ resolved the circumstances in this case fell within one of the exceptions to the going and coming rule that normally served to exclude such an injury from qualifying for benefits.

The claimant and the respondent employer agree with the ALJ's analysis.

On appeal, the respondent insurer argues the *Madden* case requires the claim be found not compensable. In *Madden* the court reiterated the longstanding rule that injuries sustained by claimants going to work from home and while returning, are not compensable because they are not seen as arising out of employment. The *Madden* opinion however, acknowledged the facts of any particular case may justify an exception to this general rule. The decision set forth four categories of evidence that may establish a travel injury to be an exception to the going and coming exclusion: (1) whether the travel occurred during working hours, (2) whether the travel occurred on or off the employer's premises, (3) whether the travel was contemplated by the employment contract and (4) whether the obligations or conditions of employment created a "zone of special danger" out of which the injury arose. The respondent points out that in the case of category (1), (2) and (4), the evidence here reveals they do not apply. In regard to category (3), it is argued the claimant was not providing any special benefit to the employer apart from the claimant's arrival at work. It is pointed out the claimant could have traveled to her office first and then gone to the court house. By going directly to the court house the claimant was able to leave home a little bit later. That, it is asserted, is a purely personal benefit to the claimant and not to the employer. Because the accident occurred on the same route the claimant would have taken to arrive at either her office or the court house, the respondent infers that to make the compensability determination turn on the solely subjective intention of the claimant is an arbitrary distinction that should not legitimately be applied.

The *Madden* opinion observed that many of the exceptions to the going and coming rule recognized in previous cases were pertinent to the third exception asking if "the travel was contemplated by the employment contract." The court then listed three

categories of cases generally recognized as exceptions to the going and coming exclusion because travel is contemplated by the employment contract: (a) the particular journey was assigned or directed by the employer, (b) the travel was at the express or implied request of the employer and conferred a benefit beyond the employee's arrival at work, and (c) the travel was singled out for special treatment as an inducement to employment. The common element in these types of cases is that the travel is a substantial part of the service to the employer. Finally, if the claimant establishes only one of the four "variables," recovery depends upon whether the evidence supporting that variable demonstrates a causal connection between the employment and the injury such that the travel to and from the work arises out of and in the course of employment. 977 P.2d at 865

We previously have determined that in situations where the claimant's job requires the claimant to travel, and the claimant is to accomplish the traveling through the use of her personal automobile, then the claimant's arrival at work via automobile confers a benefit upon the employer that constitutes more than just the advantage of the claimant's arrival at work.

In *McDade v. Mile High Child Care*, W.C. 4-417-948 (February 23, 2001), the claimant worked at two schools for the employer and once per week was required to travel to a third location for staff meetings. The claimant was required to provide a vehicle to accomplish travel between the schools and to the staff meeting. The claimant was injured in an auto accident when driving from her home to the staff meeting at the beginning of the work day. The ALJ's denial of benefits was reversed for the reason that travel by car was part of the claimant's work for the employer.

Thus, regardless of whether the employer compensated the travel to and from work as an inducement to employment, the contract of employment required the claimant to transport her personal vehicle to the employer's premises. Further, the employer received a benefit beyond the claimant's mere arrival at work because the employer was not required to maintain its own fleet of vehicles. Finally, the fact that the claimant's workday did not officially begin until she arrived at the worksite does not negate the fact that the employment contract made the claimant's vehicle a mandatory part of the work environment. *McDade* at 3.

This analysis was premised on the Court of Appeals decision in *Whale Communications*

v. Osborn, 759 P.2d 848 (Colo. App. 1988). There the court awarded death benefits in a case where the decedent was killed when driving her personal vehicle from her office to her home. The court held the death was compensable because the employer required the claimant to use the vehicle to meet clients during the workday. The court reasoned “the requirement that employee bring her automobile to work for use in pursuing employer’s business conferred an added benefit on employer beyond the mere fact” of arrival at work, and established “special circumstances” demonstrating a causal connection between the decedent’s work and her death. The court stated the rationale for the decision was that the decedent’s travel became “part of the job since it was a service to the employer to convey to the premises a major piece of equipment devoted to the employer’s purposes.”

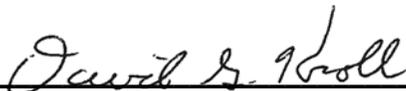
A similar holding was applied in *Lopez v. Labor Ready*, W.C. 4-538-791 (September 26, 2003). The claimant’s job required her to spend large parts of her day making sales calls on potential clients. The claimant used her personal automobile to complete the calls. While traveling to her home to eat lunch the claimant was involved in an automobile accident. We set aside the ALJ’s decision denying benefits. We reasoned a requirement that the claimant use her personal vehicle to further the employer’s business would be a circumstance which could bring the travel between home and the worksite within the scope of the employment because it would “confer a benefit on the employer beyond the claimant’s mere arrival at work.”

The present case presents no material distinction to *McDade* or to *Lopez*. The evidence was not disputed that the claimant was required to travel to perform the day to day duties of her job. She was to travel to the court house, to jails and to various other locations. This travel was, of necessity, accomplished through the use of her personal automobile. The ALJ found in her conclusions of law “the claimant’s travel to the Justice Center was contemplated by the contract of hire with her Employer and was an essential requirement in order to allow the law firm to meet its contractual obligation with the City and County of Denver to provide public defender services.” The claimant’s travel by automobile to the court house on the morning of May 20 was deemed to confer a benefit upon the employer beyond the sole fact of the claimant’s arrival at work. The ALJ concluded the circumstances of the auto accident on that date fell within the exception to the going and coming rule specified in the *Madden* decision. The travel being performed by the claimant when she proceeded to work in her car was travel contemplated by the employment contract. Because the claimant’s transport of her car to work was a benefit to the employer contemplated by the contract of hire, it was of no consequence whether the claimant was en route to the court house as opposed to her Ogden Street office. Accordingly, the ALJ determined the claimant’s auto accident injuries were incurred performing an activity which arose out of and in the course of her employment and benefits were awarded. These findings and conclusions are supported by the record and

by the case law. Section 8-43-301(8), C.R.S. We are compelled to affirm the order of the ALJ.

IT IS THEREFORE ORDERED that the ALJ's order issued December 10, 2013 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

04/23/2014 by SF .

ALICE NORMAN, PO BOX 670, INDIAN HILLS, CO, 80454 (Claimant)
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THE HARTFORD INSURANCE CO OF MIDWEST, C/O: LE ANN NEGRON, PO BOX
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THE LAW OFFICES OF SCOTT TESSMER, 6430 S FIDDLERS GREEN CIR STE 410,
GREENWOOD VILLAGE, CO, 80111 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-905-362-02

IN THE MATTER OF THE CLAIM OF

IMOGENE D. RITTHALER,

Claimant,

v.

REMAND ORDER

DENVER JEWISH DAY SCHOOL
(NON -NSURED), and/or OASIS
OUTSOURCING (PEO), (INSURED
PROFESSIONAL EMPLOYER
ORGANIZATION),

Employer,

and

ZURICH AMERICAN INSURANCE CO.,

Insurer,
Respondents.

The respondents, Oasis Outsourcing and its insurer, Zurich American Insurance (collectively referred to as PEO), seek review of an order of Administrative Law Judge Felter (ALJ) dated November 25, 2013, that granted respondent Denver Jewish Day School's (School) motion for summary judgment determining that the claimant was a covered employee under the PEO's workers' compensation policy. We set aside the ALJ's order and remand for further proceedings.

The ALJ's order reflects the following facts. Oasis Outsourcing is a Professional Employer Organization or PEO. In general a PEO is an entity that contractually assumes various employer rights and human resource responsibilities for its clients. The PEO here entered into a "Service Agreement" with the School as the client. The Service Agreement provided that the PEO hired employees and then leased the employees to the School. The Service Agreement further provided that in addition to paying the employees, the PEO also agreed to secure workers' compensation coverage for the leased employees. The PEO charged a fee for its services to cover such items as processing the payroll and deductions and the premium cost for workers' compensation insurance. The specific amount that the PEO charged under the Service Agreement varied with the number of co-employees.

The specific terms of the Service Agreement at issue include:

Section II Services: This section states that the PEO furnishes the employees to the School identified by the workers' compensation code classifications. The section also states that the School "expressly agrees and understands that no employee shall become employed by the PEO, covered by the PEO workers' compensation insurance or any other benefits or term and condition of employment" until all required paperwork is completed and the employee is "hired as a leased employee." It further provides that all wages are to be paid through the PEO and that the employees will receive no additional wages from the School. The Service Agreement also advises that the School "assumes full responsibility for workers' compensation claims...to any individual for whom payroll information is not supplied during any payroll period... or who is paid in whole or in part by [c]lient, as an employee, independent contractor, or in any other capacity."

Section III: states that the PEO shall "secure workers' compensation coverage in such amounts as is required by applicable law...for its leased employees for services which they perform as leased employees."

Section XII General Provisions: This section requires the School to allow the PEO to audit the School's books to determine the proper workers' compensation classifications of leased employees and to aid in the determination of payroll amounts paid to such leased employees. The section also states that the School is obligated to pay the PEO for any delinquency and/or unpaid premium amount found in the audit.

"Exhibit A" has a yes/no check box as to whether the School "will be covered under [the PEO's] workers' compensation policy." The box is marked "yes."

The claimant in this case was employed by the School as a teacher for 29 years. For the 2009-2010 school year, the claimant was on the PEO's payroll system and considered covered by the PEO workers' compensation insurance. When the claimant retired in 2010, the School notified the PEO and the claimant was taken off of the PEO's payroll system. Without notifying the PEO, the School continued to use the claimant as a substitute teacher on an as-needed basis paying her directly, \$75 per day. The ALJ's order states that the School intentionally did not notify the PEO about the claimant so they could save money on premiums.

On November 30, 2012, the claimant was substitute teaching at the School and tripped and fell while she was walking students to the gym. The claimant fractured her right femur and cracked her right pelvis. The claimant was in the course and scope of her job as a teacher at the time she fell. The School reported the injury to the PEO who denied the claim, contending that there was no insurance coverage for the claimant.

The claimant filed for hearing against the School and the PEO. Prior to hearing the PEO filed a motion for summary judgment arguing that the claimant was not an employee of the PEO and, pursuant to the Service Agreement, was not covered under the PEO's insurance policy. The hearing began on September 12, 2013, but was not completed. The School argued at hearing that the claimant was either an independent contractor or was covered under the PEO's workers' compensation policy. The ALJ bifurcated these two issues for hearing and granted the School an extension of time to respond to the PEO's motion. The ALJ entered an order on September 25, 2013, which retracted the bifurcation and ordered that the hearing be continued. The School filed its response and a cross motion for summary judgment arguing that the limited issue of employer-employee relationship between the claimant and the PEO was not determinative of whether or not the PEO was liable. The School asserted that because the PEO had contracted with the School to provide workers' compensation insurance for its employees, the claimant, as an employee of the School, should be covered by the PEO's insurance.

The ALJ agreed with the School and granted the School's motion for summary judgment to hold that the claimant was a covered employee under the PEO's plan and vacated the continued hearing. As we understand the ALJ's order, he determined that the claimant was a co-employee of the School and the PEO. The ALJ went on to find that the terms of the Service Agreement were ambiguous and that the reasonable expectation of the parties was that the School would not be left to "hang out to dry" as a non-insured employer and that all employees of the School would be covered. The ALJ further held that the PEO was equitably estopped from denying that the claimant was a covered employee because the PEO failed to audit the School and had they done so they would have been able to see that claimant was, in fact, employed by the School and collect past due premiums pursuant to the Service Agreement. The ALJ also summarily determined that the PEO was a statutory employer of the claimant and that the PEO and the School operated as a "joint venture," and, as such, were jointly and severally liable.

On appeal, the PEO contends that the ALJ's order is unsupported by applicable law and substantial evidence. We agree.

B.

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

civil procedure apply insofar as they are not inconsistent with the procedural or statutory provisions of the Act).

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

C.

In our view the ALJ's order is unsupported by applicable law. The ALJ used the Service Agreement between the PEO and the School to create workers' compensation liability. We disagree that a contractual arrangement between two employers can establish liability for workers' compensation if liability does not exist under the Workers' Compensation Act. See *University of Denver v. Industrial Commission*, 138 Colo. 505, 335 P.2d 292 (Colo. 1959)(parties cannot by private contract abrogate statutory requirements or conditions affecting the public policy of the state.) Because there was no contract of hire between the PEO and the claimant, the PEO is not liable for workers' compensation benefits in this situation. Section 8-40-202, C.R.S.

Although the concept of the PEO is not new, there is relatively little guidance in statute or case law for workers' compensation. The Colorado Employment Security Act specifically addresses PEOs as employee leasing companies in §8-70-114, C.R.S. This statute describes the relationship between the employee leasing company and the work-site employer as a "co-employment" relationship. Section 8-70-114 (1) and (2), C.R.S. Although the statute is limited to the unemployment insurance context, the definitions are instructive for the purposes of determining the relationship of the parties here. In addition to being a "co-employment relationship," §8-70-114 (III)(A), provides that, "[c]overed employee' or 'work-site employee' means an individual who is *in an employment relationship with both an employee leasing company and a work-site employer* and has received written notice of the co-employment with the employee leasing company." (emphasis added).

As potential co-employers, the PEO and the School are subject to the same basic tenets as any other employer to establish workers' compensation liability. The fundamental principle in a co-employment relationship is that the claimant is employed by each employer. For purposes of the Colorado Workers' Compensation Act, an employer-employee relationship is established when the parties enter into a "contract of hire." Section 8-40-202(1)(b), C.R.S.; *Younger v. City and County of Denver*, 810 P.2d 647 (Colo. 1991). It is the contract of hire with the respondent employer that triggers coverage under the Act, and the reciprocal benefits and duties of the workers' compensation system flow to each party because of their entry into that contract of hire.

A contract of hire may be express or implied, and it is subject to the same rules as other contracts. *Denver Truck Exchange v. Perryman*, 134 Colo. 586, 307 P.2d 805 (Colo. App. 1957). The essential elements of a contract are competent parties, subject matter, legal consideration, mutuality of agreement, and mutuality of obligation. *Aspen Highlands Skiing Corp. v. Apostolou*, 866 P.2d 1384 (Colo. 1994). A "contract of hire" is created when there is a "meeting of the minds" which creates a mutual obligation between the worker and the employer. *Id.* A contract of hire may be formed even though not every formality attending commercial contracts is found to exist. *Rocky Mountain Dairy Products v. Pease*, 161 Colo. 216, 220, 422 P.2d 630, 632 (1966).

The ALJ found, in effect, that the claimant was an employee of the PEO. However, the ALJ did not find, and the evidence would not support a finding, that a contract of hire, either express or implied, existed between claimant and the PEO at the time of the claimant's injury. In fact, the evidence in the record compels the contrary conclusion. The PEO did not enter into a contract of hire with the claimant. The PEO did not know the claimant was working for the School and did not pay the claimant wages. There was no mutuality of agreement between the claimant and the PEO, nor did the claimant have any expectation of remuneration from the PEO. The elements of a contract of hire could not exist. Because there was no employer-employee relationship between the claimant and PEO, under the statute there can be no workers' compensation liability.

The ALJ's order in this case discusses the School and the PEO as co-employers but actually appears to analyze the relationship using the principles of insurance law to find coverage under an insurance policy. The order treats the PEO as an "insurer" and the School as an "insured" to interpret the Service Agreement as an insurance policy in order to create coverage for the claimant. The PEO, however, is not an insurer and the Service Agreement is not an insurance policy. See §8-44-101, C.R.S.; §8-44-201, C.R.S. Rather, the PEO is an employer and the Service Agreement simply sets forth the arrangement between the PEO and the School to act as potential co-employers.

Consequently, in our view, the ALJ's reliance on the case law construing insurance coverage in this situation is misplaced. To the extent that the School can successfully set forth the argument that they relied on the terms of the contract and were led to believe that all of their employees were covered regardless of their failure to notify the PEO, or that the contractual arrangement was in some way breached by the PEO, the School's remedy is through civil litigation and not in the workers' compensation system.

The ALJ also relied on the panel order, *Gomez v. Hipolito Gonzales d/b/a H&G Framing*, W.C. 4-447-171 and 4-449-330, (February 18, 2004), as support for his conclusion that the claimant was a covered employee under the PEO's workers' compensation insurance. The facts in *Gomez* are distinguishable in that the parties there were clearly in a statutory employer relationship with a general contractor and a sub-contractor and the terms of the agreement between the PEO and the client appear to be significantly different. To the extent that the *Gomez* decision conflicts with our analysis here, it is not binding precedent.

Thus, irrespective of the contractual relationship between the School and the PEO, under these circumstances, the claimant may not be deemed an employee of the PEO within the meaning of §8-40-202, C.R.S., and the ALJ's determination that claimant was an employee of the PEO and covered by its workers' compensation policy must be set aside.

D.

Given our resolution of the issue, it follows that we disagree with the ALJ's alternative bases for determining that the claimant was a covered employee of the PEO.

In any event, we disagree that the terms of the contract were ambiguous and necessarily lead to the interpretation set forth by the ALJ. The interpretation of a contract is usually a matter of law and we may determine its meaning de novo, including whether it is ambiguous. *Fibreglas Fabricators, Inc. v. Kylberg*, 799 P.2d 371 (Colo. 1990). In determining whether a contract provision is ambiguous, the instrument must be construed as a whole and the language must be given a harmonious effect, giving words and phrases their ordinary meanings. *Allstate Insurance Co. v. Avis Rent a Car System, Inc.*, 947 P.2d 341 (Colo. 1997). An ambiguity arises when the contract is "reasonably susceptible to more than one meaning." *Cheyenne Mountain School District v. Thompson*, 861 P.2d 711, 715 (Colo. 1993), quoting *Northern Ins. Co. of New York v. Ekstrom*, 784 P.2d 320, 323 (Colo. 1989). Whether the agreement is ambiguous does not turn on the contractual "parties' own extrinsic expressions of intent." *Dorman v. Petrol Aspen, Inc.*, 914 P.2d 909, 918 (Colo. 1996). Our review of the agreement persuades us

that the Service Agreement is not ambiguous on the issue of workers' compensation coverage.

Reading the plain language of the Service Agreement in a consistent and harmonious manner, the claimant could not have been covered as an employee of the PEO unless she was, in fact, an employee of the PEO, which she was not. We disagree with the ALJ that the PEO workers' compensation liability for an unknown employee of the School could have been created by the check marked box in Exhibit A. When looking at the contract as a whole, we conclude that the one sentence in Exhibit A referring to the PEO providing coverage specifically referred to the employees of the School who were also employees of the PEO. In the "Disclosures" section located immediately above the check marked box, the School discloses that it will transmit its payroll information to the PEO via "web entry." The obvious implication is that the client's coverage under the worker's compensation policy is controlled by the information disclosed by the payroll data. However, the claimant was specifically never included by the School in its payroll disclosures. As a result, the statement in Exhibit A pertinent to worker's compensation coverage can only be read as pertaining to those individuals disclosed by the School as on the payroll and therefore subject to being an employee of the PEO. The claimant is absent from that group after 2010. Because the claimant was not an employee of the PEO under the workers' compensation act or the terms of the contract, the claimant cannot be a covered employee for purposes of receiving workers' compensation benefits.

E.

We also conclude that the ALJ erred in applying principles of estoppel in determining that there was an employment relationship between claimant and the PEO. Equitable estoppel exists where the following criteria are met: "[T]he party to be estopped must know the relevant facts; the party to be estopped must also intend that its conduct be acted on or must so act that the party asserting the estoppel has a right to believe the other party's conduct is so intended; the party asserting the estoppel must be ignorant of the true facts; and the party asserting estoppel must detrimentally rely upon the other party's conduct." See *Johnson v. Industrial Commission*, 761 P.2d 1140 (Colo. 1988).

None of the elements of equitable estoppel were met in this claim. The PEO did not know the relevant facts and did nothing to cause the claimant to believe that she was an employee of the PEO and the claimant knew she was working and being paid directly by the School, she had no reason to believe that she was an employee of the PEO. Therefore, there is no basis for applying the doctrine of equitable estoppel.

The case of *State Compensation Insurance Fund v. Wangerin*, 736 P.2d 1246 (Colo. App. 1986), cited by the ALJ, is not authority to the contrary. Underlying the *Wangerin* case is the principle that an insurer which accepts a premium, after notice of a loss, is estopped to deny coverage which would be warranted by the amount of the premium paid. *Wangerin* is inapposite to the facts of this case as no “premiums” or fees were collected for the claimant here because the PEO did not know about the claimant. We do not read the Service Agreement to create a “duty” to conduct an audit of a client especially in view of the ALJ’s finding that the School intentionally failed to disclose that the claimant was working for them.

F.

Finally, we agree with the PEO that the ALJ erred in considering the issues of statutory employer or joint venture as neither issue was raised by the motions for summary judgment and are unsupported by the evidence.

In *Krol v. CF&I*, 307 P.3d 1116 (Colo. App. 2013) the court of appeals held that a judge may not enter summary judgment on issues not raised by the moving party unless the judge first gives notice of his intent to do so and provides the parties with reasonable notice and opportunity to present evidence. Neither the PEO’s motion nor the School’s motion for summary judgment raise the issue of statutory employer or joint venture and neither respondent set forth any evidence to support these findings. Consequently, the ALJ erred in his consideration of these issues in his order.

G.

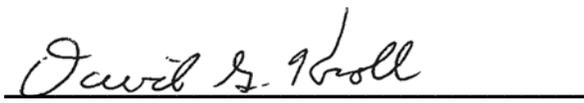
The claimant also filed a brief in opposition to the PEO’s petition to review. The claimant asserts that because the ALJ found that the claimant was an employee of the School and the School did not appeal the ALJ’s summary order, the parties are bound by this finding regardless of the outcome of the PEO’s petition to review. Given the unique posture of this case, we disagree. At hearing the School asserted that the claimant was not an employee of the School, but was an independent contractor. Although the hearing began on September 12, 2013, the parties were not able to present their evidence in support of their positions. Additionally, as we read the School’s motion for summary order, they condition their request for relief by saying “if the claimant is an employee.” The School must be given the opportunity to present their argument that the claimant is an independent contractor should they still want to pursue this issue. *See Whiteside v. Smith*, 67 P.3d 1240, 1248 (Colo. 2003) (fundamental requirement of due process is opportunity to be heard at meaningful time in a meaningful manner); *Gilford v. People*, 2 P.3d 120, 126 (Colo. 2000) (procedural due process notions require that persons whose rights are affected be given notice and opportunity to be heard).

We conclude that the claimant was not an employee of the PEO and therefore, could not have been covered under its workers' compensation policy and the PEO is dismissed from the case. The ALJ's order granting the School's motion for summary judgment is set aside and the matter is remanded for further proceedings to determine whether the claimant was an employee of the School or an independent contractor.

IT IS THEREFORE ORDERED that the ALJ's order dated November 25, 2013, is set aside and the matter is remanded for further proceedings to determine whether the claimant was an employee of the School or an independent contractor.

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


David G. Kroll

IMOGENE RITTHALER

W. C. No. 4-905-362-02

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CERTIFICATE OF MAILING

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

_____ 5/7/2014 _____ by _____ KG _____ .

IMOGENE RITTHALER, 13902 E MARINA DR #602, AURORA, CO, 80014 (Claimant)

DENVER JEWISH DAY SCHOOL (NON INSURED), C/O: AVI HAZEL, 2450 S WABASH ST, AURORA, CO, 80231 (Employer)

ZURICH AMERICAN INSURANCE CO., C/O: SEDGWICK, PO BOX 14493, LEXINGTON, KY, 40512-4493 (Insurer)

EWING & EWING PC, C/O: R CRAIG EWING, ESQ, 3601 S PENNSYLVANIA ST, ENGLEWOOD, CO, 80113 (For Claimant)

DWORKIN CHAMBERS WILLIAMS YORK BENSON & EVANS PC, C/O: DAVID J DWORKIN, ESQ., 3900 E MEXICO AVE #1300, DENVER, CO, 80210 (For Respondents)

OASIS OUTSOURCING (PEO) (INSURED PROFESSIONAL ORGANIZATION), Attn: MARI MCDANIEL, C/O: TRACI MORGAN, 2817 CATTLEMEN RD, SARASOTA, FL, 34232-6231 (Other Party)

MCCREA & BUCK LLC, C/O: JAMES B BUCK, ESQ, 600 GRANT STREET STE 825, DENVER, CO, 80203 (Other Party 2)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-800-423 &
4-795-922-01

IN THE MATTER OF THE CLAIM OF

MARGARITA SOLIS,

Claimant,

v.

FINAL ORDER

SCHWARTZ'S KRAUTBURGER
KITCHEN, INC.,

Employer,

and

TRUCK INSURANCE EXCHANGE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Henk (ALJ) dated August 30, 2013, that found the permanent impairment rating of the DIME physician to be invalid and ordered an award of permanent partial disability benefits based upon ratings provided by treating and reviewing physicians. We affirm the order.

The ALJ considered in her order two separate work injuries sustained by the claimant. On June 6, 2009, the claimant injured her right hand when she caught it in a mixer. On June 15, 2009, the claimant was rear ended while stopped at a red light while making a delivery. The claimant asserted the latter injury affected her low back and cervical spine.

The claimant was referred by the employer for treatment by Dr. John Charbonneau. Dr. Charbonneau treated the claimant with anti-inflammatory and pain medications and physical therapy. Throughout his treatment, Dr. Charbonneau made notations pertinent to complaints of pain and limitations by the claimant which were inconsistent with his examinations, his observation of her unguarded movements and objective medical tests. The doctor concluded the claimant's presentation should be characterized as involving "symptom magnification", "replete with inconsistencies" and including "non-organic features." Dr. Charbonneau ordered an MRI of the claimant's spine, an EMG study of her arm, an evaluation with Dr. Douglas Scott, a psychological evaluation by Dr. Bruns and a surgical evaluation by Dr. Nieves and Dr. Beard. Dr. Nieves read the MRI as showing degenerative disease of the spine and the EMG revealed

some nerve slowing in the right arm. He provided injections to the cervical spine. Noting “inappropriate illness behavior” he placed the claimant at MMI on April 2, 2010. Dr. Charbonneau reviewed his medical records previous to June, 2009. These records documented the claimant’s previous back injuries at work in 2001 and in 2008. She was treating with pain medication just weeks prior to her June, 2009, work injuries. Dr. Charbonneau reviewed surveillance video of the claimant taken in August, 2009, which he felt showed movements inconsistent with the claimant’s reports given to him in his office. The videos suggested no restrictions in the claimant’s ability to move or to function. Dr. Charbonneau determined the claimant was at MMI as of November 23, 2009, and assigned her a permanent impairment rating of 3% of the right upper extremity. The respondents filed a Final Admission of Liability for this rating.

The claimant’s injury was reviewed through a Division Independent Medical Exam (DIME) conducted by Dr. Caroline Gellrick. On March 23, 2010, Dr. Gellrick determined the claimant was not at MMI for her right arm injury. Following that review, Dr. Charbonneau ordered a repeat MRI and sought surgical opinions from Dr. Nieves and Dr. Beard. The MRI showed no evidence of radiculopathy. Dr. Nieves and Dr. Beard reasoned the claimant was not a surgical candidate. Dr. Charbonneau concluded the claimant was still at MMI.

Dr. Gellrick completed a follow up DIME report on August 9, 2011. The claimant informed Dr. Gellrick she had undergone an L 4-5 fusion surgery on her lumbar spine in June, 2011, performed by Dr. Dhupar. This surgery was pursued without request to, authorization of, or payment by the respondents. Dr. Gellrick found the claimant to be at MMI. The doctor calculated a 13% upper extremity impairment rating for her right hand and wrist. After being advised she was to provide an impairment rating for injuries to the claimant’s spine as well, Dr. Gellrick saw the claimant a third time on April 3, 2012. On that date the doctor determined the claimant had accumulated a 10% rating due to her surgically operated spine and a 12% rating for a lack of range of motion. Combined, the claimant was credited with a 21% whole person rating for the lumbar spine. Dr. Gellrick found no rating could be derived from the claimant’s cervical spine condition or from psychiatric impairment.

Prior to Dr. Gellrick’s determination of MMI, a medical review and examination was performed by Dr. Marc Steinmetz at the behest of the respondents. In his report, Dr. Steinmetz reviewed the considerable records of medical treatment the claimant received for her lumbar spine prior to June of 2009. Dr. Steinmetz also noted the inconsistencies in the claimant’s histories given to her various medical providers. The histories were said to be inconsistent with both the medical records and her own statements. The doctor then reviewed the surveillance video tape previously viewed by Dr. Charbonneau. He agreed with the conclusion of Dr. Charbonneau that the video showed normal function by the

claimant insofar as her lumbar or cervical spine was concerned. In his reports and in his deposition testimony, Dr. Steinmetz pointed out flaws in the DIME report of Dr. Gellrick. He reasoned the rating by Dr. Gellrick which included a table 53 diagnosis of an operated back and related range of motion deficits was not correct. Dr. Steinmetz offered the opinion that Dr. Gellrick was misled by the instructions she was given by the parties' legal counsel in the case. She wrote that she participated in a conference with the respective attorneys after her second DIME report. Dr. Gellrick related in her final report of April 3, 2012, that "request was made to consider any ratable impairment on the spine." Dr. Steinmetz observed that, as a result of Dr. Gellrick's interpretation of this instruction, she did not make determinations as to whether there was a contribution by the work injury of June, 15, 2009, to the spine condition she was rating. Dr. Steinmetz pointed to the instruction present in Table 53 of the *AMA Guides* when it references the presence of "pain and rigidity" "with medically documented injury." The doctor noted the June 15, 2009, auto accident occurred at a very low speed and the only damage to the vehicles involved was a broken taillight on the claimant's vehicle. The claimant's description of her reaction to the collision varied in every account given. Because prior documentation of treatment for a lumbar pain condition was extensive and subsequent MRIs did not reveal any acute findings, it was clear her lumbar condition was preexisting. The opinions of Dr. Charbonneau, Dr. Nieves and Dr. Beard found that not only was surgery not related to the MVA, but any surgery to the lumbar spine was also not reasonable or necessary. Dr. Steinmetz deduced then, that the 10% rating from Table 53 was not due to the work injury, and was also premised on a completely gratuitous and unnecessary surgery. Similarly, the 12% rating for the loss of range of motion was derived from deficits caused by the unrelated, unnecessary, surgery. Dr. Steinmetz surmised that no rating could be accurately assigned to the 2009 motor vehicle accident, but he conceded Dr. Charbonneau's 5% rating for the lumbar spine could be arguably supported.

The ALJ ruled that Dr. Steinmetz' opinion was persuasive and constituted clear and convincing evidence that the DIME opinion of Dr. Gellrick was in error and was not prepared in accordance with the *AMA Guides*. Because the lumbar surgery was unrelated to the work injury, it was deemed incorrect to include it in the diagnosis based rating taken from Table 53 of the *Guides*, and to include a rating derived from range of motion measurements affected by that surgery. The respondents had stipulated to accepting the 5% rating allowed by Dr. Steinmetz and Dr. Charbonneau, and the 13% extremity rating from Dr. Gellrick. Accordingly, the ALJ ordered permanent partial disability benefits calculated through the use of those ratings.

On appeal, the claimant contends the respondents failed to provide all the medical records available to the DIME physician, that the respondents did not depose the DIME physician as allowed by the ALJ, that the claimant's lumbar range of motion "has likely

increased since her lumbar surgery”, and the respondents did not cite any authority holding it was improper to reference Table 53 IIE of the *AMA Guides* after the performance of an allegedly unauthorized surgery.

The claimant’s complaint that the respondents did not provide to the DIME doctor medical records, primarily those documenting treatment prior to the date of the work injury, is unavailing. The claimant also had copies of those records. W.C. rule of Procedure 11-3 (I), 7 Code Colo. Reg. 1101-3, provides that in the event the respondents fail to timely submit medical records, the claimant may request cancellation of the DIME appointment or the claimant may submit all medical records she has available. Because the claimant did neither in this case, she has waived the right to complain at this juncture of the absence of additional records. A party is not allowed to wait until the IME review is finished to make an objection based on their dissatisfaction with the results of the review. *Hester v. Eco Express, LLC*, W.C. No. 4-838-236 (March 11, 2014).

The record of the November 9, 2012, hearing reveals the respondents did not request a deposition of Dr. Gellrick, the DIME physician. The claimant requested that deposition. The ALJ did authorize the deposition. However, the claimant cannot assert as a reason to question the ALJ’s order the respondent’s failure to take the deposition when the opportunity to take the deposition was afforded to the claimant, and not the respondents.

The claimant testified the lumbar surgery performed was a spine fusion procedure. She also stated it provided no long term benefit. Dr. Steinmetz pointed out in his deposition that a fusion surgery would serve to increase the stiffness in the claimant’s spine. Therefore, the claimant’s argument that the claimant’s lumbar range of motion “has likely increased since her lumbar surgery” is not based on any evidence in the record. In addition, an ALJ could only speculate as to whether any increased spinal range of motion would likely increase or reduce the impairment rating assigned.

The claimant argues there is no authority in the *AMA Guides* to preclude the use of an impairment rating from Table 53 in the case of an unauthorized surgery to the claimant’s back. The respondent’s position, and that of Dr. Steinmetz, was to say the surgery involved was not necessary, and that it was not required by the work injury. It was not critical that the surgery was ‘unauthorized’. The *American Medical Association Guidelines to the Evaluation of Permanent Impairment, Third Edition, Revised* (*AMA Guides*) direct that causation and aggravation must be determined for purposes of devising an impairment rating pertinent to its use in benefit systems. (Appendix A, pg. 244). The impairment determination is to evaluate changes that have occurred over a period of time because of injury or disease. (Section 1.2, pg. 3). Dr. Steinmetz noted this instruction is also present in Table 53 of the *Guides* when it references the presence of

“pain and rigidity” “with medically documented injury.” (Section 3.3, pg. 80). The pertinent “injury” is that incurred by the claimant related to work and is the subject of the claim. This is consistent with the statute when it provides for indemnity benefits due to injuries “proximately caused by an injury or disease arising out of and in the course of the employee’s employment.” Section 8-41-301(1)(c), C.R.S. The ALJ was correct in holding that the application of Table 53 must be justified by the effect of a compensable “injury” before an impairment rating may be derived.

Section 8-42-107(8)(b)(III) and (c), C.R.S. provide that the DIME physician’s finding of MMI and permanent medical impairment is binding unless overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from substantial doubt, and the party challenging the DIME physician’s finding must produce evidence showing it is highly probable the DIME physician is incorrect. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). The ALJ’s decision that the DIME physician’s determination of permanent medical impairment was successfully overcome was supported by substantial evidence in the record. We may not substitute our judgment by reweighing the evidence in an attempt to reach inferences different from those the ALJ drew from the evidence. *See Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31, 32-33 (Colo. App. 1990). Given the nature of the record and the medical dispute involved, we cannot say the ALJ committed error in setting aside the DIME’s impairment rating and affirming the stipulation of the respondents that the correct rating was 5% whole person for the lumbar spine and 13% for the right upper extremity.

IT IS THEREFORE ORDERED that the ALJ’s order issued August 30, 2013, 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

3/18/2014 by KG.

SCHWARTZ'S KRAUTBURGER KITCHEN, INC., Attn: DAVE SCHWARTZ, 820 39TH STREET, EVANS, CO, 80620 (Employer)

TRUCK INSURANCE EXCHANGE, Attn: ELIZABETH NEU, C/O: WORKER'S COMPENSATION BCO-DENVER, PO BOX 108843, OKLAHOMA CITY, OK, 73101-8843 (Insurer)

LAW OFFICES OF RICHARD K. BLUNDELL, Attn: RICHARD K BLUNDELL, ESQ, 1233 EIGHTH AVENUE, GREELEY, CO, 80631 (For Claimant)

HUNTER & ASSOCIATES, Attn: JOE ESPINOSA, ESQ., 1801 BROADWAY, STE 1300, DENVER, CO, 80202-3878 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-897-476-01

IN THE MATTER OF THE CLAIM OF

TRINA TAYLOR,

Claimant,

v.

FINAL ORDER

SUMMIT COUNTY,

Employer,

and

SELF INSURED,

Insurer,
Respondents.

The respondent seeks review of an order of Administrative Law Judge Friend (ALJ) dated September 24, 2013, that ordered the claim was not barred by the statute of limitations and ordered the respondents to provide the claimant evaluation and treatment by Dr. George. We affirm.

The respondent appeals the ALJ's order of compensability on the basis that a September 12, 2012, worker's claim for compensation pertinent to an injury occurring January 19, 2010, is barred by the two year statute of limitations provided in § 8-43-103(2), C.R.S.

The claimant injured her right hip when she slipped and fell on ice on January 19, 2010, while working as a bus driver for the respondent. The claimant reported the injury a few days later to the employer's human resources manager. She was referred to Dr. Lawrence George at High Country Healthcare. Dr. George ordered an X-ray of the hip and later, an MRI. The doctor referred the claimant to physical therapy, chiropractic treatments and acupuncture. Dr. George also prescribed ibuprofen. Dr. George maintained the claimant on full duty at work. The claimant last saw Dr. George on June 28, 2010. She treated with the chiropractor through November, 2010. The claimant reported some improvement to Dr. George, but she testified at hearing that she continues to perceive pain in her hip.

The claimant later complained of stiffness in her neck which she believed was due to the need to look above eye level to monitor controls in the bus and because her bus routinely slipped out of gear thereby jostling the claimant's neck and head. On January

11, 2011, the claimant saw Dr. Adele Morano, a partner of Dr. George at High Country Healthcare. The claimant complained to Dr. Morano about her neck and her hip. Dr. Morano recommended a modified duty restriction of “no job requiring neck extension”.

The claimant continued to experience pain in her hip. On September 12, 2012, she filed with the Division of Workers’ Compensation a Worker’s Claim for Compensation form. The respondent completed a Notice of Contest on September 26, 2012. On May 15, 2013, the claimant submitted an application for a hearing endorsing as issues compensability and medical benefits. The respondent added the issue of the statute of limitations. At the August 13, 2013, hearing, the claimant requested an order of compensability and an order that she be able to see Dr. George for additional treatment. The respondents did not deny the claimant suffered an injury to her hip on January 19, 2010, but asserted the claim for benefits was now time barred and that the claimant’s current symptoms were not related to the 2010 fall on the ice.

The ALJ submitted a summary order and then a full findings of fact, conclusions of law and order on September 24, 2013. He concluded the claim was compensable and not precluded by the statute of limitations in § 8-43-103(2). The ALJ found the two year limitations period referenced in that section did not begin to run until the claimant became aware that her injury was such that it would require her to miss more than three days from work in the future, or lead to permanent impairment. He observed that the medical treatment the claimant received in 2010 was not sufficient to put the claimant on notice that her injury was serious enough to justify missing that much time from work, or permanent impairment. The ALJ noted the claimant did not receive any restrictions pertaining to her job until January 11, 2011. Because that date was less than two years prior to the September 12, 2012, date of her claim for compensation, the claim was deemed as timely filed and was not barred.

On appeal, the respondent contends the evidence reveals a reasonable claimant would have been advised within the first six months of her medical treatment that she had suffered a disabling injury. The respondent also argues the ALJ’s finding that January 11, 2011, was the date the claimant was found to have been aware of the seriousness of her injury, and that it would be disabling, is in error because the treatment and restrictions recommended on that date pertained solely to the claimant’s neck injury.

The respondents review the treatment the claimant received prior to June of 2010, and argue the circumstances would have informed a reasonable person of the seriousness of the claimant’s hip injury. The respondents cite the securing of both an X-ray and an MRI and the small amount of relief the claimant states she obtained from the physical therapy, acupuncture and chiropractic treatments.

Section 8-43-103(2), C.R.S., provides that the right to workers' compensation benefits is barred unless a formal claim is filed within two years after the injury. The statute of limitations does not begin to run until the claimant, as a reasonable person, knows or should have known the "nature, seriousness and probable compensable character of his injury." *City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967). For purposes of the statute of limitations, a "compensable" injury is one which is disabling, and entitles the claimant to compensation in the form of disability benefits. *City of Boulder v. Payne, supra; Romero v. Industrial Commission*, 632 P.2d 1052 (Colo. App. 1981). Therefore, to recognize the "probable compensable character" of an injury, the claimant must appreciate a causal relationship between the employment and the condition. The claimant must also know that the injury is disabling and may entitle her to disability benefits. Temporary disability benefits are payable if the injury causes the claimant to miss more than three shifts from work. Section 8-43-103(1)(a), C.R.S.; *City of Englewood v. Industrial Claim Appeals Office*, 954 P.2d 640 (Colo. App. 1998); *Grant v. Industrial Claim Appeals Office*, 740 P.2d 530 (Colo. App. 1987). Entitlement to disability benefits also occurs in the case of a fatality or permanent physical impairment. Sections 8-43-101(1) and 8-43-203(1)(a).

In *City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967), the claimant was injured while working as a fireman for the employer and was treated on the date of his accident. He did not, however, file a claim for benefits until six years later. The Court found the claim was not barred by the statute of limitations. The evidence showed that despite the receipt of medical treatment, the claimant did not receive a diagnosis that linked his inability to work at his job to his work accident until many years after the accident. The court ruled that an 'injury' was distinct from the definition of an 'accident'.

Accident is the cause and Injury is the effect. It does not follow in every instance that the two occur simultaneously. At least, in many instances, the total or ultimate effect is not immediately apparent. The slow, progressive development of the ultimate effect in the instant case was neither apparent to several doctors who treated claimant nor to the claimant. Surely, it was not contemplated by the legislature that a workman have greater medical perception than a physician.

...

Since no benefits flow to a workman merely because he has been the victim of an Accident and since Injuries must be of sufficient magnitude to prevent him from working for

more than [three] days before they are compensable, it follows that the term ‘injury,’ as it is employed in [8-43-103(2)], means Compensable injury. In fact, the statute so states, in slightly different verbiage. It requires notice to be given ‘of an injury, for which compensation and benefits are payable * * * and the furnishing of medical, surgical or hospital treatment by the employer shall not be considered payment of compensation or benefits within the meaning of this section.’ *Id.* at 350-351.

The fact then, that the claimant received physical therapy, acupuncture and chiropractic treatments after the time of her accident in January, 2010, would not necessarily lead to the conclusion she was reasonably to be aware she had a compensable injury which would justify the need to file a claim for compensation. While knowledge of a compensable claim may also be seen as present when the claimant recognizes she will be required by her injury to miss more than three days from work in the future, *Born v. University of Denver*, 4-337-504 (May 9, 2001), *Ficco v. Owens Brothers Concrete*, 4-546-848 (November 20, 2003), the claimant did not receive that type of medical recommendation until she was seen for neck pain in January, 2011. Prior to that date she had always been given a full duty return to work release by her physician.

The determination of when the claimant recognized the probable compensable character of the injury is a question of fact for resolution by the ALJ. Therefore, we must uphold the ALJ’s determination if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. 2000. *Kerstiens v. All American Four Wheel Drive*, W.C. No. 4-865-825 (August 1, 2013). Substantial evidence is probative evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding, without regard to the existence of contradictory testimony or contrary inferences. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). The finding by the ALJ in this claim that the claimant was not aware of the compensable nature of her injury until some point after September of 2010, is supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.

The respondent asserts a disabling injury is not solely one that requires the payment of compensation benefits. The respondent points to *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999), as stating that “medical incapacity” is a form of ‘disability’ and to *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998), as authority that an inability to work only insofar as the ability to perform regular job duties is affected is also a ‘disability’ for purposes of the statute of limitations in § 8-43-103(2).

The respondents misconstrue a statement in *Culver* to arrive at their assertion. The Court did make an observation in that case that:

The “disability concept is a blend of two ingredients, ... The first ingredient is medical incapacity evidenced by a loss of a limb, muscular movement, or other bodily function. The second ingredient is wage-earning incapacity evidenced by an employee's inability to resume his or her prior work. *Culver*, 971 P.2d at 649.

The ‘medical incapacity’ to which the Court refers is the award of permanent partial disability benefits premised upon “permanent medical impairment” as ascertained by use of the *AMA Guides to the Evaluation of Permanent Impairment*. See § 8-42-107(8)(b.5)(II), C.R.S. (Section 8-42-107 is titled “permanent partial disability benefits” and specifies those benefits are comprised of compensation calculated using a medical impairment rating either from a ‘scheduled injury’ listed in subsection (2), or by use of an equation involving the impairment rating, age and wage rate of the claimant as set forth in subsection (8)(d)). The ‘medical incapacity’ then, as used in the *Culver* decision, is indeed a reference to ‘compensation’, not simply to functional restrictions.

The Court of Appeals in *Ortiz v. Charles J. Murphy* was not discussing the statute of limitations in § 8-43-103(2). That decision dealt with a determination of the date of injury, or ‘onset’, of an occupational disease. Unlike the terms of § 8-43-103(2) which turns on a disabling injury, §8-43-303(1) sets forth that the time limit for reopening begins to run from the “date” the accident occurred or the ‘onset,’ which is the equivalent in cases of an occupational disease. Where the claimant’s injury is in the nature of an occupational disease, the rights and liabilities of the parties are governed by the law in effect at the "onset of disability," and the disease is not compensable unless it causes disability. *Henderson v. RSI, Inc.*, 824 P.2d 91 (Colo. App. 1991). However, an occupational disease may cause "disability" which does not entitle the claimant to disability benefits. This is true because the claimant suffers the onset of disability when the occupational disease impairs the claimant’s ability to effectively and properly perform his regular employment. *Ricks v. Industrial Claim Appeals Office*, 809 P.2d 1118 (Colo. App. 1991). Under such circumstances, the claimant is "disabled" but not necessarily entitled to disability benefits if modified work is provided at the claimant’s pre-injury wage. Accordingly, the "onset of disability" rule does not govern the statute of limitations for filing a workers’ compensation claim. *Ficco v. Owens Brothers Concrete Co.*, W.C. No. 4-546-848 (November 20, 2003), *rev’d in part*, *Ficco v. Industrial Claim Appeals Office*, (Colo. App. No. 2005CA2269, November 24, 2004) (not selected for

publication), and *Ficco v. Owens Brothers Concrete Co.*, W.C. No. 4-546-848 (January 5, 2006). *Contra, Ott v. Pediatric Services*, W.C. No. 4-705-444 (January 14, 2009).

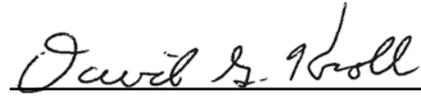
The standard then, that applies is that set forth in *City of Boulder v. Payne, supra*, that the statute of limitations does not begin to run until the claimant, as a reasonable person, knows or should have known the "nature, seriousness and probable compensable character of his injury," with "compensable" meaning entitlement to the payment of compensation benefits.

Finally, the respondents assert the ALJ was in error in making a finding that the claimant was not adequately put on notice as to the compensable nature of her claim until January 11, 2011. The respondents point out that on that date the claimant saw Dr. Morano with complaints pertaining to a neck injury, and the work restrictions provided were explicitly directed at the neck condition. Regardless of the merits of this contention, it is not critical to the finding of the claimant's knowledge she may have a disabling injury as compared to the date she filed her claim for compensation. The ALJ did not find the claimant should have been aware she sustained a disabling injury prior to September 12, 2010. That would be two years prior to the filing of her claim for compensation. The ALJ's finding was that "the fact that claimant received several medical and chiropractic treatments after the time of her accident in 2010 would not necessarily lead to the conclusion she was reasonably to be aware she had a compensable injury which would justify the need to file a claim for compensation." (Conclusions of law, ¶ 7). This was the treatment the claimant received prior to September 12, 2010. Accordingly, the ALJ's finding that the claim for benefits was timely filed is supported by his findings of fact and conclusions of law. The reference to work restrictions imposed in January, 2011, would be of no consequence to the statute of limitations issue. As noted above, we find the ALJ's conclusion the claimant was not aware she suffered a disabling injury within two years of the date of her claim for compensation is supported by substantial evidence in the record. It may eventually turn out that the claimant's hip injury never entitles her to compensation benefits. That eventuality however, does not affect her ability to file her claim for benefits in 2012.

Based upon the ALJ's findings, supported by the record, we agree the claimant's claim for benefits was timely filed and the ALJ's award of medical benefits need not be set aside.

IT IS THEREFORE ORDERED that the ALJ's order issued September 24, 2013, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Handwritten signature of David G. Kroll in cursive script.

David G. Kroll

Handwritten signature of Kris Sanko in cursive script.

Kris Sanko

CERTIFICATE OF MAILING

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

_____ 3/18/2014 _____ by _____ KG _____ .

TRINA TAYLOR, PO BOX 2333, BRECKENRIDGE, CO, 80424 (Claimant)
SUMMIT COUNTY, Attn: DONNA CORBETT, PO BOX 68, BRECKENRIDGE, CO, 80424
(Employer)
SELF INSURED, Attn: DEBBIE MCDERMOTT, C/O: CTSI, INC., 800 GRANT ST #400,
DENVER, CO, 80203 (Insurer)
THE BREWER LAW OFFICES, P.C., C/O: AMY L. BREWER, ESQ., PO BOX 2309,
BRECKENRIDGE, CO, 80424 (For Claimant)
DWORKIN, CHAMBERS, WILLIAMS,, Attn: DAVID J. DWORKIN, ESQ., C/O: YORK,
BENSON & EVANS, P.C., 3900 EAST MEXICO AVE, STE 1300, DENVER, CO, 80210 (For
Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-884-343-03

IN THE MATTER OF THE CLAIM OF

LUCRETIA WILCOX,

Claimant,

v.

FINAL ORDER

JHCI HOLDINGS,

Employer,

and

ZURICH AMERICAN INSURANCE
COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Cannici (ALJ) dated July 1, 2013, that denied and dismissed the claimant's claim for workers' compensation benefits. We affirm the ALJ's order.

A hearing was held on the issues of compensability, medical benefits and whether benefits should be reduced by 50 percent for willfully misleading the employer. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant was employed as an on-site truck driver for the employer. On February 17, 2012, at approximately 2:45 a.m., the claimant allegedly sustained an injury to her right shoulder while closing the door of a trailer at work. The claimant reported the incident to her supervisor, Mr. Rivers. The claimant did not request medical care but sought to go home. At about 5:15 a.m. on this date, the claimant visited the Lutheran Emergency Room because of severe right shoulder pain. The claimant reported that she was lifting a 100 gallon fish tank and experienced a burning sensation down her right arm. The doctor suspected a right rotator-cuff tear and referred the claimant to her personal physician, Dr. Maybach. The claimant visited Dr. Maybach later that day and again reported that she had injured her right shoulder after moving a heavy fish tank four days earlier.

The claimant had a prior workers' compensation injury to her right shoulder with a different employer in 2008. The claimant was placed at maximum medical improvement

(MMI) for this injury with permanent work restrictions of no lifting in excess of 15 pounds, occasional reaching away from the body and occasional overhead reaching with the right arm. The claimant settled this claim on a full and final basis. Rivers, and co-worker Jim Horton, testified at hearing that the claimant had difficulties performing her job with the respondent employer because her right shoulder would pop in and out from the old injury and prior surgery.

On February 21, 2012, the claimant visited Dr. Erickson for an evaluation. Dr. Erickson treated the claimant for the 2008 workers' compensation injury. Dr. Erickson stated that the claimant's "case was closed, but she was still having significant difficulties." Referring to the 2008 injury, Dr. Erickson further stated that, "I believe that her current problems are a continuation of her work injury." Dr. Erickson continued that, "as the patient never reached a point where her shoulder was functioning anywhere close to normal and still painful, I believe that she was placed at MMI without justification and that her condition, even while she attempted to continue working, has progressed. I believe her current condition is definitely related to her prior work injury." On February 22, 2012, the claimant prepared a statement for the respondent employer reiterating that her right shoulder condition was an old injury and that she was recently advised that she required shoulder replacement surgery and that this was not the responsibility of the respondent employer.

On May 4, 2012, Dr. Erickson authored a letter in which he stated that he had changed his opinion and that the claimant actually sustained all of the damage to her shoulder while performing work activities for the respondent employer. Dr. Erickson later stated on August 14, 2012, that there had been a significant error with the claimant's clinical history because the claimant's friend had erroneously completed registration sheets. In Dr. Erickson's opinion, the February 17, 2012, incident actually "caused a severe aggravation, requiring joint replacement."

The claimant testified at hearing that she initially told medical providers that she injured her right shoulder while lifting a fish tank because she did not want to be treated by workers' compensation. The claimant also stated that she told Dr. Erickson about trailer door incident but that Dr. Erickson initially attributed her condition to the prior work injury because the claimant's roommate's daughter incorrectly completed her registration paperwork.

Dr. Shih conducted an independent medical examination of the claimant and noted the numerous discrepancies in the claimant's explanation of her right shoulder symptoms. According to Dr. Shih, the medical records were inconsistent regarding the mechanism of the claimant's right shoulder injury and he was unable to attribute the right shoulder symptoms to the February 17, 2012, incident.

The ALJ found the opinion of Dr. Shih more credible and persuasive than the opinion of Dr. Erickson and the testimony of the claimant. The ALJ, therefore, concluded that the claimant failed to demonstrate that her employment duties on February 17, 2012, aggravated, accelerated or combined with her pre-existing right shoulder condition to produce the need for medical treatment.

On appeal the claimant asserts that the ALJ erred in his determination to deny the claim. The claimant argues that the respondents conceded there was an incident on February 17, 2012, and that the evidence compels a conclusion that the claimant aggravated her pre-existing shoulder condition on this date. We are not persuaded the ALJ erred.

As the claimant correctly points out, a pre-existing condition does not disqualify a claimant from receiving workers' compensation benefits. Rather, where the industrial injury aggravates, accelerates or combines with a preexisting disease or infirmity to produce the need for treatment, the treatment is a compensable consequence of the industrial injury. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). However, where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove a causal relationship between a work-related injury and the condition for which benefits are sought. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (1997).

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. 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 her 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. This standard of review requires us to consider the evidence in the light most favorable to the prevailing party and defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Panera Bread, LLC v. Industrial Claims Appeals Office*, 141 P.3d 970, 972 (Colo. App. 2006). We have no authority to substitute our judgment for that of the ALJ concerning the credibility of witnesses and we may not reweigh the evidence on appeal. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993).

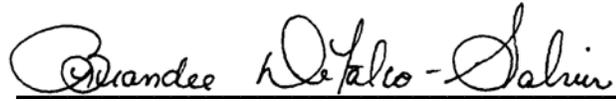
Here, the ALJ determined that the claimant failed to prove she sustained an injury at work on February 17, 2012. The ALJ's order reflects that he considered the claimant's explanations as to how she injured her right shoulder and the discrepancies in her reporting of the alleged injury and that he rejected those explanations. In rejecting the claimant's testimony and Dr. Erickson's opinion, the ALJ's order pointed out the numerous inconsistencies in the claimant's version of events. It was for the ALJ to resolve any inconsistencies and assign such weight and credibility as the ALJ determined was appropriate. *See Monfort, Inc. v. Rangel*, 867 P.2d 122 (Colo. App. 1993). The mere fact the evidence might support a different result affords no basis for relief on appeal. *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001). We may not interfere with the ALJ's decision to credit the testimony of witnesses unless, in extreme circumstances, the testimony is overwhelmingly rebutted by such hard certain evidence the ALJ would err as a matter of law in crediting it. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000). That is not the case here.

The claimant contends that the respondents conceded at hearing that her injury occurred at work. The respondent's attorney, however, stated at hearing, "Respondents concede that she sustained an *incident* at work," with the trailer door. February 19, 2013, Tr. at 17 (*emphasis added*). Contrary to the claimant's assertion, we do not understand the respondents to have conceded that the claimant sustained an *injury* as a result of this incident and that was the issue for ALJ's resolution. *See City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967) (no benefits flow to the victim of an industrial accident unless the accident results in a compensable injury.)

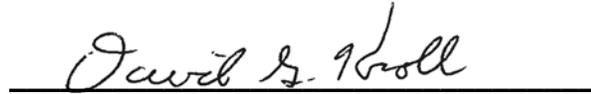
We conclude that the ALJ's dispositive findings are supported by substantial evidence and that the ALJ did not abuse his discretion in making his findings. The ALJ's findings, in turn, support his decision to deny the claimant's claim for benefits and we perceive no basis upon which to disturb the order on review. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated July 1, 2013, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

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Brandee DeFalco-Galvin

Handwritten signature of David G. Kroll in cursive script, written above a horizontal line.

David G. Kroll

CERTIFICATE OF MAILING

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

_____ 1/23/2014 _____ by _____ RP _____ .

LUCRETIA WILCOX, 8511 FRANKLIN STREET, DENVER, CO, 80229 (Claimant)
ZURICH AMERICAN INSURANCE COMPANY, Attn: SHARON CAMARA, C/O:
GALLAGHER BASSETT INSURANCE COMPANY, P O BOX 4068, ENGLEWOOD, CO,
80155 (Insurer)
DARRELL S. ELLIOTT, P.C., Attn: ROBERT F. JAMES, ESQ., 1600 PENNSYLVANIA
STREET, DENVER, CO, 80203 (For Claimant)
THE KITCH LAW FIRM, Attn: MARSHA A. KITCH, ESQ., 3064 WHITMAN DRIVE,
SUITE 200, EVERGREEN, CO, 80439 (For Respondents)

Court of Appeals No. 13CA0928
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-820-266

DATE FILED: May 8, 2014
CASE NUMBER: 2013CA928

City and County of Denver,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado and Russell Andrews,

Respondents.

ORDER AFFIRMED

Division V
Opinion by JUDGE GRAHAM
Bernard and Berger, JJ., concur

Announced May 8, 2014

Scott Martinez, City Attorney, Christian M. Lind, Assistant City Attorney,
Denver, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Law Office of O'Toole & Sbarbaro, P.C., Neil D. O'Toole, Denver, Colorado, for
Respondent Russell Andrews

¶ 1 This case raises a question of statutory interpretation that has not yet been addressed by any division of this court or by the Colorado Supreme Court: What constitutes “employment” for purposes of calculating the five-year time period under the “firefighter cancer presumption statute”? § 8-41-209, C.R.S. 2013.

¶ 2 Petitioner here, the City and County of Denver (also referred to as the Denver Fire Department or Denver), seeks review of a final order of the Industrial Claim Appeals Office (Panel) which affirmed the order of an administrative law judge (ALJ) awarding claimant, Russell Andrews, medical benefits and temporary and permanent disability benefits. The Panel held claimant was entitled to the presumption of compensability created by section 8-41-209. The Panel included claimant’s four years of service as a volunteer firefighter and emergency medical technician (EMT) for the Elbert Fire Protection District and his training at the Rocky Mountain Fire Academy when it calculated the five years of “employment as a firefighter” needed to apply the statutory presumption. Denver contends the Panel improperly calculated claimant’s length of service and argues that the presumption should not have been

applied to claimant's case. We agree with the Panel's interpretation, however, and conclude that the presumption applies to claimant's claim. We therefore affirm the Panel's decision.

I. Background

¶ 3 The facts in this case are not disputed. Claimant is a first grade firefighter for the Denver Fire Department. He was hired by Denver on October 1, 2004. Prior to taking his oath of office as a firefighter for Denver in February 2005, claimant completed a seventeen-week course at the Rocky Mountain Fire Academy as a probationary firefighter for Denver. Claimant also garnered four years' experience as a volunteer firefighter and EMT for the Elbert Fire Protection District before entering the fire academy.

¶ 4 In October 2009, claimant experienced flu-like symptoms, which were attributed to a virus. Although the flu-like symptoms dissipated, claimant continued to feel tired and weak, and, in the following months, lost about twenty pounds. After an episode of acute shoulder and abdominal pain in late January 2010, claimant sought treatment in the emergency room.

¶ 5 On February 12, 2010, claimant was diagnosed with chronic

myelogenous leukemia (CML). He filed a claim for workers' compensation benefits under section 8-41-209 for his cancer treatments, invoking the statute's presumption that certain cancers contracted by firefighters with five or more years of service are compensable occupational diseases. Relying on the testimony of Denver's medical expert, the ALJ found the onset of claimant's CML occurred in November 2009.

¶ 6 At the hearing, Denver argued that claimant did not meet the statute's mandate of five-years of "employment as a firefighter" to trigger the presumption. The ALJ disagreed, however, finding that claimant's four years as a firefighter in Elbert County and his time spent at the fire academy could be included in the length-of-employment calculation, giving claimant more than the required five years' service. The Panel affirmed, and this appeal followed.

II. Analysis

¶ 7 Denver contends that the ALJ and Panel misinterpreted section 8-41-209(1) by including in the length of claimant's "employment as a firefighter" both (a) the entire length of time claimant served as volunteer firefighter and (b) his time training at

the fire academy. It argues that it did not “employ” claimant as a firefighter, within the meaning of section 8-41-209(1), until he took his oath of office as a firefighter in February 2005. Therefore, it maintains, claimant does not meet the statutory requirement for five years of service, and the presumption is inapplicable to his situation. We disagree.

¶ 8 The firefighter cancer presumption statute provides:

(1) Death, disability, or impairment of health of a firefighter of any political subdivision *who has completed five or more years of employment as a firefighter*, caused by cancer of the brain, skin, digestive system, hematological system, or genitourinary system and resulting from his or her employment as a firefighter, shall be considered an occupational disease.

(2) Any condition or impairment of health described in subsection (1) of this section:

(a) Shall be presumed to result from a firefighter’s employment if, at the time of becoming a firefighter or thereafter, the firefighter underwent a physical examination that failed to reveal substantial evidence of such condition or impairment of health that preexisted his or her employment as a firefighter; and

(b) Shall not be deemed to result from the firefighter’s employment if the firefighter’s employer or insurer shows by a preponderance

of the medical evidence that such condition or impairment did not occur on the job.

§ 8-41-209 (emphasis added). The statute does not indicate what service qualifies when calculating the five-year period nor does it state how the service should be calculated. Denver urges us to read “employment” narrowly so as to exclude time not in service and time spent in training, and to permit home rule municipalities to define the term themselves. For the reasons set forth below, we decline to do so.

A. Rules of Statutory Interpretation

¶ 9 The parties have not identified any case law addressing what activities satisfy the requirement that an individual complete five years of “employment as a firefighter” before the statutory presumption applies, and we have found none. See § 8-41-209(1). Consequently, we must turn to the rules of statutory construction and interpretation to determine the legislature’s intended meaning.

¶ 10 As with all statutory construction, when we interpret a provision of the Workers’ Compensation Act (Act), if its language is clear “we interpret the statute according to its plain and ordinary meaning.” *Davison v. Indus. Claim Appeals Office*, 84 P.3d 1023,

1029 (Colo. 2004). In addition, “when examining a statute’s plain language, we give effect to every word and render none superfluous . . . because [w]e do not presume that the legislature used language idly and with no intent that meaning should be given to its language.” *Colo. Water Conservation Bd. v. Upper Gunnison River Water Conservancy Dist.*, 109 P.3d 585, 597 (Colo. 2005) (quoting *Carlson v. Ferris*, 85 P.3d 504, 509 (Colo. 2003) (some internal quotation marks omitted)).

¶ 11 While we are not bound by the Panel’s interpretation or its earlier decisions, *Olivas-Soto v. Indus. Claim Appeals Office*, 143 P.3d 1178, 1180 (Colo. App. 2006), and review statutory construction de novo, *Ray v. Indus. Claim Appeals Office*, 124 P.3d 891, 893 (Colo. App. 2005), *aff’d*, 145 P.3d 661 (Colo. 2006), we give deference to the Panel’s reasonable interpretations of the statute it administers. *Sanco Indus. v. Stefanski*, 147 P.3d 5, 8 (Colo. 2006); *Dillard v. Indus. Claim Appeals Office*, 121 P.3d 301, 304 (Colo. App. 2005), *aff’d*, 134 P.3d 407 (Colo. 2006). In general, “an administrative agency’s interpretation of its own regulations is . . . entitled to great weight and should not be disturbed on review

unless plainly erroneous or inconsistent with such regulations.” *Jiminez v. Indus. Claim Appeals Office*, 51 P.3d 1090, 1093 (Colo. App. 2002). The Panel’s interpretation will therefore be set aside only “if it is inconsistent with the clear language of the statute or with the legislative intent.” *Support, Inc. v. Indus. Claim Appeals Office*, 968 P.2d 174, 175 (Colo. App. 1998).

B. Service as a Volunteer Firefighter

¶ 12 Denver acknowledges that the definition of “employee” set out in the Act expressly includes “all members of volunteer fire departments.” § 8-40-202(1)(a)(I)(A), C.R.S. 2013. But, it points out, the same statutory definition applies “while said persons are actually performing duties as volunteer firefighters or as members of such volunteer rescue teams or groups.” *Id.* Relying on this provision, Denver argues that only those days that claimant actually worked suppressing fires for the Elbert Fire Protection District — not the entire period during which he volunteered his skills and stood ready to serve — should be included in the calculation of his length of employment. However, it cites to no authority in support of its position.

¶ 13 The Panel rejected Denver’s suggested interpretation. It observed that defining volunteer firefighters as “employees” while they are “performing duties . . . is little more than a requirement that any injury an individual sustains must have arisen out of and in the course of the employee’s volunteer employment if it is to be deemed compensable.” In the Panel’s view, then, the definition’s limitation is merely another iteration of the general requirement that a worker be engaged in work-related activity when injured in order for the injury to be compensable. *See* § 8-41-301(1), C.R.S. 2013. In contrast, the Panel noted, the five-year requirement serves a different purpose: to ensure claimants are involved in the firefighting process and thus periodically exposed to the carcinogens found in fires. We find the Panel’s reasoning sensible and consistent with the legislative intent. *See Sanco Indus.*, 147 P.3d at 8; *Jiminez*, 51 P.3d at 1093.

¶ 14 By including volunteer firefighters in the definition of “employee,” the legislature made clear its intent that injuries sustained by volunteer firefighters in the course and scope of their volunteer work be compensable under the Act. Nothing in the

firefighter cancer presumption statute suggests that the legislature intended to put the presumption beyond volunteer firefighters' reach. Given the express intent to include volunteer firefighters in the definition of employees, and the absence of any express exclusion of volunteer firefighters from the scope of the firefighter cancer presumption statute, in our view, the legislative purposes of both of these statutes can only be accomplished if a volunteer firefighter's entire time of service, not just the time of active engagement, is included when calculating length of service under section 8-41-209(1). If the time period of service for volunteer firefighters were calculated in the manner suggested by Denver — which, in this case, was at the rate of 19 days of service over 31 months or 7.6 days of service per year — it would take a volunteer firefighter 240 years to reach 5 years of active service. Thus, volunteer firefighters would be effectively excluded from the benefits of the presumption, an outcome at odds with the legislature's intent to include them in the definition of "employee."

¶ 15 The hypothetical situations Denver advances do not persuade us to reach a contrary conclusion. Although it is true that counting

the time period a volunteer firefighter is available for service, rather than the number of days spent actively engaged in firefighting, may result in the presumption being applied to volunteers who have only fought one or two fires, we believe considering a volunteer firefighter's total volunteer time carries out the legislature's intent. In our view, Denver's position is undermined by the fact that: (1) the legislature relied on years of service, *not* number of fires fought by a firefighter, when establishing a limit on the presumption; and (2) the presumption of compensability for cancer suffered by a volunteer firefighter who had fought few, if any, fires can be rebutted by medical evidence demonstrating the lack of causality between the cancer and the volunteer firefighter's firefighting activities.

¶ 16 Accordingly, we agree with the Panel that length of firefighting service under section 8-41-209 should begin to run from the date on which a volunteer firefighter fights his or her first actual or training fire.

C. Time Spent at the Fire Academy

¶ 17 Denver also contends that it did not employ claimant "as a

firefighter” until he took his oath of office in February 2005. It argues that because probationary firefighters, as it refers to its recruits in its appointment letter, are not full-fledged firefighters, their time at the fire academy should not count toward the presumption’s calculation of “employment as a firefighter.” See § 8-41-209(1). It cites to no Colorado statutory or precedential case law in support of its position, however. Rather, it relies upon a California case, *City of Sacramento v. Workers’ Compensation Appeals Board*, 115 Cal. Rptr. 2d 63 (Cal. Ct. App. 2002). We are not persuaded by this California precedent.

¶ 18 In *City of Sacramento*, the California Court of Appeal held that “fire recruits do not engage in firefighting” and therefore are not entitled to “enhanced benefits” statutorily provided to firefighters because fire recruits are separately classified from firefighters. *Id.* at 66. Unlike the statute at issue here, though, firefighter and fire recruit are each specifically defined in the applicable California and Sacramento codes. Moreover, although the recruit was not entitled to “enhanced” benefits provided to firefighters, he was considered an employee and received standard workers’ compensation benefits

for his injuries. *Id.*

¶ 19 Here, in contrast, the question is not whether claimant was a firefighter or a recruit. The only question presented is whether claimant had “five or more years of employment as a firefighter” for purposes of section 8-41-209(1). The parties do not dispute that claimant was employed by Denver while he trained at the fire academy. Indeed, the record establishes that claimant’s probationary employment period commenced October 1, 2004, when Denver hired him. It appears undisputed that Denver paid him from that date.

¶ 20 Denver has not pointed us to any regulation or code it may have defining “probationary firefighter.” It does not argue that a “probationary firefighter” injured while at the fire academy would not receive benefits. It points to no code or regulation excluding probationary firefighters from the realm of full-fledged firefighters. It claims only that time spent at the academy should not count toward “employment” under section 8-41-209(1).

¶ 21 The Panel expressly rejected this contention. The Panel noted that under Denver’s reasoning, days training to be a volunteer

firefighter counted, but “the several months spent training at the Denver Fire Academy are ignored.” It also observed that probationary firefighters are exposed to numerous, albeit controlled, fires as part of their training. For these reasons, the Panel found Denver’s analysis excluding time at the fire academy “not persuasive.”

¶ 22 We find the Panel’s interpretation to be reasonable and consistent with the legislative intent. Absent a showing that the legislature intended to exclude probationary firefighters, we perceive no basis to set aside the Panel’s conclusion that time spent at the fire academy should be included in determining a firefighter’s length of service. *See Sanco Indus.*, 147 P.3d at 8; *Jiminez*, 51 P.3d at 1093.

D. Home Rule Authority to Define Firefighters’ Employment

¶ 23 Lastly, Denver contends that its status as a home rule municipality gives it the right and authority to define “firefighter” and “probationary firefighter” as it sees fit. It argues that article XX, section 1 of the Colorado Constitution grants it broad powers to set the qualifications for its employees, including firefighters.

¶ 24 While we agree that home rule municipalities are granted broad authority to govern themselves and set the scope of their employees' duties, training, and qualifications, *see Fraternal Order of Police v. City & Cnty. of Denver*, 926 P.2d 582, 592 (Colo. 1996), Denver has not pointed to any definition within its code expressly defining “firefighter,” “probationary firefighter,” “firefighting recruit,” or any other term that it may apply to firefighters-in-training. Its reliance on *City & County of Denver v. State*, 788 P.2d 764 (Colo. 1990), is therefore misplaced.

¶ 25 In that case, Denver sought to uphold a provision in its City Charter requiring city employees to be residents of the city. The Colorado Supreme Court determined that the residency of city employees was a matter of local concern, preempting the state's attempt to prohibit residency requirements. Because residency was a matter of local concern, Denver, as home rule municipality, could “enact charter provisions or ordinances requiring employees to reside within the corporate limits of the municipality as a condition of continuing employment.” *Id.* at 772.

¶ 26 Here, in contrast, Denver has not codified its definition of

firefighter or probationary firefighter. It seeks to advance an interpretation that it favors here, but has not shown that the definition it puts forth is based on any previously stated qualifications. It relies on a scope of “firefighter” that benefits it here, without demonstrating that it applies these definitional differences uniformly, in other contexts, or for other purposes.

¶ 27 Section 8-41-209 makes no distinction between time served as a firefighter for different cities or districts. To the contrary, the statute makes clear that time spent employed as a firefighter “of any political subdivision” is included in calculating length of service. See § 8-41-209(1). Denver’s insistence, then, that it should define whom it considers a firefighter in its employ risks conflicting with another city’s or district’s stated interpretation. Because time spent in different firefighting districts collectively counts as “employment” under the statute, allowing a home rule municipality to impose its own definition of firefighter could result in varying outcomes, by which one city may include recruits as firefighters while another excludes them. To avoid such inconsistency, the scope of “employment as a firefighter” under the firefighter cancer

presumption statute must be considered a matter of state-wide concern which a home rule municipality may not supersede. Moreover, we note that workers' compensation benefits are generally considered a matter of state-wide concern. *See City & Cnty. of Denver v. Thomas*, 176 Colo. 483, 486, 491 P.2d 573, 574 (1971).

III. Conclusion

¶ 28 Accordingly, we hold that the statute's requirement that a claimant demonstrate "five or more years of employment as a firefighter" before the statutory presumption of compensability applies, runs from the time an individual commences service as a volunteer firefighter or commences training at the fire academy. Including this service when calculating claimant's length of employment, results in more than five years of "employment as a firefighter" under section 8-41-209(1). Thus, the Panel correctly held that claimant was entitled to the statutory presumption of compensability for his CML.

¶ 29 The order is affirmed.

JUDGE BERNARD and JUDGE BERGER concur.

13CA1748 Western States Fire v ICAO 03-27-2014

COLORADO COURT OF APPEALS

DATE FILED: March 27, 2014
CASE NUMBER: 2013CA1748

Court of Appeals No. 13CA1748
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-891-495

Western States Fire Protection/API Group, Inc. and Ace American Insurance
Company,

Petitioners,

v.

Industrial Claim Appeals Office of the State of Colorado and Paul Olsen,

Respondents.

ORDER AFFIRMED

Division II
Opinion by JUDGE ASHBY
Casebolt and Richman, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(f)
Announced March 27, 2014

Thomas Pollart & Miller LLC, Brad J. Miller, Greenwood Village, Colorado, for
Petitioners

No Appearance for Respondent Industrial Claim Appeals Office

The Eley Law Firm, P.C., Clifford E. Eley, Denver, Colorado, for Respondent
Paul Olsen

In this workers' compensation action, employer Western Fire

Protection Group, Inc., and its insurer, ACE American Insurance Company (collectively employer), seek review of the final order of the Industrial Claim Appeals Office (Panel), which affirmed the decision of the administrative law judge (ALJ) awarding claimant, Paul Olsen, medical benefits and temporary total disability (TTD) benefits. The ALJ found claimant sustained an occupational disease to his back as a result of sitting in and driving employer's pick-up truck. Because we conclude that substantial evidence in the record supports these factual findings, we affirm.

I. Background

Claimant worked for employer as a NICET Level 3 fire life safety technician from January 12 through June 29, 2012. Employer issued claimant a company truck – a 2004 Chevrolet Colorado with approximately 180,000 miles on it – to drive from his home in Bailey, Colorado, to employer's office in Fort Collins, and to his clients' locations in northern Colorado and southern Wyoming. Claimant testified that he "repeatedly" complained to employer that the truck's driver's seat was uncomfortable and "very well worn," that the truck's "suspension was extremely rough," and that the

more he drove the truck “the more it hurt [his] back.”

Claimant first noticed the back pain about a month after he commenced working for employer and driving the truck. Claimant testified that his back pain generally resolved itself after he got out of the truck and moved around. But, on June 29, 2012, after driving the truck approximately 400 miles and conducting a nearly two-hour conference call from the driver’s seat while the truck was parked on the side of the road, he experienced “extreme” back pain and required his wife’s assistance to get out of the truck. Since that date, claimant has not been able to return to work.

Employer contested claimant’s claim for benefits, arguing that claimant’s condition was preexisting and that the truck seat functioned properly and could not be the cause of claimant’s injury. The ALJ was not persuaded, however, and found that claimant had demonstrated by a preponderance of the evidence that his job duties had caused an occupational disease to his back. The ALJ therefore awarded claimant medical and TTD benefits, which were to continue until “termination thereof is warranted by law.” The Panel determined that substantial evidence supported the ALJ’s

decision and affirmed. This appeal followed.

II. Analysis

Employer contends that there is insufficient evidence to support the ALJ's decision. It argues that the evidence presented can only lead to the conclusion that claimant did not sustain a compensable injury arising out of his employment. It further claims that the evidence overwhelmingly establishes that the truck seat was not defective and therefore could not have caused claimant's occupational disease. We are not persuaded.

A. Governing Law

Under the Workers' Compensation Act, an occupational disease is

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

§ 8-40-201(14), C.R.S. 2013. An occupational disease arises "from

a prolonged exposure occasioned by the nature of the employment.”
Colo. Mental Health Inst. v. Austill, 940 P.2d 1125, 1128 (Colo. App.
1997).

To prove the existence of a work-related occupational disease, a claimant must establish, by a preponderance of the evidence, that the disease “was directly and proximately caused by the claimant’s employment or working conditions.” *Wal-Mart Stores, Inc. v. Indus. Claims Office*, 989 P.2d 251, 252 (Colo. App. 1999); *see also Cowin & Co. v. Medina*, 860 P.2d 535, 537 (Colo. App. 1992) (“[A] claimant must establish the existence of a disease, that it was directly and proximately caused by claimant’s employment or working conditions and resulted from exposure to a hazard presented by those conditions, and the extent of the resulting disability.”).

Whether a claimant has met this burden is a question of fact for determination by the ALJ. *See Subsequent Injury Fund v. Indus. Claim Appeals Office*, 131 P.3d 1224, 1228 (Colo. App. 2006) (whether worker’s death was caused by an occupational disease is a question of fact); *Rockwell Int’l v. Turnbull*, 802 P.2d 1182, 1183-84 (Colo. App. 1990) (affirming ALJ’s decision weighing evidence in

claimant's favor). Like the Panel, we may not disturb the ALJ's determination if it is supported by substantial evidence in the record. *See Wal-Mart Stores, Inc.*, 989 P.2d at 252.

B. Substantial Evidence Supports the ALJ's Decision

Employer argues that the evidence established that the truck's seat was not defective and was not a hazard unique to claimant's employment. It is true that an occupational disease must not arise from "a hazard to which the worker would have been equally exposed outside of the employment." § 8-40-201(14); *see also Anderson v. Brinkhoff*, 859 P.2d 819, 823 (Colo. 1993) (noting the statutory elements of an occupational disease).

Here, the ALJ found that claimant had established the statutory elements of an occupational disease, with a last injurious exposure on the day claimant's back condition became disabling. We conclude that the evidence supports this determination.

There is no evidence in the record that claimant was exposed to any other hazard or condition that aggravated his back.

Employer asserts that claimant "would have been equally exposed" to the driving hazard "outside of his employment," but offers no

evidence indicating where else claimant may have been exposed to an uncomfortable seat or other condition that may have contributed to his back injury. The evidence suggests a temporal connection between claimant's back pain and his use of the truck, as both claimant and one of his coworkers testified that claimant began to complain of back pain caused by the seat within a month after he began driving the truck. Claimant also testified that his back, even with evidence of degenerative disc disease, was asymptomatic until he drove the truck. Indeed, it is undisputed that claimant's severe and debilitating back pain commenced immediately after a particularly lengthy drive in the truck. This evidence supports the ALJ's determination that the seat caused his occupational disease.

Contrary to employer's contention, the lack of definitive evidence establishing that the seat was defective does not preclude compensation. We know of no authority, and employer has not pointed to any, mandating that claimant prove the seat was defective before benefits can accrue. As explained by a physician retained by claimant, Dr. Jeffrey Kleiner, a seat need not malfunction to be the cause of back pain; the seat could be the

source of the problem simply because it did not provide the right support for claimant “and his body habitus.”

Moreover, despite employer’s insistence that the evidence did not establish that the seat was defective, the ALJ concluded, with record support, that the tests conducted on the seat were inadequate and unpersuasive. An occupational therapist who examined the seat at employer’s request only analyzed if the seat’s mechanisms functioned; she did not drive the vehicle, observe how the seat fit claimant, or check its suspension or springs. Claimant was not present for any of the seat testing.

Employer’s own medical expert, Dr. Lawrence Goldman, testified that because claimant was not present for any of the testing of the seat, the tests did not meet his criteria or recommendation for an ergonomic evaluation. And, as Dr. Kleiner explained, because “everyone’s different,” an individual can sustain an injury “from things which wouldn’t hurt other people who are not susceptible.” Thus, Dr. Kleiner concluded, a normal, non-defective seat could cause a worker to sustain an injury like claimant’s. The record thus amply supports the ALJ’s conclusion

that the seat caused claimant's injury.

Nor are we persuaded to reach a different result by employer's suggestion that, henceforth, employers may be liable for an occupational disease to anyone who drives a couple of hours per day. In our view, this outcome is specific to the facts of this case, and the determination that the seat was a hazard to this claimant is supported by the evidence presented to the ALJ. Any future claim for back pain caused by a car's seat would have to be evaluated on the totality of circumstances unique to that case and the credibility of the evidence weighed by an ALJ on its own merits. *See Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995) (appellate court defers to the ALJ's credibility determinations and resolution of conflicts in the evidence, including the medical evidence).

Finally, to the extent employer contends that the evidence does not support the conclusion that claimant sustained an injury, we note that the evidence here, too, amply supports the ALJ's factual determination. In particular, Dr. Kleiner testified and opined that because claimant's back pain became symptomatic after driving the

truck, it was medically probable that the truck's seat caused claimant's back injury. Although Dr. Goldman testified that it was only possible, but not medically probable, that the seat was the culprit, the ALJ was free to weigh the credibility of the physicians' testimony. Doing so, the ALJ exercised his discretion when he concluded that Dr. Goldman's opinion was less credible and persuasive than that of Dr. Kleiner. *See Rockwell Int'l*, 802 P.2d at 1183 (“[T]he weight to be accorded to [expert] testimony is a matter exclusively within the discretion of the [ALJ] as fact-finder.”).

Because the weight and credibility given expert witnesses is within the ALJ's sound discretion, such findings “may not be disturbed absent a showing that the ALJ's credibility determination is ‘overwhelmingly rebutted by hard, certain evidence’ to the contrary.” *Heinicke v. Indus. Claim Appeals Office*, 197 P.3d 220, 224 (Colo. App. 2008) (quoting *Arenas v. Indus. Claim Appeals Office*, 8 P.3d 558, 561 (Colo. App. 2000)). Consequently, we may not disturb the ALJ's finding that Dr. Kleiner's testimony and opinions were more credible and persuasive than Dr. Goldman's.

Because substantial evidence supports the ALJ's factual

findings and conclusions, we cannot set aside the ALJ's decision. See § 8-43-308, C.R.S. 2013; *Wal-Mart Stores, Inc.*, 989 P.2d at 252 (where substantial evidence supported ALJ's determination that claimant's neck problems were work-related, decision would not be disturbed). Accordingly, we conclude that the Panel committed no error when it affirmed the ALJ's order awarding claimant medical and TTD benefits. See § 8-43-301(8), C.R.S. 2013.

The order is affirmed.

JUDGE CASEBOLT and JUDGE RICHMAN concur.

The Supreme Court of the State of Colorado
2 East 14th Avenue • Denver, Colorado 80203

2014 CO 30

Supreme Court Case No. 12SC501
Certiorari to the Colorado Court of Appeals
Court of Appeals Case No. 11CA2331

Petitioner:

Industrial Claim Appeals Office,

v.

Respondents:

Softrock Geological Services, Inc.; and Colorado Division of Employment and Training,
n/k/a Colorado Division of Unemployment Insurance.

Judgment Affirmed

en banc

May 12, 2014

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JUSTICE BOATRIGHT delivered the Opinion of the Court.

¶1 In this appeal, we consider whether an individual is an independent contractor as opposed to an employee for unemployment tax liability purposes. Under the Colorado Employment Security Act (“CESA”), §§ 8-70-101 to 8-82-105, C.R.S. (2013), employers must pay unemployment taxes on wages paid to employees but not on compensation paid to independent contractors. Section 8-70-115(1)(b), C.R.S. (2013), provides that an individual is only classified as an independent contractor if the employer can prove that the individual is “free from control and direction in the performance of the service, . . . and such individual is customarily engaged in an independent trade, occupation, profession, or business related to the service performed.” In this case, there is no dispute that the employer did not exercise control over the individual, so the only issue is what test should be used to determine whether the individual is “customarily engaged in an independent trade, occupation, profession, or business related to the service performed.”

¶2 We agree with the court of appeals that whether an individual is “customarily engaged in an independent trade, occupation, profession, or business related to the service performed” is a question of fact that can only be resolved by analyzing several factors; whether the individual worked for another is not dispositive of whether the individual was engaged in an independent business. Softrock Geological Servs., Inc. v. Indus. Claim Appeals Office, 2012 COA 97, ¶¶ 9, 23–26. We disagree, however, with the court of appeals’ conclusion that whether an individual is engaged in an independent trade or business can be determined by applying a nine-factor test developed based on the list of nine factors that a document must contain to create a

presumption of an independent contractor relationship under section 8-70-115(1)(c). See id. at ¶ 24. Instead, we hold that the determination must be based on a totality of the circumstances test that evaluates the dynamics of the relationship between the putative employee and the employer; while the factors listed in section 8-70-115(1)(c) may be relevant to this determination, the section does not provide an exhaustive list of factors that may be considered. As such, we affirm the judgment of the court of appeals and remand the case to that court to return the case to the Industrial Claim Appeals Office for proceedings consistent with this opinion.

I. Facts and Proceedings Below

¶3 Waterman Ormsby is a geologist who contracted to work on a project basis for Softrock Geological Services, Inc. (“Softrock”), a company that provides geologic services for the oil and gas industry. Relevant to this case, Ormsby worked for Softrock from 2007 through 2010 under various contracts. Softrock did not provide Ormsby with training or tools during this time; rather, Ormsby was expected to, and did, use his own vehicle, tools, and equipment (except for certain specialized equipment that he rented from Softrock) to complete the jobs. Ormsby also had his own business cards, maintained his own liability insurance, and did not represent himself as a Softrock employee.

¶4 Throughout the entire period that Ormsby contracted with Softrock, Softrock classified Ormsby as an independent contractor, not as a Softrock employee. In March 2011, the Division of Employment and Training audited Softrock and issued a notice of liability on the grounds that Softrock should have treated Ormsby as an employee for

the purposes of CESA, meaning that Softrock should have paid unemployment tax premiums on Ormsby's wages.¹

¶5 Softrock appealed the Division's decision to the Industrial Claim Appeals Office ("ICAO"), and a hearing officer reversed the Division's decision. The hearing officer concluded that Ormsby was an independent contractor and not an employee because Softrock did not control Ormsby and Ormsby was engaged in an independent trade or business while he worked for Softrock. The hearing officer reached this conclusion despite the fact that Ormsby had not provided services to another company during the relevant time-period. According to the hearing officer, not providing services for another in the field is not dispositive proof of the nonexistence of an independent trade or business. The hearing officer explained that Ormsby did not work for other companies because he was unaware that other opportunities existed in the area; however, had he known of other opportunities, he would have pursued them.

¶6 A hearing panel at the ICAO subsequently reversed the hearing officer's determination that Ormsby was not a Softrock employee. The ICAO panel concluded that Ormsby was an employee during the period in question because he only provided services to Softrock, and therefore, he did not have an independent trade or business.

¶7 Softrock sought review in the court of appeals and the court appeals vacated the ICAO panel's order. Softrock Geological Servs., ¶ 1. The court of appeals concluded

¹ Under CESA, a business must pay state unemployment taxes on wages paid to employees but not on compensation paid to independent contractors. See § 8-76-102.5, C.R.S. (2013); Colo. Div. of Emp't & Training v. Accord Human Res., Inc., 2012 CO 15, ¶ 13.

that the ICAO panel incorrectly relied on a single factor -- whether Ormsby was providing similar services for anyone else -- to determine that Ormsby was an employee and not an independent contractor. Id. at ¶ 26. Rather, the court of appeals found that the ICAO panel should have determined whether Ormsby was an independent contractor by considering the nine factors in section 8-70-115(1)(c). Id. As a result, the court of appeals remanded the case to the ICAO panel to apply the nine-factor test. Id.

¶8 We granted certiorari to consider what the test is for determining whether an individual is engaged in an independent business.² While we agree with the court of appeals that there is no single-factor test and that the nine factors laid out in section 8-70-115(1)(c) should be considered, we decline to adopt the court of appeals' test because we find that the fact-finder must consider the dynamics of the relationship between the employer and the putative employee and should not be limited to only considering nine factors.

II. Standard of Review

¶9 The employer has the burden of proving that the putative employee is an independent contractor under section 8-70-115. Long View Sys. Corp. USA v. Indus. Claim Appeals Office, 197 P.3d 295, 298 (Colo. App. 2008). Whether the employer has

² Specifically, we granted certiorari to consider the following issue:

Whether the court of appeals erred by openly departing from longstanding court of appeals precedent and holding that a worker's failure to provide similar services to others at the same time he is working for a putative employer does not automatically dispose of a claim that the worker is an independent contractor rather than an employee.

met this burden is a question of fact. Id. We will not disturb the ICAO panel's determination as long as the ICAO panel properly applied the law and the findings of fact support its conclusion. § 8-74-107(6)(c) to (d), C.R.S. (2013); Allen Co. v. Indus. Comm'n, 762 P.2d 677, 680 (Colo. 1988) (holding that the ICAO's decision "should not be disturbed if it is supported by substantial evidence"). However, whether the ICAO panel applied the appropriate test is a question of law that we review de novo. Davison v. Indus. Claim Appeals Office, 84 P.3d 1023, 1029 (Colo. 2004).

III. Analysis

¶10 In this appeal, we address the question of what it means -- for the purpose of being considered an independent contractor under CESA -- for an individual to be customarily engaged in an independent business. To answer this question, we begin by reviewing the overarching statutory framework for determining whether an employer may classify an individual as an independent contractor rather than an employee for CESA unemployment tax liability purposes. We then consider the specific issue raised by this case, namely how the General Assembly intended for the courts and agencies to determine if an individual is customarily engaged in an independent trade or business. We conclude that the General Assembly intended for courts and agencies to make this determination based on an evaluation of the totality of the circumstances relevant to understanding the dynamics of the relationship between the individual and the employer.

¶11 CESA establishes an unemployment insurance fund that is financed by employer-paid premiums. Under CESA, an employer must pay premiums into the

fund based on wages paid to current employees and the amount of claims made by former employees. §§ 8-76-101, -102.5, C.R.S. (2013); Colo. Div. of Emp't & Training v. Accord Human Res., Inc., 2012 CO 15, ¶ 13. Services performed by one person for another “shall be deemed to be employment” for tax liability purposes unless the employer can prove that the putative employee is actually an independent contractor. § 8-70-115(1)(b). Under the statute, the employer can prove that the putative employee is actually an independent contractor by satisfying two conditions. Id.; Long View Sys., 197 P.3d at 298. First, the employer must demonstrate that the individual is free from the employer’s “control and direction.” § 8-70-115(1)(b). Second, the employer must prove that the individual is “customarily engaged in an independent trade, occupation, profession, or business related to the service performed.” Id.

¶12 The first prong of this test is not at issue in this case, as the hearing officer and the ICAO panel both concluded that Ormsby was free from Softrock’s control. As a result, we focus our analysis solely on the meaning of the second prong and consider when an individual is customarily engaged in an independent trade or business. Although the court of appeals has analyzed this section of the statute on several occasions, we have yet to consider it and are not bound by the court of appeals’ decisions. See Grossman v. Sherman, 198 Colo. 359, 361, 599 P.2d 909, 911 (1979).

¶13 Initially, we note that CESA does not explicitly provide a test for determining if an individual is customarily engaged in an independent business.³ Therefore, we are

³ Section 8-70-115(1)(c), the section of CESA that the court of appeals relied on, provides nine factors for determining whether a document establishes a presumption that the

left to develop a test that is consistent with the intent of the General Assembly. Davison, 84 P.3d at 1029. To effectuate the legislative intent, we consider the statutory scheme as a whole and seek to create a test that works harmoniously with the other provisions of the scheme. See Marquez v. People, 2013 CO 58, ¶ 8.

¶14 Section 8-70-102, C.R.S. (2013), explains that the purpose of CESA is to help protect employees from the negative consequences of involuntary unemployment. Thus, we must interpret section 8-70-115 in a manner that is consistent with this statutory goal. In accordance with this requirement, and reading section 8-70-115 as a whole, we find that the statute requires an inquiry into the nature of the relationship between the individual and the employer when determining whether an individual is engaged in an independent trade or business.

¶15 Section 8-70-115(1)(c) explains that to prove that an individual is an independent contractor, the employer can either provide evidence satisfying the two-prong test set out in section 8-70-115(1)(b) or submit a written document signed by both the employer and the putative employee that meets nine conditions. The nine conditions in section 8-70-115(1)(c) establish limits on the relationship between the employer and the putative employee. Specifically, under section 8-70-115(1)(c), the document must establish that the employer will not do any of the following:

- I. Require the individual to work exclusively for the person for whom services are performed; except that the individual may choose to work exclusively for the said person for a finite period of time specified in the document;

putative employee is an independent contractor; the section does not provide a general test for determining whether an individual is an independent contractor.

- II. Establish a quality standard for the individual; except that [the employer] can provide plans and specifications regarding the work but cannot oversee the actual work or instruct the individual as to how the work will be performed;
- III. Pay a salary or hourly rate but rather a fixed or contract rate;
- IV. Terminate the work during the contract period unless the individual violates the terms of the contract or fails to produce a result that meets the specifications of the contract;
- V. Provide more than minimal training for the individual;
- VI. Provide tools or benefits to the individual; except that materials and equipment may be supplied;
- VII. Dictate the time of performance; except that a completion schedule and a range of mutually agreeable work hours may be established;
- VIII. Pay the individual personally but rather makes checks payable to the trade or business name of the individual; and
- IX. Combine [the employer's] business operations in any way with the individual's business, but instead maintains such operations as separate and distinct.

While these criteria are the requirements for a written document and are not a statutory test for determining if a worker is customarily engaged in an independent business, we find them to be indicative of what the General Assembly thought are important distinctions between employees and independent contractors. As such, we conclude that they should be considered when determining whether an individual is engaged in an independent business for the purposes of unemployment insurance tax liability.

¶16 As has been pointed out in other cases, however, we find that other factors may also be relevant. In Long View Systems, the court of appeals suggested that when evaluating a claim that the putative employee maintained an independent trade or business, the Division and the ICAO could consider whether the putative employee: maintained an independent business card, listing, address, or telephone; had a financial

investment such that there was a risk of suffering a loss on the project; used his or her own equipment on the project; set the price for performing the project; employed others to complete the project; and carried liability insurance. 197 P.3d at 300 (citing Dep't of Labor, Licensing, & Regulation v. Fox, 697 A.2d 478, 485–86 (Md. 1997)).

¶17 Given the wide array of factors that could be relevant, we conclude that rather than requiring a rigid check-box type inspection, a more accurate test to determine if an individual is customarily engaged in an independent business involves an inquiry into the nature of the working relationship. The ICAO and the Division may consider the nine factors in section 8-70-115(1)(c) as well as any other information relevant to the nature of the work and the relationship between the employer and the individual. Accordingly, we decline to adopt the court of appeals' test that exclusively considers only the nine factors enumerated in section 8-70-115(1)(c).

¶18 Similarly, we also reject the ICAO's argument that whether the individual actually provided services for someone other than the employer is dispositive proof of an employer-employee relationship.⁴ While this single-factor test certainly protects an employee against the "vagaries of involuntary unemployment," see SZL, Inc. v. Indus. Claim Appeals Office, 254 P.3d 1180, 1183 (Colo. App. 2011), it cannot be what the

⁴ This argument is based on several court of appeals decisions. See, e.g., Carpet Exch. of Denver, Inc. v. Indus. Claim Appeals Office, 859 P.2d 278, 282 (Colo. App. 1993) ("To be customarily engaged in an independent business, a worker must actually and customarily provide similar services to others at the same time he or she works for the putative employer."); Barge v. Indus. Claim Appeals Office, 905 P.2d 25, 27 (Colo. App. 1995) (same); Speedy Messenger & Delivery Serv. v. Indus. Claim Appeals Office, 129 P.3d 1094, 1098 (Colo. App. 2005) (same).

General Assembly intended because it is possible to accomplish this goal without simultaneously subjecting an employer unfairly to the decisions of the putative employee and an unpredictable hindsight review. Indeed, under the single-factor test, the determinative issue is whether the putative employee chose to work for another in the field, regardless of, among other things, the intent of the parties, the number of weekly hours the putative employee actually worked for the employer, or whether the putative employee even sought other work in the field.

IV. Conclusion

¶19 We hold that whether an individual is customarily engaged in an independent business is a question that can only be resolved by applying a totality of the circumstances test that evaluates the dynamics of the relationship between the putative employee and the employer; there is no dispositive single factor or set of factors. Hence, we affirm the judgment of the court of appeals and remand the case to that court to return the case to the ICAO for proceedings consistent with this opinion.