

BROWN BAG SEMINAR

Thursday, November 19, 2015

(third Thursday of each month)

Noon - 1 p.m.

633 17th Street

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

1 CLE (including .4 ethics)

Presented by

Craig Eley

Prehearing Administrative Law Judge
Colorado Division of Workers' Compensation

Sponsored by the Division of Workers' Compensation

Free

This outline covers ICAP and appellate decisions issued through
November 6, 2015

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-903-810-04

IN THE MATTER OF THE CLAIM OF

WILLIAM BENTON,

Claimant,

v.

REMAND ORDER

LOWE ENTERPRISES, INC.,

Employer,

and

FEDERAL INSURANCE COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Margot Jones (ALJ) dated May 7, 2015, that denied the claimant's request that he be allowed to continue treating with Dr. Nystrom after Dr. Nystrom moved from one facility to another, pursuant to § 8-43-404(5)(a)(V) C.R.S. (claimant may continue care when physician moves to new medical facility location). We set aside the ALJ's order and remand the matter for additional findings.

The claimant injured his low back at work for the respondent employer on November 1, 2012. The claimant began treating at the Concentra Clinic in Thornton. He was followed by Dr. Robert Nystrom at that facility. The claimant was treated with physical therapy and other conservative measures. The claimant was referred to Dr. Castro for a single level lumbar fusion surgery which was completed on October 31, 2013. In approximately December, 2013, Dr. Nystrom moved his practice to the Concentra clinic in Greeley, and then to the Concentra clinic in Ft. Collins. When Dr. Nystrom relocated, the claimant was referred to other Concentra doctors in the Denver area for treatment, including Dr. Hattem. Dr. Hattem first saw the claimant on March 14, 2014. He prescribed physical therapy, pool therapy, an epidural injection and pain medications. Dr. Hattem referred the claimant back to Dr. Castro for a recommended surgical follow up visit. On August 18, 2014, Dr. Hattem saw the claimant and remarked that the claimant was nearing maximum medical improvement (MMI).

The claimant filed an application for a hearing on September 24, 2014, in regard to the issue of a change of physician. Dr. Hattem determined the claimant was at MMI on October 6, 2014, and assigned a permanent impairment rating of 22% whole person. The doctor suggested post MMI maintenance treatment consisting of the refill of prescriptions for ibuprofen and a follow up appointment with Dr. Castro. Dr. Hattem testified in his deposition that he was willing to see and treat the claimant in regard to these post MMI recommendations. However, the claimant did not arrange any further appointments with Dr. Hattem. The respondents submitted a Final Admission of Liability and the claimant requested a Division Independent Medical Exam (DIME). The DIME appointment was still pending at the time of the March 17, 2015, hearing.

At the hearing, claimant's counsel argued the claimant was not seeking a change to a physician of his selection pursuant to § 8-43-404(5)(a)(VI). Instead, he asserted the respondents should be ordered by the ALJ to pay for the claimant to treat with Dr. Nystrom in his current location as provided by § 8-43-404(5)(a)(V). That subsection specifies:

(V) If the authorized treating physician moves from one facility to another, or from one corporate medical provider to another, an injured employee may continue care with the authorized treating physician, ...

The respondents contended the claimant was simply requesting a change of physician as referenced in § 8-43-404(5)(a)(VI). They presented evidence to establish that the claimant did not have sufficient grounds to justify such a change.

The ALJ found the claimant was originally treated by Dr. Nystrom who then moved to Greeley in December, 2013. However, the ALJ determined the claimant never requested an appointment with Dr. Nystrom after that date until September 24, 2014, when he filed his application for a hearing. The ALJ concluded the claimant had not made a proper showing to support a change of physician pursuant to § 8-43-404(5)(a)(VI).¹ The ALJ noted the claimant had received a comprehensive course of treatment from Dr. Hattem and Dr. Castro that included diagnostic procedures, injections, prescription medication, surgery and physical therapy. The ALJ did not find adequate

¹ The ALJ inadvertently cites to § 8-43-404(5)(a)(III) as the basis for a request to change physicians. However, that section only applies to requests made within 90 days of the injury. The ALJ's reference to *Hoefner v. Russell Stover Candies*, W.C. No. 4-541-518 (June 3, 2003), indicates she was actually applying § 8-43-404(5)(a)(VI) [formerly designated § 8-43-404(5)(a)].

evidence of any breakdown in the therapeutic relationship with Dr. Hattem and there was no other reason the claimant was unable to recover from his injury under the care of Dr. Hattem.

The claimant appeals the ALJ's decision, contending these findings are inapplicable to his request for treatment with Dr. Nystrom pursuant to § 8-43-404(5)(a)(V) and that he has established the conditions under which that section is applicable. He asserts the ALJ has no further discretion to deny his request.

I.

Initially, the respondents contend the ALJ's order is not reviewable as an order that grants or denies a benefit or a penalty as required by § 8-43-301(2). Unlike an order that grants a request for change of physician without specific medical benefits, the panel has previously held that an order that denies a request for a change of physician to a specific doctor is equivalent to the denial of a specific benefit and, therefore, is final and reviewable. *Vigil v. City Cab Company*, W.C. No. 3-985-493 (May 23, 1995); *Landeros v. CF & I Steel*, W.C. No. 4-395-493 (October 26, 2000); *Pavelco v. Southwest Heating*, W.C. No. 4-897-489 (September 4, 2015).

II.

The claimant argues § 8-43-404(5)(a)(V) allows him to follow Dr. Nystrom to the Ft. Collins Concentra clinic solely upon a showing the doctor has changed facilities by moving his practice to that new location.

Section 8-43-404(5)(a)(V) is part of an extensive amendment to § 8-43-404(5)(a) accomplished in 2008 with the passage of H.B. 07-1176. The amendment sought to provide an injured employee some choice in the selection of his treating physician while, at the same time, maintaining the employer's ability to have some control over that choice. The amendment required the employer to provide the employee a list of designated corporate medical providers or physicians. Originally, the list required two choices but was amended in 2014 to require four. (There are exceptions for smaller communities featuring fewer doctors). While the list may contain a combination of corporate medical providers and physicians, at least one must be at a distinct address and feature separate ownership. From this list, the injured employee "may select the physician who attends the injured employee." A corporate medical provider includes a medical organization in business as a sole proprietorship, professional corporation or partnership. § 8-43-404(5)(a)(I)(A).

The 2008 amendment also allowed the employee to change his authorized treating physician selected from the employer's list to another physician from the list, on one occasion, to occur within 90 days of the date of injury. The employee need not provide any reason for his desire to change his authorized treating physician. Section 8-43-404(5)(a)(III). In addition, the amendment contained § 8-43-404(5)(a)(V), quoted above, allowing an employee to follow a treating physician moving his practice. The statute retained § 8-43-404(5)(a)(VI) [formerly § 8-43-404(5)(a)] allowing for the director or an ALJ to authorize a physician of the employee's selection to treat the employee upon a "proper showing" by the employee.

A review of the 2008 amendment convinces us the claimant has not correctly interpreted § 8-43-404(5)(a)(V). That section requires that in order for the claimant to enjoy continued care with the physician moving his practice, the record must show the physician was (1) authorized, (2) that the physician moved his practice to another facility or another corporate medical provider, and (3) the physician was "the" authorized treating physician. The legislature, in drafting this paragraph, is concerned that the claimant not have his choice of physician abrogated due to the move of that physician while at the same time seeking to maintain the integrity of the employer's choice of providers represented by its initial list provided to the claimant at the time of the injury. It is significant then, that § 8-43-404(5)(a)(V) does not refer to "an" authorized treating physician, but rather, to a single authorized treating physician or to "the" authorized treating physician.. The claimant may be treating with a number of physicians. However, this subsection does not allow the claimant to switch his treatment from one facility or corporate provider to another simply on the basis that one physician out of the galaxy of treaters has moved his practice. The difficulty with the ALJ's findings is that they do not attempt to resolve this issue as to whether Dr. Nystrom is to be seen as 'the' authorized treating physician.

The legislature's use of the article "the" before "authorized physician" in § 8-43-404(5)(a)(V), as opposed to that of "an" authorized physician has been the subject of previous decisions of the Court of Appeals. In *Popke v. Industrial Claim Appeals Office*, 944 P.2d 677 (Colo. App. 1997), the claimant contested the cessation of his temporary benefits when he was provided a return to regular work release by one of his providers pursuant to § 8-42-105(3)(c). That section allowed the termination of temporary benefits when "the attending physician" gives the employee a release to return to regular employment. The claimant had received authorized treatment by a group of doctors at a clinic. One of the doctors referred the claimant to a chiropractor for several sessions of treatment. At the point that the chiropractor finished the prescribed treatment, he issued a return to work release. When the employer stopped paying temporary benefits as a result,

the claimant contended the chiropractor did not qualify as “the” attending physician. The court agreed. It was pointed out there can be more than one attending physician. The court found the statutes’ use of the word “treating” or “attending” served an interchangeable function in this respect. This phrase was noted to refer to a doctor “who takes care of a claimant” or “minister to: a nurse attending a patient.” The Court concluded “... the statute does not provide for a release by ‘any attending physician.’ Consequently, the author of an effective release for return to employment must be the health care provider identified as ‘the attending physician.’”*Id.* at 681. The Court remanded the matter to the ALJ to determine who was the attending physician, the chiropractor or one of the doctors at the clinic at which he treated. Similarly, in *Bestway Concrete v. Industrial Claim Appeals Office*, 984 P.2d 680 (Colo. App. 1999), the claimant treated with an osteopathic doctor. The D.O. authored a return to work release. The claimant then treated with an orthopedic surgeon and also with a chiropractor. Those subsequent providers did not agree with the return to work opinion of the D.O. The ALJ considered the medical evidence pertinent to the return to work issue and determined the authorized treating physician did not provide a return to work release. This finding was upheld by the Court.

In contrast, the Court in *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002), construed § 8-42-107(8)(b)(I) which provides that “an authorized treating physician shall make a determination” as to the achievement of MMI. The claimant had been treating with a physician who then referred the claimant to a specialist for a surgical opinion. The specialist saw the claimant on one occasion and, several months later, completed a form stating the claimant was at MMI. The Court held that because the statute had been amended recently to alter a reference from “the authorized treating physician” to “an” authorized treating physician, an MMI determination by any of the treating physicians was sufficient to support a determination of MMI. Finding that the specialist was seen by the claimant for the purpose of possible treatment, the Court noted the specialist was an authorized treating physician and his opinion that the claimant was at MMI, despite the absence of any agreement on that point from the claimant’s other treating physician, would be adequate under the statutory language to support the application of MMI, subject to a later DIME review.

The analysis in *Popke*, *Bestway Concrete*, and *Town of Ignacio* are instructive here. Section 8-43-404 uses the phrase “an authorized treating physician” at one point, *see* § 8-43-404(7), when it refers to the need for treatment to be prescribed by “an” authorized treating physician in order that it be characterized as authorized. However, § 8-43-404(5)(a)(V) specifically refers to “the authorized treating physician” when it allows a claimant to continue care with a physician that has moved his practice. As in

Popke, the ALJ must determine if Dr. Nystrom is to be considered the authorized treating physician, in order to allow the claimant to continue treating with him pursuant to § 8-43-404(5)(a)(V).

Here, the record shows the claimant had been treating for a period of 10 months with Dr. Hattem and Dr. Castro subsequent to his last treatment with Dr. Nystrom. This circumstance presents the same challenge as that faced in *Popke* and in *Bestway Concrete* wherein a treating physician at one point in the history of the claimant's care offered an opinion regarding a return to work yet the claimant continued to receive care from other doctors who did not share that opinion. In enacting § 8-43-404(5)(a)(V) the legislature would be concerned about the claimant's ability to shop around among facilities and corporate providers based upon the movement of a doctor who had long since ceased providing care. This circumstance would result in diluting the effect of the employer's listing of specified physician providers without simultaneously providing a beneficial continuation of the claimant's care with the doctor he had initially selected.

Section 8-43-404(5)(a)(V) is concerned with the ability of the claimant to "continue care" with the authorized treating physician. It is necessary to remand this matter to the ALJ to allow her to make findings as to whether Dr. Nystrom can be properly construed as 'the' authorized treating physician with whom it is most necessary for the claimant to 'continue' his care. We contemplate this analysis will require an examination of the evidence in the record to note what type of care is required in the future, to what extent Dr. Nystrom has been involved in the care to be continued, and to what degree the claimant's care will be compromised by his inability to continue treatment with Dr. Nystrom. While the statute does not impose any time limitation on the point at which a claimant must request or assert his desire to follow the treating physician to a new facility, as argued by the claimant, it is relevant for the ALJ to note the proximity of such a request to the doctor's change of facility and to compare it to the progress or frequency of continued medical treatment as a factor to be weighed. Here, the ALJ found the claimant not persuasive when he testified he did make a request to see Dr. Nystrom in December, 2012.

III.

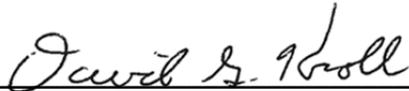
The ALJ made findings in regard to whether the claimant had made a proper showing pursuant to § 8-43-404(5)(a)(VI) to have a physician of the claimant's selection treat the claimant. In the context of this record the ALJ was in error to apply that section. As discussed above, § 8-43-404(5)(a)(V) specifically provides that in the circumstance where an authorized treating physician has moved from one facility or corporate medical

provider to another, that section is pertinent. Due to this more explicit description in § 8-43-404(5)(a)(V) of the circumstances to which it applies, the legislature intended that section to control when those conditions are present. Here, it is undisputed Dr. Nystrom was authorized to treat and did treat the claimant. It is also undisputed that Dr. Nystrom moved from one Concentra facility to another. In that case, the ability of the claimant to continue care with Dr. Nystrom is controlled by § 8-43-404(5)(a)(V) and not by subsection (VI).

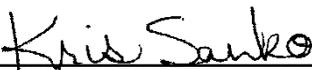
Accordingly, we set aside the May 7, 2015, decision of the ALJ and remand the matter for additional findings pursuant to our discussion in section II above. At the ALJ's discretion, she may conduct additional evidentiary proceedings to assist in those findings.

IT IS THEREFORE ORDERED that the ALJ's order issued May 7, 2015, is set aside and remanded for additional findings.

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

_____ 9/14/2015 _____ by _____ RP _____ .

THE FRICKEY LAW FIRM, Attn: ADAM MCCLURE, ESQ., 940 WADSWORTH BLVD.,
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ESQ., 3801 E. FLORIDA AVE., SUITE 210, DENVER, CO, 80210 (For Respondents)
ALJ MARGOT W. JONES, ESQ., % OFFICE OF ADMINISTRATIVE COURTS, ATTN:
RONDA MCGOVERN, 1525 SHERMAN STREET, 4TH FLOOR, DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-878-425-06

IN THE MATTER OF THE CLAIM OF

DAVID WEIBEL,

Claimant,

v.

FINAL ORDER

THE KROGER COMPANY,

Employer,

and

SEDGWICK CMS,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Margot Jones (ALJ) dated March 30, 2015, that rejected the respondents' assertion that the claimant's claim for permanent total disability benefits was barred by the doctrine of claim preclusion. We set aside the ALJ's order.

This matter went to hearing on the issue of permanent total disability benefits and offset of pension benefits. The respondents asserted at hearing that the claimant's claim for permanent total disability benefits was barred by the doctrine of claim preclusion. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant sustained an admitted injury on January 26, 2012, while working as an industrial refrigeration technician. On this date the claimant injured his right and left shoulders when he slipped down a ladder through a manhole, resulting in his arms being forcefully abducted over his head. The claimant received treatment for both shoulders and was eventually placed at maximum medical improvement (MMI) on January 8, 2013, and given a 13 percent extremity rating for each shoulder.

The respondents filed a final admission of liability admitting for permanent partial disability benefits and ongoing maintenance medical treatment. The claimant objected to the final admission and requested a Division Independent Medical Examination (DIME) which was performed by Dr. Gellrick. The DIME physician agreed with the treating physician's MMI date but assigned a 33 percent whole person rating for the claimant's

shoulders and damage to the cervical spine. The respondents filed an application for hearing on November 19, 2013, to overcome the DIME physician's impairment rating and also listing the issue of maintenance medical benefits. The claimant filed a response on November 21, 2013 listing the issues of compensability, medical benefits, disfigurement, temporary total disability benefits, whole person conversion, and termination of employment in addition to the issues listed by the respondents. The ALJ also found that the claimant filed another response on November 27, 2013, listing safety rule violation in addition to the earlier issues. On February 27, 2014, a hearing was held on the issues of permanent partial disability, overcoming the DIME, conversion to whole person and safety rule violation. By order dated April 11, 2014, an ALJ determined that the respondents failed to overcome the DIME physician's impairment rating. The ALJ also determined that the claimant's rating should be converted to a whole person rating and denied the imposition of a safety rule violation. On April 28, 2014, the respondents filed a final admission of liability consistent with the ALJ's order.

The claimant timely objected to the final admission and then applied for a hearing on the issue of permanent total disability. The respondents argued at the outset of the hearing that the claim for permanent total disability was barred by the doctrine of claim preclusion. The ALJ rejected the respondents' contention. The ALJ determined that although the elements necessary to apply claim preclusion of finality, identity of the parties and subject matter were met; the identity of claims for relief did not exist. The ALJ then credited the claimant's testimony regarding his inability to work and rejected the respondents' vocational counselor's testimony that the claimant was capable of earning a wage and determined that the claimant was entitled to permanent total disability benefits subject to certain offsets.

On appeal, the respondents do not contest the ALJ's determination of permanent total disability or offset. The respondents assert that the claim for permanent total disability benefits is barred by claim preclusion because the claimant failed to endorse the issue of permanent total disability benefits when he filed his November 21, 2014, response to the respondents' application for hearing on the issue of permanent disability. We agree with the respondents that the relevant statute and case law mandate this result and we, therefore, set aside the ALJ's award of permanent total disability benefits.

In *Holnam Inc. v. Industrial Claim Appeals Office*, 159 P.3d 795 (Colo. App. 2006), the court of appeals noted that claim preclusion works to bar the re-litigation of matters that have already been decided as well as matters that could have been raised in a prior proceeding but were not. Claim preclusion protects "litigants from the burden of re-litigating an identical issue with the same party or his privy and ... promote[s] judicial

economy by preventing needless litigation." *Lobato v. Taylor*, 70 P.3d 1152, 1165-66 (Colo. 2003)(quoting *Parklane Hosiery Co. v. Shore*, 439 U.S. 322, 326, 99 S. Ct. 645, 649, 58 L.Ed.2d 552 (1979)). For a claim in a second proceeding to be precluded by a previous judgment, there must exist: (1) finality of the first judgment, (2) identity of subject matter, (3) identity of claims for relief, and (4) identity of or privity between parties to the actions. *Holnam v. Industrial Claim Appeals Office*, *supra*; *Cruz v. Benine*, 984 P.2d 1173, 1176 (Colo.1999).

As to the first requirement for finality, the ALJ found that there is no dispute that the ALJ's April 11, 2014, order is a final order. The claimant on appeal now denies the finality of the April 11, 2014, order on permanent partial disability. We agree with the ALJ. Neither party appealed the April 11, 2014, order and thus, the order became final. Section 8-43-301(10), C.R.S. When the April 11, 2014, order became a final order, the adjudicatory process was completed. *See Smeal v. Oldenettel*, 814 P.2d 904 (Colo. 1991) (claim preclusion requires a final judgment that completes the trial court's adjudicatory process.)

The parties do not dispute that the second element necessary to invoke claim preclusion is met because both proceedings involve the scope of the employer's liability for the injuries that the claimant asserts arose out of the industrial injury. *See Holnam, Inc. v. Industrial Claims Appeals Office*, *supra*. The fourth element is also not in dispute, as the parties in both proceedings are the same.

The limited issue addressed by the ALJ was whether there was identity in the claims for relief. The ALJ found that the claimant's claim for permanent total disability is not the same as the claim for permanent partial disability benefits resolved in the April 11, 2014 order. Citing to §8-43-203(2)(b)(II), the ALJ held that the issue of permanent total disability did not become ripe until the respondents filed the final admission of liability after the April 11, 2014, order. We disagree with this interpretation of the statute and pertinent case law.

Initially, we note that the claimant contends that the respondents did not raise the issues of ripeness or waiver before the ALJ and may not do so now on appeal. It is true that failure to raise an issue before the ALJ in a workers' compensation proceeding will preclude consideration of such issue by the panel on review. *See Lewis v. Scientific Supply Co.*, 897 P.2d 905 (Colo. App. 1995). We disagree, however, that the issues were not raised here. In the October 7, 2014, response to the application for hearing, the respondents listed as other issues to be heard, "offsets claim preclusion issue preclusion claim closed." The respondents made an oral motion at the outset of the hearing citing to

DAVID WEIBEL

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§8-43-203(2)(b)(II), C.R.S. and the same case law they now rely on for appeal. The majority of the respondents' argument to the ALJ was based on the relevant statute and case law addressing ripeness and waiver and therefore, the issues were raised and are now properly before us on appeal. See *Sneath v. Express Messenger Serv.*, 931 P.2d 565 (Colo. App. 1996).

In setting forth the argument that there was an identity in the claims for relief, the respondents point the ALJ to the well-settled principle that permanent partial disability and permanent total disability benefits both compensate for loss of future earning capacity. *Waymire v. City of Las Animas*, 924 P.2d 1168 (Colo. App. 1996). Therefore, when a final admission of liability takes a position on permanent partial disability and a claimant fails to timely object, the issue of permanent total disability is closed. *Olivas-Soto v. Industrial Claim Appeals Office*, 143 P.3d 1178 (Colo. App. 2006). In *Olivas-Soto*, the claimant was placed at MMI and then underwent a DIME. The employer filed a final admission of liability admitting for the DIME physician's MMI and impairment rating. The claimant filed an application for hearing listing several issues, including MMI, but did not endorse permanent total disability. The claimant filed additional applications for hearing listing the same issues but in his fourth application for hearing he also listed the issue of permanent total disability and maintenance medical benefits. Relying on §8-43-203(2)(b)(II), the court of appeals concluded that by admitting for permanent partial disability benefits, the respondents necessarily denied liability for permanent total disability benefits in the final admission of liability and the issue of permanent total disability was legally ripe for adjudication when the claimant filed his first application for hearing. Accordingly, the court determined that the issue of permanent total disability was closed and not subject to further litigation absent reopening.

The situation in the present case is in a different procedural posture because here, the respondents are contending that the claimant is precluded from pursuing permanent total disability because of the claimant's failure to endorse the issue on the response to hearing when the respondents were seeking to overcome the DIME. Section 8-43-203(2)(b)(II), C.R.S., specifically addresses this situation as well. Where the respondents seek to overcome a DIME, the statute requires the claimant to file a response within 20 days on any disputed issues that are ripe. The statute provides, in pertinent part:

The respondents have twenty days after the date of mailing of the notice from the division of the receipt of the IME's report to file an admission or to file an application for hearing. The claimant has thirty days after the date respondents file the admission or application for hearing to file an

application for hearing, *or a response to the respondents' application for hearing, as applicable, on any disputed issues that are ripe for hearing.* §8-43-203(2)(b)(II), C.R.S. 2015 (Emphasis added).¹

Here, the respondents filed an application for hearing to challenge the DIME on November 19, 2013. The issue of permanent total disability was ripe when the respondents filed the application for hearing to address permanency because the DIME placing the claimant at MMI removed any legal impediment to a determination of his eligibility for permanent total disability benefits. *See Olivas-Soto v. Industrial Claim Appeals Office supra.*

Consistent with this language in §8-43-203(2)(b)(II), C.R.S. and *Olivas-Soto*, the panel in *Talboys v. The Greenhouse Restaurant*, W.C. No. 4-597-998 (September 25, 2015), stated that the ALJ's determination of the appropriate permanent partial disability rating "is a concomitant denial of PT benefits." In *Talboys*, the panel stated *Olivas-Soto* was authority to deem the issue of permanent total disability closed if a party failed to endorse permanent total disability benefits as an issue at the time a response was due. Moreover, the fact that respondents filed a final admission of liability after the matter went to hearing does not change the result. *Drinkhouse v. Mountain Board of Cooperative Education Services*, W.C. No. 4-368-354 (February 7, 2003), *aff'd Drinkhouse v. ICAO*, (Colo. App. No. 03CA0438, March 4, 2004) (not selected for publication)(claimant's failure to object to disputed issues on first final admission closed the issues and claimant's objection to a revised admission was immaterial); *Compare Leeway v. industrial Claim Appeals Office*, 178 P.3d 1254 (Colo. App. 2007)(second admission superseded first admission when filed before expiration of objection period of prior admission).

We, therefore, conclude that the ALJ's order is a misapplication of the law. Section 8-43-203(2)(b)(II), C.R.S., statutorily closed the issue of permanent total disability benefits. Thus issue of permanent total disability is not subject to further litigation absent reopening pursuant to §8-43-303, C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated March 30, 2015, is set aside.

¹ Section 8-43-203(2)(b)(II), C.R.S., was amended in 2013 by SB 13-249 with minor language changes. Regardless of which version applies, the critical language relied upon in this case was not substantively altered by the amendment.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



David G. Kroll

DAVID WEIBEL
W. C. No. 4-878-425-06
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CERTIFICATE OF MAILING

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

_____ 9/22/2015 _____ by _____ RP _____ .

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-906-018-01

IN THE MATTER OF THE CLAIM OF

CARMEN BARAN,

Claimant,

v.

ORDER OF REMAND

AMGEN INC.,

Employer,

and

ACE AMERICAN INSURANCE COMPANY,

Insurer,
Respondents.

The claimant seeks “limited” review of an order of Administrative Law Judge Turnbow (ALJ) dated March 18, 2015. In that order, the ALJ found that the claimant’s left shoulder adhesive capsulitis was related to her admitted workers’ compensation wrist injury, and she ordered the medical care and treatment the claimant received for her left shoulder injury as reasonable and necessary. To the extent the ALJ’s order also determined maximum medical improvement (MMI) and permanent impairment, we set aside those determinations and remand for new findings and a new order on those two issues.

This claim involves an admitted left wrist injury. The claimant developed work-related tenosynovitis and DeQuervain’s syndrome in her left wrist. The claimant was treated by Dr. Mars and then referred to a surgeon, Dr. Koch, for assessment. On January 18, 2013, Dr. Koch performed left DeQuervain’s release surgery on the claimant’s left wrist and bone spur removal on the claimant’s left thumb to treat her injury.

Post-surgery, Dr. Mars assigned restrictions on the use of the claimant’s left hand. The claimant was not allowed to work or to use her left hand from immediately following the January 18, 2013, surgery date until March 12, 2013. The claimant’s left wrist was placed in an Ace wrap and later in a brace. The claimant wore her brace most times, but could not wear it all the time because the brace put pressure on her surgical incision

which caused additional pain. On March 12, 2013, the claimant was released back to work light duty with no use of her left hand.

In February or March 2013, the claimant began feeling achiness in her left arm. This progressed to a feeling of swollenness, then stiffness, and finally her shoulder stopped moving. The claimant reported her left shoulder pain to her physical therapist and to Dr. Mars. On June 19, 2013, Dr. Mars diagnosed the claimant with adhesive capsulitis in her left shoulder and opined that the claimant's left shoulder condition is related to her splinting of the left arm due to her wrist pain. In his treatment plan, Dr. Mars stated that the claimant "has a frozen shoulder and I want the therapist to start working on this to regain range of motion. She may need to be referred back to the orthopedist for a second opinion. . . ." Dr. Mars referred the claimant to physical therapy for her left shoulder and then back to Dr. Koch for follow-up.

The claimant subsequently underwent a MRI on her left shoulder which revealed supraspinatus tendonopathy and mild fraying of the superior and posterior labrum. After reviewing the MRI, Dr. Koch agreed with Dr. Mars that the claimant's shoulder pain, stiffness, and adhesive capsulitis were related to the claimant's wrist surgery.

Thereafter, on June 17, 2014, Dr. Mars placed the claimant at MMI and assigned a 19% upper extremity impairment rating which converts to an 11% whole person impairment. In particular, Dr. Mars gave the claimant 2% upper extremity impairment for lost range of motion of the left thumb, 5% upper extremity impairment for lost range of motion of the left shoulder, 12% upper extremity impairment for moderate crepitus of the left shoulder, and 1% upper extremity impairment for decreased sensitivity of the radial nerve distally from the wrist surgical incision.

The respondents subsequently filed an Application for Hearing pursuant to the version of Workers' Compensation Rule of Procedure 5-5, 7 CCR 1101-3, in effect at that time.¹ The respondents endorsed, as issues to be heard at the hearing, medical benefits, reasonably necessary, permanent partial disability (PPD) benefits, and whether the scheduled rating for the claimant's industrial injury was correct. The respondents contended that the claimant's left shoulder condition was not related to her admitted

¹ At the time the respondents filed their Application for Hearing, W.C. Rule 5-5(H) provided that after a determination of permanent impairment from an authorized Level II accredited physician is mailed or delivered, the insurer shall either file a final admission of liability consistent with the physician's opinion, or set the matter for hearing at the Office of Administrative Courts. This Rule was amended effective January 1, 2015.

injury, the treatment the claimant received for her left shoulder was not reasonable and necessary, and the claimant's scheduled impairment was only 3% of the left upper extremity.

In her response to the respondents' Application, the claimant identified medical benefits, authorized provider, reasonably necessary, and temporary partial disability (TPD) benefits from 5/1/2014, through 8/26/2014. For "other issues" the claimant identified temporary total disability (TTD) benefits and TPD benefits from 5/1/2014 to continuing.

Thereafter, at the commencement of the hearing, the claimant argued that even though the respondents had endorsed the issue of PPD benefits in their Application for Hearing, this issue was not ripe for hearing because the claimant was not yet entitled to a Division-sponsored Independent Medical Examination (DIME) to determine MMI, and MMI had to be determined before impairment. The claimant also argued that the ALJ could not determine a permanent impairment rating before the claimant went to a DIME on a possible non-scheduled rating, since her shoulder condition likely was related to the admitted injury and could be converted to a whole person permanent impairment rating. In response, the respondents asserted that the ALJ had the jurisdiction to determine the issues set forth in their Application for Hearing. Tr. at 7.

The ALJ ultimately rejected the claimant's argument, determining instead that the issues of relatedness and impairment would be heard. The ALJ determined that the applicable version of W.C. Rule 5-5 in effect gave the respondents the choice of applying for a hearing based on the Authorized Treating Physician's (ATP) determination of MMI and impairment or filing a Final Admission of Liability (FAL). The claimant then argued that the ALJ should delay considering the issue of impairment until she obtained a DIME. The ALJ, however, again rejected the claimant's contention, and determined that the issue of permanent impairment would be considered.

The ALJ subsequently entered her order determining that the claimant's left shoulder adhesive capsulitis was related to the original worker's compensation injury, and the medical care and treatment she received for her left shoulder injury as reasonable and necessary. The ALJ found that Dr. Mars placed the claimant at MMI on June 17, 2014, and assigned the claimant a 19% upper extremity impairment rating, which converted to an 11% whole person impairment. The ALJ found that the respondents failed to satisfy their burden of proving that the claimant's correct scheduled impairment was 3% of the upper extremity. The ALJ instead concluded that the upper extremity

impairment rating given by Dr. Mars was “appropriate.” Finally, the ALJ directed the respondents to file a FAL within 20 days.

The claimant has petitioned to review the ALJ’s order, raising a “limited issue.” The only argument the claimant raises on appeal concerns whether the ALJ’s order can be read as denying the DIME process by determining MMI, impairment, and/or conversion.² The claimant contends that if the ALJ’s order can be read in this manner, then such a ruling is unsupported by applicable law. In response, the respondents argue that the ALJ’s order is not reviewable since it does not deny the claimant any benefit or penalty.

Initially, we disagree with the respondents’ argument that the ALJ’s order does not deny the claimant any benefit or penalty and, therefore, is not reviewable. Instead, the ALJ’s order appears to decide the issues of MMI, impairment, and medical benefits. As stated above, in her order, the ALJ found that Dr. Mars placed the claimant at MMI on June 17, 2014, and his 19% upper extremity impairment was “appropriate.” The ALJ also ordered that the medical care and treatment that the claimant received for her left shoulder injury was reasonable and necessary. Consequently, we conclude that the ALJ’s order awards the claimant benefits and is, therefore, reviewable. Section 8-43-301(2), C.R.S.

It is well settled that an ATP makes the initial finding of MMI, and assigns a permanent impairment rating if appropriate. If a party wishes to challenge the ATP’s MMI determination, the impairment rating, or both, the party must request a DIME in accordance with the procedures established in §8-42-107.2, C.R.S. Section 8-42-107(8)(b)(II), C.R.S.; §8-42-107(8)(c), C.R.S.; *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186, 190 (Colo. App. 2002). The DIME physician’s opinions concerning MMI and permanent impairment then become binding on the parties and the ALJ unless overcome by clear and convincing evidence. Section 8-42-107(8)(b)(III) and (8)(c), C.R.S.; *Cordova v. Industrial Claim Appeals office, supra*.

Additionally, the initial question of whether a claimant sustained a scheduled or non-scheduled rating is one of fact for determination by the ALJ. That determination depends on whether the claimant establishes the industrial injury caused functional impairment not found on the schedule of disabilities. *Strauch v. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo. App. 1996). Although the opinions and findings of the

² In her Brief In Support, the claimant asserts that the DIME process is underway. Brief at 8 FN 2.

DIME physician may be relevant to this determination, a DIME physician's opinion is not mandated by the statute nor is the ALJ required to afford it any special weight. *See Delaney v. Industrial Claim Appeals Office*, 30 P.3d 691 (Colo. App. 2000). It is only after the ALJ determines the claimant sustained whole person impairment that the DIME physician's rating becomes entitled to presumptive effect under §8-42-107(8)(c), C.R.S. *See Egan v. Industrial Claim Appeals Office*, 971 P.2d 664 (Colo. App. 1998)(DIME provisions do not apply to the rating of scheduled injuries).

In *Delaney v. Industrial Claim Appeals Office*, 30 P.3d 691 (Colo. App. 2000), the Colorado Court of Appeals addressed a situation that is similar to that presented here. In *Delaney*, the claimant suffered an admitted industrial injury, originally diagnosed as a cervical strain. The ATP placed her at MMI with 5% impairment of each upper extremity because of diffuse shoulder girdle myofascial pain. The physician opined the claimant suffered no impairment of the cervical spine.

The claimant applied for a hearing on medical and temporary disability benefits and on compensability of a second injury, and the respondents endorsed the issue of permanent impairment benefits. The claimant filed for a DIME to dispute the ATP's extremity rating, and she also moved to strike the issue of permanency, arguing that the DIME could not be completed by the time of the scheduled hearing, and she would be unable to meet her burden of proof as to that issue. The ALJ denied the motion.

Hearings eventually were held, and at the beginning of the first hearing, the claimant argued that the permanency issue was not ripe because the DIME had not yet taken place. The ALJ disagreed, concluding that a DIME report was a prerequisite to a hearing on permanent disability only in cases involving non-scheduled injuries. Then, based on the evidence presented at the hearing, the ALJ determined that the claimant had failed to prove she sustained a non-scheduled impairment and was thus entitled only to a scheduled benefits award. The Panel affirmed.

On appeal to the Court of Appeals, the claimant argued that the ALJ erred in awarding her benefits for a scheduled injury under §8-42-107(2), C.R.S. rather than for whole person impairment under §8-42-107(8), C.R.S. The claimant contended that under §8-42-107(8)(c), C.R.S., injured workers have an absolute right to a DIME before a hearing can be held on permanency, regardless of whether scheduled or non-scheduled injuries are involved. She argued that because she requested a DIME, the ALJ erred in adjudicating her right to whole person impairment benefits before he received the DIME physician's report, and he also erred in declining to reopen the evidence to consider the DIME report.

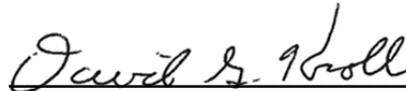
While the Court did not agree with the claimant's statutory interpretation, the Court did agree with the claimant's argument that resolution of the permanency issue should have been deferred until after the DIME report had been filed. The Court explained that it was not a case in which it was undisputed that only a scheduled injury was involved. Instead, the Court held that at the time the hearing was held, there was a legitimate dispute as to whether the claimant had a non-scheduled impairment, and the claimant had requested a DIME to challenge the ATP's determination as to this issue. According to the Court, whether the claimant had a non-scheduled as well as a scheduled impairment was central to determining her entitlement to permanent benefits. Consequently, the Court held that in the particular circumstances, even though the statute did not so require, the claimant should have been given the opportunity to have the DIME report considered before the permanent benefits issue was resolved or, at a minimum, to have the evidence reopened when the report became available. The Court explained that considerations of due process and fairness make such a procedure appropriate since the respondents, and not the claimant, sought to have the permanency issue resolved at a time when the DIME had not yet been performed. The Court therefore concluded that where an employer endorses the issue of permanency for hearing, a legitimate dispute has been raised as to whether the claimant has a non-scheduled injury, and a DIME has been requested, resolution of the permanent impairment issue should be deferred until after the DIME report has been filed.

Here, while it is undisputed that the claimant had not requested a DIME prior to the time the hearing was held, we nevertheless view the holding in *Delaney* to be instructive in this matter. Similar to *Delaney*, in their Application for Hearing, the respondents sought to have the permanency issue resolved at a time when the DIME had not yet been performed, and the claimant raised a legitimate dispute at the hearing as to whether she was at MMI and whether she had sustained a non-scheduled injury. That is, in her Response to the respondents' Application for Hearing, the claimant endorsed medical benefits, and TPD and TTD from 5/1/14 to continuing under "other issues" as issues for hearing. Further, in her Case Information Sheet, the claimant identified medical benefits, TPD, and TTD as issues remaining for hearing. Because temporary benefits must cease at the point of MMI, the endorsement of this issue of temporary benefits is necessarily a contention that MMI is in dispute. Section 8-42-105(3)(a), C.R.S. Also, during the hearing, the claimant testified that she felt as though she was not 100%, and that she believed she needed further treatment. Tr. at 95-96. Additionally, during the hearing, the claimant repeatedly argued that the ALJ should defer ruling on permanency until the DIME had been completed on the issues of MMI and whole person conversion. Tr. at 4-8, 15-16, 29, 72, 96-97, 103. As stated above, while it is for the ALJ to decide whether the claimant sustained a scheduled or non-scheduled rating, the issues

of MMI and impairment are DIME issues. Section 8-42-107(8)(b)(III) and (8)(c), C.R.S. Thus, similar to the holding in *Delaney*, even though the statute did not so require, the claimant should have been given the opportunity to have the DIME report considered before the permanent benefits issue was resolved.³

IT IS THEREFORE ORDERED that the ALJ's order dated March 18, 2015, is set aside on the issues of MMI and permanent impairment and remanded for additional findings and a new order on these two issues.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

Examiner Kroll submits the following concurring opinion:

I agree with the decision to remand this matter to the ALJ for additional proceedings. In that regard, I submit below additional considerations to justify that determination.

The respondents argued prior to the hearing that §8-42-107.2(2)(a), C.R.S. prohibits the claimant from requesting a DIME review. The claimant did not dispute this reading. Instead, the respondents took the interesting view that the ALJ could determine the impairment rating (which in their view was limited to a scheduled rating), require the respondents to then file a FAL and at that point allow the claimant to proceed with a DIME review on the issue of MMI. The ALJ agreed and ruled that the claimant did not

³ The current version of W.C. Rule 5-5 provides that if the insurer files an application for hearing it shall concurrently notify the claimant that he or she may request a DIME on the issues of MMI and/or conversion to whole person impairment, as well as a copy of the division's notice and proposal form. This version of W.C. Rule 5-5 is effective January 1, 2015.

have a right to proceed with her requested DIME on MMI prior to the ALJ's determination of permanent impairment. In her order, the ALJ determined the appropriate impairment rating and ordered the respondents to file a FAL for that rating, presumably to allow the claimant her opportunity to have a DIME decision regarding MMI.

The ALJ's order appears to misconstrue §8-42-107.2(2). In the same fashion, it mischaracterizes the amendment to W.C. Rule of Procedure 5-5(E)(1)(c).

Section 8-42-107.2(2)(b) provides in its first sentence that "if any party disputes a finding or determination of the authorized treating physician, such party shall request the selection of an IME." The subsection then sets forth in its concluding sentence: "Unless such notice and proposal are given within thirty days after the date of mailing of the final admission of liability or the date of mailing or delivery of the disputed finding or determination, as applicable pursuant to paragraph (a) of this subsection (2), the authorized treating physician's findings and determinations shall be binding on all parties and on the division." Paragraph (a) states that the time for selection of an IME is either the date of mailing of a FAL by the respondents or the date the treating doctor's MMI and impairment finding is sent to the respondents. Accordingly, subsection §8-42-107.2(2)(b) states that a party 'may' request a DIME when they dispute a treating physician's MMI or impairment determination. However, when either of the two prerequisite events referenced in paragraph (a) are present, a party 'must' do so within 30 days upon pain of seeing those determinations become binding. The claimant then, did have the right to request a DIME review of the MMI determination prior to the ALJ's conclusion of the January 13, 2015, hearing. She sought to dispute a finding or determination of the treating physician and the statute directed her to "request the selection of an IME." Because there had been no FAL filed, the claimant was not required to do so within 30 days, and the treating doctor's determinations did not become binding due to any failure to adhere to that 30 day deadline. This allows the claimant to pursue a conclusion to her claim through a DIME even in those situations where the respondents may have filed a notice of contest and not an admission, where the respondents were never sent the treating doctor's determinations, where they forgot to file a FAL or where, as here, they filed an application for a hearing to dispute only the scheduled impairment rating.

Here, the ALJ ruled at the initiation of the hearing that the claimant was prohibited by the Rule from first obtaining a DIME review of the MMI issue. She instead, adopted the respondents' contention that the impairment rating should be decided first and then the issue of MMI could be determined by the DIME physician. The statute however,

requires that MMI be determined before permanent impairment may be assigned. See §8-42-107(8)(b.5). In the event the DIME physician found the claimant was not at MMI, the ALJ's determination of the appropriate impairment rating would not be immediately applicable. In that event, to eventually reach MMI to the satisfaction of the DIME, the claimant may be required to undergo a long course of additional treatment which may be extremely beneficial to the extent her permanent impairment may be largely eliminated. However, the respondents' argument, and the ALJ's order, would assert that the impairment rating found by the ALJ as appropriate months or even years earlier would still be the measure of a permanent disability award. It is for that reason MMI must be ascertained prior to the determination of permanent impairment.

The ALJ determined in her order that the amendment to W.C. Rule of Procedure 5-5(E)(1)(c) effective January 1, 2015, would allow the claimant to request a DIME regarding MMI in the event the respondents did not file a FAL because they chose instead to request a hearing pertinent to a scheduled impairment rating. The ALJ ruled however, that because the respondents requested their hearing prior to January 1, 2015, the claimant was not allowed to take advantage of the amendments to the Rule. However, the ability of the claimant to request a DIME in these circumstances was already extant and was not affected by the new Rule.

As indicated in *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002), the Division has allowed claimants to obtain DIME reviews at points distinct from the two events referenced in § 8-42-107.2(a). In *Cordova*, the claimant secured a DIME after the 30 days set forth in § 8-42-107.2(b) had run. The Court in *Cordova* noted the Act was silent regarding whether a DIME could be requested at that juncture. The Court did note that although the claimant was allowed to have a DIME review, the fact that the 30 days had expired and the treating physician's determinations became "binding" meant the DIME determinations were not entitled to the special statutory significance attributed to a timely DIME opinion. The significance for this matter is the fact that the Division did not restrict access to a DIME procedure even prior to the amendment of Rule 5-5(E)(1)(c) in January, 2015.

The adoption of the amendment to Rule 5-5(E)(1)(c) indicates the Director does not believe § 8-42-107.2(b) limits a claimant to a DIME only after a FAL has been filed. The amendment states that even in the situation where a respondent declines to file a FAL, but elects instead, to request a hearing pertinent to a scheduled impairment rating, the claimant may still request a DIME review regardless of the absence of a FAL. While the amendment is effective January 1, 2015, it does not reflect any change in the statute. The Director, in fact, cannot change the statute through the adoption of a rule. *See*,

Saxton v. Industrial Commission, 41 Colo. App. 309, 584 P.2d 638; *Romero v. Martin LTD*, W.C. No. 4-55-142 (March 8, 2004); *Reichart v. Maxtor Corp.*, W.C. No. 4-585-635, (April 4, 2005); *Adams v. Manpower*, W.C. No. 4-389-466 (August 2, 2005). The amendment to the rule then, is only designed to require notice be given to the claimant of their right to request a DIME in those circumstances. It does not reflect any change in the statute regarding the ability of a claimant to request a DIME before the existence of a FAL. That right existed both prior to January 1, 2015, and subsequent to that date. To the extent the ALJ in this matter found the date of the respondents' application for a hearing prior to January 1 to be significant, she is in error.

In addition, the amendment to the Rule does appear to coincide with the relief granted in the *Delaney* decision. Because *Delaney* was decided in 2000, the holding in that decision clearly applied to the circumstances in this matter. I agree with the analysis set forth in Examiner Sanko's opinion and concur that this case should be remanded as set forth in her decision.

CERTIFICATE OF MAILING

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

_____ 10/16/2015 _____ by _____ RP _____ .

THE ELLIOTT LAW OFFICES, P.C., Attn: ALONIT KATZMAN, ESQ., 7884 RALSTON ROAD, ARVADA, CO, 80002 (For Claimant)
RITSEMA & LYON, P.C., Attn: RICHARD A. BOVARNICK, ESQ., 999 18TH STREET, SUITE 3100, DENVER, CO, 80202 (For Respondents)
ALJ KIMBERLY B. TURNBOW, % OFFICE OF ADMINISTRATIVE COURTS, ATTN: RONDA MCGOVERN, 1525 SHERMAN STREET, 4TH FLOOR, DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-869-578-02

IN THE MATTER OF THE CLAIM OF

EDWIN JOHN R. EVENDEN,

Claimant,

v.

AAA MOBILE SERVICES,
CHERYL and CLETUS BISSELL,

Employer,

Uninsured,

Respondents.

ORDER OF REMAND

Cletus and Cheryl Bissell seek review of an order of Administrative Law Judge Mottram (ALJ) dated April 16, 2015, that ordered them personally liable for payment of the indemnity and medical benefits due the claimant in this matter. We set aside the order and remand the matter to the ALJ for further proceedings, findings, and a new order.

In a previous order of March 25, 2012, the ALJ found the claimant sustained a compensable injury to his foot. The respondent employer, AAA Mobile Services (AAA), was ordered to pay the claimant temporary total disability benefits beginning the day after the claimant's injury, January 21, 2011. The employer was also directed to pay for the reasonable and necessary medical care related to the treatment of the injury including an emergency room bill and treatment by Dr. Armstrong. The employer was found to be uninsured and was directed to post a bond in the amount of \$26,500 to guarantee the payment of the benefits.

No benefits were paid by the employer. On November 4, 2014, a second hearing was convened by the ALJ in regard to the claimant's request to have the amount of the benefits owed the claimant updated and set forth in specific amounts by the ALJ. The claimant intended to then file the ALJ's award with the District Court so as to enable collection of the monies owed pursuant to § 8-43-408(3), C.R.S. In that regard, the claimant also sought to pierce the corporate veil of the employer and obtain an order for the payment of the benefits personally by Cletus and Cheryl Bissell.

The March 25, 2012, ALJ order did not identify the employer, AAA Mobile Services, as any specific type of business entity. The order instead, held the employer was an “association of persons,” pursuant to § 8-40-203(1)(b), C.R.S. and included AAA, Kody Reeder and Dustin Bissel. Both Reeder and Bissel testified at the March 2012, hearing. However, there was no indication the order was sent to Kody Reeder or Dustin Bissel, and they do not appear to have been parties to the hearing. On August 27, 2012, subsequent to the March 25, 2012, order, AAA filed with the Colorado Secretary of State a Statement of Dissolution for AAA Mobile Service, LLC. The Statement asserted AAA had ceased operations as of December 11, 2011.

The ALJ submitted the order under review on April 16, 2015. The ALJ determined the corporate veil should be pierced in this matter and the Bissells should be found personally liable for the \$49,717.39 in temporary benefits accrued since the date of injury as well as the outstanding medical bills the claimant asserted amounted to \$48,385.81.¹

The Bissells, appearing *pro se*, argued at the hearing and on appeal, that there were insufficient grounds to hold either of the Bissells personally liable, and particularly not Cletus Bissell. They point out that the named employer, AAA Mobile Services, was not a corporation. It was a Limited Liability Company (LLC). They also disagree with the ALJ’s findings pertinent to the comingling of personal business with that of the employer, AAA, and the reasons AAA was eventually dissolved.²

Initially, we note that the Bissells have attached several documents to their brief submitted on appeal. We may not consider the additional factual details included in their brief or the documents that accompany the brief that were not admitted as exhibits in the hearing. The Panel’s review is limited to the evidence in the record of the hearing before the hearing officer. §8-43-301(4), C.R.S.

¹ In ¶ 7 of the ALJ’s conclusions of law it is determined a clear and convincing evidence standard applies to the issue of piercing the corporate veil. The ALJ also found this applies to a party’s challenge to the determination of a Division Independent Medical Examiner. We surmise this reference to a DIME was an oversight by the ALJ as this case does not feature a review by a DIME physician. We also note the Court of Appeals has held the burden on the issue of the corporate veil is subject to a preponderance of the evidence standard. *McCallum Family, LLC v. Winger*, 221 P.3d 69 (Colo. App. 2009).

² The Bissells also argue on appeal that the claimant should be denied temporary benefits due to his failure to report his injury in writing within four days as required by § 8-43-102, C.R.S. However, the assertion of this penalty claim is an affirmative issue which the employer must raise and give notice of prior to the hearing. *Postlewait v. Midwest Barricade*, 905 P.2d 21 (Colo. App. 1995). Here, the Bissells did not file either a response to the application for hearing or a Case Information Sheet, or provide any other notice prior to the hearing of their intent to pursue this issue. For that reason the ALJ did not consider the issue, nor do we.

To pierce the corporate veil, the court must conclude (1) the corporate entity is an alter ego or mere instrumentality; (2) the corporate form was used to perpetrate a fraud or defeat a rightful claim; and (3) an equitable result would be achieved by disregarding the corporate form. Courts consider a variety of factors in determining alter ego status, including whether (1) the entity is operated as a distinct business entity; (2) funds and assets are commingled; (3) adequate corporate records are maintained; (4) the nature and form of the entity's ownership and control facilitate insider misuse; (5) the business is thinly capitalized; (6) the entity is used as a mere shell; (7) legal formalities are disregarded; and (8) entity funds or assets are used for non-entity purposes. *Phillips v. Englewood Post No. 322*, 139 P.3d 639 (Colo. 2006). The veil of limited liability may also be pierced in regard to an LLC. § 7-80-107(1), C.R.S. However, the legal configuration of an LLC does not allow for all of the above listed factors to apply.

The evidence introduced at the November 4, 2014, hearing revealed AAA Mobile Services was not a corporation. Instead, it did originate as an LLC. In Colorado, a limited liability company is a creature of statute. It is established in accordance with the Colorado Limited Liability Company Act, § 7-80-101, C.R.S. *See* Brandon R. Ceglian, *Satisfying Creditor Claims Against Colorado LLCs, Members, and Managers*, 36 *The Colorado Lawyer* 23 (January, 2007). The Supreme Court, in *Weinstein v. Colborne Foodbotics, LLC*, 302 P.3d 263, 267 (2013), described the legislative scheme involved in the Act:

The LLC allows owners great flexibility in creating rights and duties for its members because Colorado's LLC Act permits the operating agreement to override the LLC Act's provision in all but a few instances. *See* §§ 7-80-108(1)(a); 7-80-108(4) ("it is the intent of this article to give the maximum effect to the principle of freedom of contract and to the enforceability of operating agreements.") Colorado's LLC statute, with its flexibility in LLC formation and limitation on personal liability, is consistent with general legal authorities' analyses of LLCs.

AAA Mobile Services LLC officially came into existence when Cheryl Bissell filed an Articles of Organization form with the Secretary of State on August 11, 2006. The Articles, as required by §7-80-204, C.R.S. revealed only that AAA was managed by

its members, and not by a manager, and that it had at least one member. The Bissells provided no other documents pertinent to the official operation of AAA with the exception of a Statement of Dissolution form from August, 2012. They did provide AAA tax returns and copies of AAA checks paid to Reeder and Dustin Bissell.³

According to the LLC Act, a ‘member’ of an LLC is a term of art. It is defined in § 7-80-102(9), C.R.S. to designate an ownership interest. A ‘manager’ is referenced in §7-80-102(8), C.R.S. as a person to manage the company. The terms are not interchangeable. In section § 7-80-108(1)(b), C.R.S. an LLC is bound by its operating agreement (OA). An OA may only restrict the legal rights of its members, not its managers, § 7-80-108(1)(e), C.R.S. A person may form a LLC without being a “member”, § 7-80-203, C.R.S. An OA may either vest management decision in its members, or in its managers, § 7-80-401, C.R.S. In the event the OA provides for managers, decisions with respect to the management of the LLC are made by a majority of the managers, § 7-80-401(1), C.R.S. Should the OA specify it does not use managers, it is run by its members.

The impetus for the recognition of LLCs as a form of business entity began in the 1980s. The LLC was intended to take advantage of the limited liability feature of a corporation, while avoiding the tax liability of corporations. They enjoy the flexibility of a partnership but the protection of limited personal liability for its members. *See Herrick K. Lidstone, Single Member LLCs and Asset Protection*, 41 *The Colorado Lawyer* 39 (March, 2012).

At the November 2014 hearing both the claimant and the ALJ treated AAA as a corporation. Several references were made to the failure of AAA to have regular stockholder meetings, and to keep minutes of the meetings. It was argued AAA was undercapitalized and was therefore no more than a shell of a corporation. The ALJ held that “corporate funds” were misused and the “shareholders” disregarded legal formalities to avoid personal liability. Conclusions of Law, ¶ 8. While the Bissells’ slack record keeping did not help themselves, or the ALJ, in regard to deciding the issue of personal liability, we conclude the ALJ applied the law incorrectly when deciding the issue in this matter.⁴

³ The Bissells complain on appeal that the ALJ improperly made an adverse inference to Cheryl Bissell’s evoking of the 5th Amendment to avoid responding to a question regarding the AAA assets. In civil cases, an adverse inference may be drawn against a party who invokes the Fifth Amendment privilege against self-incrimination. *See Asplin v. Mueller*, 687 P.2d 1329, 1332 (Colo. App. 1984).

⁴ We are not persuaded the ALJ was biased against the claimant or that the hearing was unfair to the claimant. *See Nesbit v. Industrial Commission*, 43 Colo. App. 398, 607 P.2d 1024 (1979) (substantial showing of bias necessary to

The Colorado Limited Liability Company Act, § 7-80-705, provides that members are not liable for the debts or obligations of an LLC pursuant to any order of a court. The statute provides that a party may move to hold the “members” of an LLC personally responsible for the improper actions of an LLC by piercing the corporate veil as determined under Colorado Law. However, the observation that the LLC does not adhere to the formalities or requirements relating to the management of its business and affairs “is not in itself a ground for imposing personal liability.” Section 7-80-107(2), C.R.S. The conduct of the LLC’s business is determined by the OA. The OA need not be in writing. Section 8-80-102(11)(a), C.R.S. Where, as here, the LLC is to be operated by its members, the decisions in regard to the LLC are made by a majority of its members. Each member is an agent of the LLC. Section 7-80-405(2), C.R.S. If there is just one member, that member may make the decisions. In the case of a single member, the OA may consist of any writing signed by the member pertinent to the LLC’s affairs and conduct of the LLC’s business. Sections 7-80-102(11)(b)(I) & (II), C.R.S. There is no requirement for regular meetings or minutes. Capitalization is not required. A member may make a contribution to the LLC in the form of cash, property, an I.O.U. or the performance of services. Section 7-80-501, C.R.S. Individuals may be admitted as members of the LLC without making any contribution to the LLC, and they may be members without receiving any membership interest in the LLC. Section 7-80-501, C.R.S. These procedures are not similar to those with businesses using a corporate business model.

In 2009, the Colorado Court of Appeals, in *Sheffield Services Company v. Trowbridge*, 211 P.3d 714 (Colo. App. 2009), held that in the circumstances described by *Phillips v. Englewood Post No. 322*, *supra*, the corporate veil, or the limited liability provision, for an LLC may be pierced to hold an LLC manager personally liable for LLC debts. However, in *Weinstein v. Colborne Foodbotics, LLC*, 302 P.3d 263 (Colo. 2013), the Supreme Court specifically reversed *Sheffield* on this point. The Court noted that § 7-80-107(1) limits the piercing of the corporate veil in the case of LLCs only to “members,” not managers and that section, as well as § 7-80-109, directs the common law is not normally to be applied in the case of LLCs.

Accordingly, the ALJ in this matter may only pierce the corporate veil of AAA, insofar as it subjects a ‘member’ to personal liability. The ALJ did not make a determination as to who constituted a member or members. In this case that represents a challenge. Neither the Bissells, nor Reeder or Dustin Bissell, appeared to have in existence a written OA. Section 7-80-408(1)(c), C.R.S. specifies the LLC is to keep a list

support conclusion that hearing was unfair); *In Re Marriage of Johnson*, 40 Colo. App. 250, 576 P.2d 188 (Colo. App. 1977) (adverse ruling alone does not support conclusion that trial judge was biased).

of the names of members. While the list need not be in writing, “it must be capable of conversion into written form within a reasonable time.” Section 7-80-408(4), C.R.S. The record also shows the absence of such a list. The only written documents include the Articles of Organization and the Statement of Dissolution signed by Cheryl Bissell. Cletus Bissell testified Cheryl was the only member, and he was no more than an employee of AAA. Tr. at 10, 22, (Nov. 4, 2014). He also stated he somehow transferred the business to Reeder and Dustin Bissell. Respondents’ exhibit, pg. 1. It is not clear as to whether he was referring solely to a delegation of work functions, or to an attempted legal transfer of the LLC to new members. However, it is required that the ALJ must determine these individuals qualified as members before he may pierce the corporate veil in order to hold the member or members personally liable.

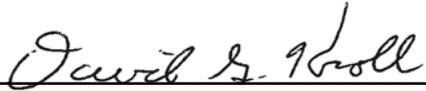
Without limiting the ALJ’s authority to make the necessary findings pertinent to membership in the LLC, the statute does suggest some avenues to follow. There was testimony received in regard to the disposition of real property owned by AAA. A distribution of an LLC’s property or assets may only be made to members. Sections 7-80-503 & 7-80-604, C.R.S. When an LLC is dissolved, its remaining property is to be distributed to its members. Section 7-80-803(1)(d), C.R.S. The trail regarding the journey this property took may suggest which individuals were considered to be members. Cletus Bissell testified there were some regular meetings held regarding the management of AAA. The nature of these meetings and decisions made may also imply the identity of the members. In order to authorize the LLC to act outside the ordinary course of the business, the consent of the members must be obtained. Section 7-80-401(2)(c), C.R.S. The authorization of such activity at such a meeting may indicate the presence of members and their identity. However, because a member is allowed to transact business with, and lend money to, an LLC, as are strangers to the LLC, the fact of general participation in the affairs of the LLC must be carefully weighed when used to uncover the identity of a possible member. Section 7-80-404(5), C.R.S. A review of the statutory scheme involving LLCs may suggest other sources of evidence pertinent to uncovering membership in AAA.

For the reason that the ALJ imposed personal liability upon Cletus and Cheryl Bissell through the application of law pertaining to corporations, and not to that of LLCs, we set aside the decision of the ALJ and remand the matter to the ALJ for new findings as discussed above. At his discretion, the ALJ may conduct additional evidentiary proceedings in the matter in order to arrive at the required factual and legal conclusions.

IT IS THEREFORE ORDERED that the ALJ’s order issued April 16, 2015, is set aside and remanded to the ALJ for further proceedings, findings, and a new order.

EDWIN JOHN R. EVENDEN
W. C. No. 4-869-578-02
Page 7

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

EDWIN JOHN R. EVENDEN
W. C. No. 4-869-578-02
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CERTIFICATE OF MAILING

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

_____ 10/28/2015 _____ by _____ KG _____ .

AAA MOBILE SERVICES, C/O: CLETUS AND CHERYL BISSELL, P O BOX 798, DELTA,
CO, 81416 (Employer)

KILLIAN DAVIS RICHTER & MAYLE, P.C., Attn: CHRISTOPHER H. RICHTER, ESQ.,
P O BOX 4859, GRAND JUNCTION, CO, 81502 (For Claimant)

ALJ KEITH E. MOTTRAM, ESQ., % OFFICE OF ADMINISTRATIVE COURTS, ATTN:
RONDA MCGOVERN, 1525 SHERMAN STREET, 4TH FLOOR, DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-951-444-03

IN THE MATTER OF THE CLAIM OF

ERIC KASPER,

Claimant,

v.

FINAL ORDER

U.S. BEEF CORPORATION,

Employer,

and

XL SPECIALTY INSURANCE CO./
BROADSPIRE,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Broniak (ALJ) dated April 10, 2015, that found the claimant not responsible for his wage loss and ordered the respondents to pay temporary total disability benefits. We affirm the ALJ's order.

This matter went to hearing on the issue of temporary total disability benefits and offsets for unemployment benefits. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The employer is a fast food chain. The claimant worked for the employer as an assistant manager in one of its restaurants. The claimant sustained an admitted injury to his left shoulder on April 15, 2014. The claimant returned to modified duty and continued to work for the employer within his restrictions.

The employer provided a computer in the office at the restaurant site in which the claimant worked. The claimant was authorized to use the company computer and did so for the purpose of accessing a web application called "Job Apps," which allowed the claimant to access the online applications of individuals who had applied for employment with the employer. The claimant signed a statement certifying that he read the policies outlined in the company handbook and agreed to abide by them. One of the policies the claimant agreed to comply with was the "Electronic Communications System" policy. The policy provides:

Electronic Communications System tools are provided for business purposes and are not used for any other reason, including solicitations for commercial venture, religious or political causes or other personal uses. Inappropriate messages are strictly prohibited. Team members are responsible for avoiding anything that is offensive, disruptive, harmful to morale or considered to be harassment.

In April of 2014, the employers' employees were experiencing difficulty accessing the Jobs Apps web application through whichever web browser they had been using so the employer installed the Google Chrome web browser. On April 22, 2014, the claimant logged on to the company computer and accessed the Google Chrome web browser to obtain an internet connection. That same time, he also logged into Google Chrome using his personal Gmail account login name and password. When the claimant finished working on the computer he did not log out of his personal account. Prior to reporting to work that day, the claimant had accessed a number of adult websites on his mobile device using the Google Chrome web browser. The claimant did not log out of the Google Chrome browser on the employer's computer so the adult websites accessed on the claimant's mobile device appeared in the browsing history on the employers computer. The employer's IT department found pornographic material on the computer located at the restaurant where the claimant worked. The ALJ further noted that the websites were accessed over only a 10 minute period prior to the claimant beginning his work shift. The claimant was suspended on April 29, 2014, pending a completion of an investigation into the inappropriate websites.

The employer contended that the claimant was accessing inappropriate websites from the work computer but employer documents also recognized that the same sites were in the claimant's browsing history and accessed from his mobile device. The claimant refused to sign a document dated May 2, 2014, which stated that he was accessing the websites from the work computer. The claimant was terminated on May 2, 2014 for violating the Electronic Communications System policy.

The ALJ credited the claimant's testimony that the claimant did not understand that logging into Google Chrome with his personal Gmail account would cause the browsing history to appear on the employer's computer. The claimant also did not realize that logging into his personal account was in violation of the employer's policy. The ALJ found that there is no evidence in the record that the claimant actually accessed any inappropriate web sites or any other personal sites, including e-mail, while logged into Google Chrome at work. The claimant continues to be restricted from work and has not been placed at maximum medical improvement.

Based on these findings, the ALJ concluded that the claimant did not commit a volitional act that constituted a violation of an established company policy when he logged into Google Chrome with his personal Gmail login and password. The ALJ found that the claimant made a mistake by logging in with his personal account and that this did not constitute a volitional act under the circumstances. The ALJ awarded the claimant temporary disability benefits from May 2, 2014, and continuing, subject to offset for the receipt of unemployment benefits.

The employer filed a petition to review alleging that the ALJ erred in and abused her discretion in failing to find that the claimant was responsible for his termination of employment and awarding indemnity benefits. The employer did not file a brief in support of the petition to review and, therefore, the effectiveness of our review is limited *Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986). Although the respondents requested that a transcript be prepared in an amended petition to review, the transcript was not prepared or submitted and in an order dated July 27, 2015, the request was stricken. We, nonetheless, have reviewed the record provided and see no basis to disturb the ALJ's order.

Sections 8-42-105(4), C.R.S., and 8-42-103(1)(g), C.R.S. (referred to as the termination statutes), contain identical language stating that in cases "where it is determined that a temporarily disabled employee is responsible for termination of employment the resulting wage loss shall not be attributable to the on-the-job injury." In *Colorado Springs Disposal v. Industrial Claim Appeals Office*, 58 P.3d 1061 (Colo. App. 2002), the court held that the term "responsible" reintroduced into the Workers' Compensation Act the concept of "fault" applicable prior to the decision in *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Prior panel orders have recognized that the concept of "fault" as it is used in the unemployment insurance context is instructive for purposes of the termination statutes. *See e.g. Maldonado v. Celebrity Resort Services*, W.C. No. 4-647-849 (October 25, 2010). In that context, "fault" requires that the claimant must have performed some volitional act or exercised a degree of control over the circumstances resulting in the termination. *Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1995), *opinion after remand*, 908 P.2d 1185 (Colo. App. 1985). That determination must be based upon an examination of the totality of circumstances. *Id.* As the ALJ correctly recognized here, the burden to show that the claimant was responsible for his discharge is on the respondents. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 18 P.3d 790 (Colo. App. 2000).

ERIC KASPER

W. C. No. 4-951-444-03

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The question whether the claimant acted volitionally or exercised a degree of control over the circumstances of the termination is ordinarily one of fact for the ALJ. See *Gonzales v. Industrial Commission*, 740 P.2d 999 (Colo. 1987); *Aragon v. Western LCM, Inc.* W.C. No. 4-878-169 (December 13, 2012). Accordingly, we must uphold the ALJ's findings if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). This standard of review requires us to view the evidence in the light most favorable to the prevailing party, and to accept the ALJ's resolution of conflicts in the evidence as well as plausible inferences which she drew from the evidence. *Industrial Commission v. Royal Indemnity Co.*, 124 Colo. 210, 236 P.2d 293 (1951); *Metro Moving & Storage Co. v. Gussert supra*. Resolving conflicting inferences which could be drawn from the competing testimony is solely in the ALJ's discretion. *Id.* This standard of review is deferential and the scope of our review in this regard is "exceedingly narrow." *Id.* Under this standard of review it is also the ALJ's sole prerogative to evaluate the credibility of the witnesses and the probative value of the evidence. We may not substitute our judgment for that of the ALJ regarding credibility matters unless there is such hard, certain evidence contradicting the ALJ's determination that it would be error as a matter of law. See *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986).

It appears that the respondents contend that the ALJ erred in her decision to credit the claimant and in her reading of the company policy. We disagree. Although the ALJ found that the claimant logged on using the identifying information from his personal Gmail account, the ALJ found no credible or persuasive evidence that the claimant accessed his personal email or used the business computer for his personal purposes in violation of company policy. The ALJ found that simply logging on to the Google Chrome account, using the claimant's personal identifying information, did not constitute a violation. Based on our reading of the relevant policies in evidence, we cannot say the ALJ erred in her finding. The ALJ's reading of the policies was a plausible interpretation. The ALJ resolved conflicts in the evidence based upon weighing of the evidence and her credibility determinations. Further, without a transcript we must presume the ALJ's findings are supported by the evidence. *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988); see also *Hanna v. Print Expeditors*, 77 P.3d 863 (Colo. App., 2003)(burden is on appellant to provide record justifying reversal). The ALJ's findings support the conclusion that the claimant was not responsible for his termination from employment. Thus, the ALJ correctly applied the law and did not err in awarding temporary disability benefits.

The claimant filed a motion to dismiss appeal and a request for attorney fees. The claimant contends that the appeal was not taken in good faith as evidenced by the fact

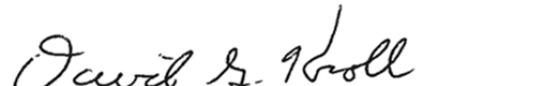
that the respondents were challenging factual determinations made by the ALJ but failed to have a transcript prepared or submitted and did not file a brief. The claimant requests dismissal and attorney fees pursuant to §8-43-301(14), C.R.S. in the amount of \$350.

Pursuant to § 8-43-301(14), C.R.S., attorney fees and costs may be awarded against an attorney who submits a petition to review or brief in support of a petition which is not well grounded in fact or warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law. We decline to impose attorney fees. Although the evidence supporting the respondents' contentions is sparse, we cannot say that the respondents' arguments are so lacking in merit that they may be classified as not well grounded in fact or law. *See BCW Enterprises, Ltd. v. Industrial Claim Appeals Office*, 964 P.2d 533 (Colo. App. 1997); *Brandon v. Sterling Colorado Beef Co.*, 827 P.2d 559 (Colo. App. 1991) (resort to judicial review is not considered frivolous or in bad faith as long as there is a reasonable basis for party to challenge the ALJ's order).

IT IS THEREFORE ORDERED that the ALJ's order dated April 10, 2015, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


David G. Kroll

ERIC KASPER
W. C. No. 4-951-444-03
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CERTIFICATE OF MAILING

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

_____ 10/30/2015 _____ by _____ KG _____ .

XL SPECIALTY INSURANCE CO/BROADSPIRE, Attn: SANDY O'BRIEN, P O BOX 14348,
LEXINGTON, KY, 40512-4348 (Insurer)
BORQUEZ LAW OFFICE, Attn: ROBERT P. BORQUEZ, ESQ., 600 17TH STREET, SUITE
2800-SOUTH, DENVER, CO, 80202-5428 (For Claimant)
MESSNER REEVES, LLP, Attn: KATHLEEN J. MOWRY, ESQ., 1430 WYNKOOP STREET,
SUITE 300, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-883-847-04

IN THE MATTER OF THE CLAIM OF

ROBERT QUINA,

Claimant,

v.

ORDER OF REMAND

EMPLOYMENT SOLUTIONS
MANAGEMENT, INC.,

Employer,

and

AMERICAN CASUALTY CO. OF
READING PA.,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Margot Jones (ALJ) dated May 28, 2015, that determined the respondents failed to overcome the Division Independent Medical Examination (DIME) physician's opinion on maximum medical improvement (MMI) and ordered them to pay for medical treatment. It is unclear as to whether this order is final and reviewable because we are unable determine whether specific medical benefits were ordered. Therefore, we remand the matter for further findings and clarification regarding the award of medical benefits.

On February 12, 2012, the claimant sustained an admitted injury to his left shoulder when he slipped and fell on ice. The claimant underwent surgery to repair his left shoulder. By September, 2012, the claimant was experiencing pain in his joint involving his upper arm, popping and reported soreness. The claimant had a follow-up visit with Dr. Papilion in November, 2012. Dr. Papilion ordered a post-surgical MRI which showed that a suture anchor from the original surgery may be bent or broken. Dr. Papilion noted that the claimant was a good candidate for a repeat arthroscopy and rotator cuff repair. The surgery was scheduled but the respondent denied authorization relying on a record review performed by Dr. Fall who stated that she was unable to state within a reasonable degree of medical probability that the need for the second shoulder surgery

was related to the work injury. Dr. Papilion continued to recommend a repeat examination under anesthesia, arthroscopy and a revision rotator cuff repair to the left shoulder and maintained his position that this was related to the original injury.

The claimant eventually underwent a DIME pursuant to §8-42-107(8)(b)(II)(A)-(D), C.R.S., with Dr. Thomas Fry on August 26, 2014. The DIME physician concluded that the claimant was not at MMI and, in his opinion, the broken shoulder anchor made it reasonable to relate the claimant's condition to a failure to heal from the original injury and surgery and was, therefore, a work-related condition.

The respondents filed an application for hearing to overcome the DIME report. The respondents also checked the boxes on the application for medical benefits and reasonably necessary. The claimant filed a response listing the issue of whether the respondents should "have to pay for second shoulder surgery?" The hearing transcripts do not discuss the issue of specific medical benefits. The position statements by the parties do, however, discuss the repeat surgery in conjunction with overcoming the DIME. The ALJ's order states that the only issue for hearing is whether the respondents proved by clear and convincing evidence that the DIME determination regarding MMI is most probably incorrect. In this regard the ALJ found that the medical records and opinions by Dr. Papilion and Dr. Fry were the most credible and persuasive that the need for additional surgical repair of the recurrent rotator cuff tear is related to the original work injury and subsequent surgical intervention. There was no discussion on reasonably necessary. The ALJ concluded that the respondents failed to overcome the DIME physician's determination that the claimant is not at MMI and ordered them liable for "medical treatment to cure and relieve claimant of the effects of the left shoulder recurrent rotator cuff tear."

The respondents appealed contending that the order is not supported by substantial evidence. Section 8-43-301(2), C.R.S., provides that a party dissatisfied with an order "that requires any party to pay a penalty or benefits or denies a claimant any benefit or penalty may file a petition to review..." It is well settled that orders which do not require the payment of benefits or penalties, or deny the claimant any benefit or penalty, are interlocutory and not subject to immediate review. *See Ortiz v. Industrial Claim Appeals Office*, 81 P.3d 1110 (Colo. App. 2003). Further, an award must determine the amount of benefits to be awarded before it may be considered final and reviewable. *United Parcel Service v. Industrial Claim Appeals Office*, 988 P.2d 1146 (Colo. App. 1999). The panel frequently has held that general awards of medical benefits are not final and reviewable unless the ALJ determines the respondents' liability for specific treatment. *Thomas v. Four Corners Health Care*, W.C. No. 4-484-220 (December 17, 2002); *Atkins v.*

Centennial School District R-1, W.C. No. 4-275-987 (February 7, 2002); *Tooley v. Johnson & Sons Trucking*, W.C. No. 4-376-713 (January 28, 2000). The basis for these decisions is that the respondents remain free to challenge the reasonableness and necessity of specific treatments.

Here, the ALJ's order generally awards medical benefits. The evidence, however, shows that there are specific recommendations for medical treatment for the claimant's shoulder and that reasonable and necessary medical benefits was listed as an issue for hearing. Since the order does not specify which medical benefits are being awarded, it is unclear as to whether the order is final and reviewable. Consequently, we remand for further findings as to which, if any, specific medical benefits the ALJ is ordering. Section 8-43-301(8), C.R.S. See *Lewis v. Badger Drilling Company*, W.C. No. 4-785-117 (September 8, 2011).

IT IS THEREFORE ORDERED that the ALJ's order dated May 28, 2015, is remanded to the ALJ for additional findings and clarification as to what specific medical benefits, if any, are awarded.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



David G. Kroll

ROBERT QUINA
W. C. No. 4-883-847-04
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CERTIFICATE OF MAILING

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

_____ 10/8/2015 _____ by _____ RP _____ .

DODGE LAW FIRM, LLC, Attn: SHELLEY P. DODGE, ESQ., 3515 S. TAMARAC DRIVE,
SUITE 200, DENVER, CO, 80237 (For Claimant)

HALL & EVANS, LLC, Attn: DOUGLAS J. KOTAREK, ESQ., 1001 17TH STREET, SUITE
300, DENVER, CO, 80202 (For Respondents)

ALJ MARGOT W. JONES, % OFFICE OF ADMINISTRATIVE COURTS, ATTN: RONDA
MCGOVERN, 1525 SHERMAN STREET, 4TH FLOOR, DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-784-196-12

IN THE MATTER OF THE CLAIM OF

DAVID VALDEZ,

Claimant,

v.

ALSTOM, INC.,

Employer,

and

ZURICH AMERICAN INSURANCE
COMPANY,

Insurer,
Respondents.

ORDER OF REMAND

The claimant seeks review of an order of Administrative Law Judge Felter (ALJ) dated June 17, 2015, that granted the respondents' motion for summary judgment and dismissed the claimant's petition to reopen his claim on the ground of issue preclusion. We set aside the decision and remand this matter for the ALJ's further consideration.

The claimant sustained the injury that is the subject of this claim on January 9, 2009. The claimant tripped over an air hose at work and injured his neck, back and left shoulder. The claimant had previously injured his neck and upper back in 1987. The previous injury featured treatment in the form of a cervical fusion surgery. The claimant received Social Security Disability benefits for approximately a year in 2008. The claimant's 2009 injury was admitted by the respondents. His treating physician placed the claimant at maximum medical improvement (MMI) as of December, 2010. A Division Independent Medical Exam (DIME) was conducted by Dr. McCranie. Dr. McCranie agreed with the date of MMI and determined the claimant had returned to his baseline condition extant prior to the January, 2009, work injury. The claimant was found by Dr. McCranie to have no permanent impairment attributable to the work injury and any future medical treatment was noted to be justified by the claimant's preexisting condition and not by the work injury.

The claimant challenged these findings of the DIME physician at a hearing before an ALJ. ALJ Walsh found the claimant had not overcome the DIME determinations by clear and convincing evidence. The claimant pursued an appeal to the Industrial Claim Appeals Office which affirmed the decision of the ALJ. The claimant's further appeal to the Court of Appeals met with a similar result.

The claimant filed a petition to reopen his claim on August 8, 2014. The claimant then filed an application for a hearing. The claimant alleged his medical condition had worsened. He also contended he had a right to further contest the findings of the DIME physician and that the DIME doctor was incorrect when she apportioned his symptoms of permanent impairment to his previous injuries. The respondents submitted a motion for summary judgment on May 28, 2015. In their motion, the respondents argued that any change in the claimant's medical condition was alleged by the claimant to have occurred to body parts which had been adjudicated as not further affected by his work injury. Given that the claimant's appeals had been exhausted, and the rulings were against him, the respondents claimed the claimant was now barred from further seeking benefits for injuries due to his January, 2009, work injury. The respondents therefore asked the ALJ to dismiss the claimant's application for a reopening of his claim, and his plea for medical benefits and permanent total disability benefits.¹

In his June 17, 2015, order the ALJ granted the motion for summary judgment. The ALJ observed the claimant was asserting a legal right to overcome the determinations of the DIME and that there should have been no apportionment of his permanent disabilities to a prior injury. The ALJ noted the claimant had provided a medical report from Dr. Andy Fine, dated May 22, 2015, which described how the claimant's preexisting condition had been aggravated by his January, 2009, work injury, and his condition had worsened since that date. The doctor asserted there were no intervening factors that led to this worsening and that the claimant had undergone two surgeries in 2015 due to the work injury of January, 2009. The ALJ, however, reasoned that the status of the January, 2009, work injury had been fully litigated. That litigation was held to have found that any symptoms the claimant had after his date of MMI in December, 2010, were not casually related to his work injury. The ALJ ruled "thus it follows that it has been finally adjudicated that there was no change in condition or worsening of the admitted work related injury of January 9, 2009. In sum, there is no work related matter to reopen."

¹ The file from the ALJ does not include a copy of the claimant's petition to review nor does it feature a copy of his application for a hearing. However, the parties do not appear to dispute this recitation of these facts in either the respondents' motion or the ALJ's order so we are proceeding on the basis that these findings are accurate.

The claimant appears in this matter without the benefit of legal representation. In his petition to review the ALJ's order, the claimant asserts he can prove his condition is related to his work injury. He contends the ALJ erred by not crediting the opinion of Dr. Fine that his worsening and current need for treatment are related to the work injury. He claims his case was mishandled and there is a causal connection between his disability and the January, 2009, work injury.

We find the ALJ committed error when the claimant's request to reopen was dismissed on the grounds that the causation of his current symptoms had been previously adjudicated against him.

Section 8-43-303(1) provides that an ALJ may reopen a claim on the ground of "fraud, an overpayment, and error, a mistake, or a change in condition." Here, the ALJ determined a reopening based upon a change of condition was not possible as a legal matter because of issue preclusion. The ALJ found the same parties had previously litigated the issue of the relationship of the work injuries to any symptoms post MMI and it had been decided there was no connection. That had been the determination of the DIME physician and the claimant's attempt to overcome that determination had been unavailing. Since the claimant was now challenging the previous judicial resolution of that same issue, his challenge was found to be barred and could not now serve as the basis for a reopening.

Because the ALJ's authority in regard to reopening is discretionary, we may not interfere with the ALJ's decision to deny a petition to reopen unless the ALJ's rule constitutes an abuse of discretion. *Renz v. Larimer County School District Poudre R-1, supra; Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). An abuse of discretion is not shown unless the ALJ's order is beyond the bounds of reason, as where it is unsupported by the evidence or is contrary to the applicable law. *Coates Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1994). However, the claimant is pursuing not solely an argument that his condition has changed. He is contending there was an error or mistake. He argues the DIME physician was mistaken in her conclusion he had returned to baseline at the point of MMI and that his condition no longer was affected by his work injury.

In our view *Berg v. Industrial Claim Appeals Office* 128 P.3d 270 Colo. App. 2005) is controlling. In *Berg* the court determined that a finding of maximum medical improvement by the DIME physician could be reopened based on a mistake of fact. We note that the argument advanced by the respondents, is similar to an argument made by the respondents in *Berg*. In *Berg* the respondents argued that the claimant was, in effect,

challenging the FAL and the DIME physician's determination of maximum medical improvement, but that he had not followed the statutory requirements. In *Berg* the Panel accepted the respondents' argument and therefore determined that claimant was precluded from circumventing the conclusive effect of the DIME by seeking to reopen the determination of MMI. However, the court of appeals reversed the Panel and concluded that because the power to reopen is discretionary, there is an inherent protection against improper collateral attacks on a DIME determination of MMI. The court noted the reopening statute was designed to apply even in these circumstances where the determination of the DIME physician is sought to be questioned:

A mistake in diagnosis has previously been held sufficient to justify reopening. *See Standard Metals Corp. v. Gallegos*, 781 P.2d 142 (Colo.App.1989)(under circumstances where there is a mistake in diagnosis because the medical technology available to the treating physician at the time of the initial order is limited, a petition to reopen based on a mistake of fact may properly be granted).

At the time a final award is entered, *available medical information may be inadequate*, a diagnosis may be incorrect, or a worker may experience an unexpected or unforeseeable change in condition subsequent to the entry of a final award. When such circumstances occur, § 8-43-303 provides recourse to both the injured worker and the employer by giving either party the opportunity to file a petition to reopen the award. The reopening provision, therefore, reflects a legislative determination that in 'worker's compensation cases the goal of achieving a just result overrides the interest of litigants in achieving a final resolution of their dispute.' *Standard Metals Corp. v. Gallegos, supra*, 781 P.2d at 146 (quoting *Grover v. Indus.Comm'n*, 759 P.2d 70

(Colo.1988). Further, as stated in 8 A. Larson, *Larson's Workers' Compensation Law* § 131.05 [2] [b], at 131-62 (2004):

[T]he desirability of preserving a right to reopen for genuine mistake seems too self-evident for argument. In the nature of things, there are bound to be many occasions when even the most thorough and [skillful] diagnosis misses some hidden compensable condition. Should the claimant then be penalized because of an erroneous disposition, either by award or settlement, when the only fault lies in the imperfections of medical science?

Berg, supra at 273 (emphasis in original).

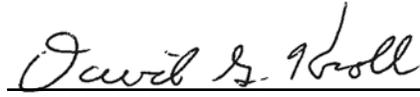
Accordingly, the ALJ's dismissal of the petition to reopen premised on the ground that the previous DIME determination of causation had been judicially affirmed is inconsistent with the goal and import of § 8-43-303(1). *See Krauth v. Great West Life*, W.C. No. 4-744-278 (Sept. 25, 2009). The ALJ's order granting summary judgment and dismissing the request to reopen on this basis is set aside.

The question of whether the DIME physician made an erroneous conclusion that the claimant was at MMI, that the claimant's condition of disability was not related to the work injury, or that the claimant would not need any future medical treatment caused by his work injury is one of fact for determination by the ALJ. *See Industrial Commission v. Canfield*, 172 Colo. 18, 469 P.2d 737 (1970). The claimant raised these factual issues before the ALJ, who erred by not making corresponding findings. It is therefore necessary to remand this matter to the ALJ for further proceedings to determine whether the DIME did commit an error or mistake in his findings pertinent to MMI or the cause of the disability, and the probable compensable nature of the injuries at issue. Whether the ALJ needs to consider any additional issues for hearing endorsed by the parties depends on his resolution of the compensability of the claim for further benefits.

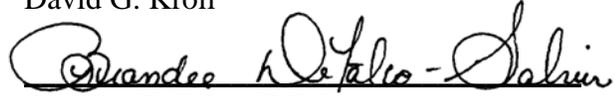
IT IS THEREFORE ORDERED that the ALJ's order dated June 17, 2015, is set aside and this matter is remanded to the ALJ for additional findings and a new decision, accordingly.

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INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Brandee DeFalco-Galvin

DAVID VALDEZ
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CERTIFICATE OF MAILING

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

_____ 11/03/2015 _____ by _____ KG _____ .

DAVID VALDEZ, 5777 WEST ALAMO DRIVE, LITTLETON, CO, 80123 (Claimant)
ZURICH AMERICAN INSURANCE COMPANY, Attn: BEA CALVERT, C/O:
GALLAGHER BASSETTSERVICES, INC., P O BOX 4068, ENGLEWOOD, CO, 80155-4068
(Insurer)
THOMAS, POLLART & MILLER, LLC, Attn: BRAD J MILLER, ESQ., 5600 S QUEBEC
STREET, SUITE 220-A, GREENWOOD VILLAGE, CO, 80111 (For Respondents)
DAVID VALDEZ, 15241 E. RADCLIFF DRIVE, AURORA, CO, 80015 (Other Party)
ALJ EDWIN L. FELTER, JR., c/o OFFICE OF ADMINISTRATIVE COURTS, ATTN:
RONDA MCGOVERN, 1525 SHERMAN STREET, 4TH FLOOR, DENVER, CO 80203

15CA0697 Precision Home v ICAO 10-22-2015

COLORADO COURT OF APPEALS

DATE FILED: October 22, 2015
CASE NUMBER: 2015CA697

Court of Appeals No. 15CA0697
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-938-822-02

Precision Home Buildings, LLC,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado and Venancia De La Paz Herrera,

Respondents.

ORDER AFFIRMED

Division VII
Opinion by JUDGE MILLER
Ashby and Márquez*, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(f)
Announced October 22, 2015

David K. Williams, Jr., Denver, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

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

In this workers' compensation proceeding, respondent, Precision Home Buildings, LLC (Precision) seeks review of the final order of the Industrial Claim Appeals Office (Panel) setting aside that portion of the administrative law judge's (ALJ) order that determined it was not a statutory employer and not liable for Venancio De La Paz Herrera's (claimant) benefits. We affirm the Panel's order.

I. Background

Conceptos Painting and Remodeling, Inc. (Conceptos), also a respondent, hired claimant as a laborer and painter. On July 10, 2012, claimant sustained compensable injuries when he fell off a ladder while painting a house's interior. Precision had hired Conceptos in mid-2012, to paint the newly constructed house. When Precision hired Conceptos, Conceptos provided it with a false workers' compensation certificate of insurance. It was undisputed that Conceptos was an uninsured employer.

Precision hires contractors for home building and remodeling. It also invests in oil and gas wells, fire safety companies, and "fix and flip" homes. Precision and its two co-owners do not perform any actual construction work and serve only as a broker or general

contractor between the homeowner, who is its client, and individual contractors who perform different parts of the construction work on the homes.

Following a contested evidentiary hearing on compensability, temporary disability, medical benefits, and penalties for an uninsured employer, the ALJ found, as relevant here, that Precision did not have workers' compensation insurance. The ALJ also found that specialized painting work was not part of Precision's regular business operations, and would not ordinarily be performed by Precision's two co-owners. The ALJ determined that the evidence established Precision exercised no control over the painters or Conceptos and that claimant failed to show painting to be an integral part of Precision's total business operation. The ALJ concluded, therefore, that Precision did not meet the test for statutory employer and was not liable for benefits.

On review, the Panel determined that the ALJ had erred in relying on the facts that Precision did not actually perform any of the contracting work, such as painting, and that it had other business interests outside of its general contracting services. The Panel reasoned that such facts were not dispositive. The Panel

observed that neither party disputed the ALJ's finding that Precision was hired to build a house and that, as part of the house's construction, it had hired Conceptos to do the painting. Based on that finding, the Panel concluded that painting the house was a regular part of Precision's business, which, but for the use of subcontractors, it would have had to perform. The Panel determined, therefore, that claimant satisfied his burden of establishing that Precision was a statutory employer and was jointly liable with Conceptos for the benefits due him.

II. Statutory Employer

Precision contends that the Panel erred when it set aside the ALJ's order and found that it qualified as a statutory employer for purposes of workers' compensation liability. Precision argues that determining whether a person or entity qualifies as a statutory employer is generally a factual question for the ALJ, whose resolution of that question may not be overturned if substantial evidence supports it. Because we conclude that the ALJ misapplied the "regular business" test in determining that Precision was not a statutory employer, the Panel did not overstep its authority by setting aside that determination.

We must uphold the ALJ’s factual findings if substantial evidence supports them. § 8-43-308, C.R.S. 2015; *Kieckhafer v. Indus. Claim Appeals Office*, 2012 COA 124, ¶ 12. Whether a person or entity has the status of statutory employer is generally a question of fact. *See Thornbury v. Allen*, 991 P.2d 335, 339 (Colo. App. 1999). However, where the facts are undisputed, the ALJ’s determination of that status from the undisputed facts is a question of law that we review de novo. *See Newsom v. Frank M. Hall & Co.*, 101 P.3d 1107, 1110 (Colo. App. 2004), *rev’d on other grounds*, 125 P.3d 444 (Colo. 2005).

Under the Workers’ Compensation Act, an injured employee receives compensation from his or her employer without regard to negligence, while the employer gains immunity from common law negligence liability. *Finlay v. Storage Tech. Corp.*, 764 P.2d 62, 63 (Colo. 1988). This reciprocal arrangement exists even if the employer is not the injured worker’s direct employer, so long as the employer qualifies as a statutory employer. *Humphrey v. Whole Foods Mkt. Rocky Mountain/Sw. L.P.*, 250 P.3d 706, 708-09 (Colo. App. 2010). Thus, if the immediate employer is uninsured, the injured worker becomes the “employee” of the contracting employer,

who is directly liable for the injury. *See Herriott v. Stevenson*, 172 Colo. 379, 382, 473 P.2d 720, 722 (1970). The statutory employer scheme prevents employers from evading compensation coverage by contracting out work instead of directly hiring the worker. *Curtiss v. GSX Corp.*, 774 P.2d 873, 874 (Colo. 1989); *M & M Mgmt. Co. v. Indus. Claim Appeals Office*, 979 P.2d 574, 577 (Colo. App. 1998).

Section 8-41-401(1)(a)(I), C.R.S. 2015, provides that a company that contracts out any part of its business to a subcontractor is deemed an employer for purposes of workers' compensation. *Newsom*, 101 P.3d at 1110. Section 8-41-401(1)(a)(III) then defines a "statutory employer" as an employer responsible for paying workers' compensation benefits under subparagraph (1)(a)(I).

The test for determining whether an alleged employer is a statutory employer is whether the work contracted out is part of the employer's "regular business" as defined by its total business operation. *See Krol v. CF & I Steel*, 2013 COA 32, ¶ 25; *Thornbury v. Allen*, 39 P.3d 1195, 1198 (Colo. App. 2001). The test requires an ALJ to consider the elements of routineness, regularity, and the importance of the contracted service to the regular business of the

employer. *Finlay*, 764 P.2d at 67. An employer is a statutory employer if the services the employee provides are part of the employer's regular business such that, if they were not provided by the subcontractor, the employer's own employees would have to provide them. *Id.* at 66; *Humphrey*, 250 P.3d at 710.

We agree with the Panel that the ALJ incorrectly concluded that, under the regular business test, the fact that Precision had no employees and that it engaged in business endeavors unrelated to its construction and remodeling services meant that it was not a statutory employer. As the Panel discussed, the correct focus was on the fact that painting comprised part of the house building job Precision was hired to do, and that, whether or not it used subcontractors, it retained responsibility to have the painting accomplished. Although Precision's co-owners regularly contracted out all painting work, no evidence supported the ALJ's finding that interior house painting was "specialized." Nor was there evidence supporting any inference that the residential home project was unique or somehow outside Precision's usual building or remodeling projects. Therefore, based on the undisputed facts here,

the ALJ erred in determining that claimant's painting work did not constitute part of Precision's regular business operations.

Precision argues that the ALJ's decision was correct because it had been informed that it did not need workers' compensation insurance because it had no employees. However, Precision only points to the testimony of one of its co-owners, who simply indicated that he understood there was no reason to have such insurance if you had no employees, and nobody to protect. Precision has provided no authority showing it was not legally obligated to carry workers' compensation insurance, or other proof showing it received incorrect advice. Its understanding does not change its legal responsibilities under the Act.

Further, because the operative facts were undisputed, the Panel appropriately reviewed this matter under the *de novo* standard of review.

III. Joint and Several Liability

Although Precision also challenges the Panel's decision holding it jointly and severally liable with Conceptos, it advances no argument on that issue. Consequently, we need not address it. *See Holley v. Huang*, 284 P.3d 81, 87 (Colo. App. 2011) (bald assertions

of error lacking meaningful explanation violate C.A.R. 28(a)(4) and will not be addressed on appeal).

The order is affirmed.

JUDGE ASHBY and JUDGE MÁRQUEZ concur.

VIRGINIA:

BEFORE THE SECOND DISTRICT SUBCOMMITTEE
OF THE VIRGINIA STATE BAR

IN THE MATTER OF
JOHN GEORGE CRANDLEY

VSB Docket No. 14-021-099622

SUBCOMMITTEE DETERMINATION
(PUBLIC REPRIMAND WITHOUT TERMS)

On October 07, 2015 a meeting was held in this matter before a duly convened Second District Subcommittee consisting of Dennis T. Lewandowski, chair, Kenneth N. Whitehurst, III, and Dennis M. Wance. During the meeting, the Subcommittee voted to approve an agreed disposition entered into by the Virginia State Bar, by M. Brent Saunders, Assistant Bar Counsel, and John George Crandley, Respondent, and Louis Napoleon Joynes, II, Esquire, counsel for Respondent, for a Public Reprimand Without Terms pursuant to Part 6, § IV, ¶ 13-15.B.4. of the Rules of the Supreme Court of Virginia.

WHEREFORE, the Second District Subcommittee of the Virginia State Bar hereby serves upon Respondent the following Public Reprimand Without Terms:

I. FINDINGS OF FACT

1. At all times relevant hereto, Respondent was licensed to practice law in the Commonwealth of Virginia.
2. The complainant, John E. Basilone (“Basilone”), has been licensed to practice law in the Commonwealth of Virginia since 1988.
3. Basilone represented Danny L. Reed (“Reed”), the plaintiff in a personal injury case filed in the Chesapeake Circuit Court in 2012 (*Danny L. Reed v. Alisha N. Williams and Amanda D. Volk*, Case No. CL12-1678). The case arose from a 2010 motor vehicle accident in which Reed was a passenger in a vehicle being driven by defendant Amanda D. Volk (“Volk”) whom Respondent represented in the case.
4. Depositions of Reed and Volk were conducted in the case on May 28, 2014, at Basilone’s office. Present for the deposition session were Basilone, his law partner J. Russell Fentress, IV,

Reed, Volk, attorney Suzanne B. Teumer (counsel for the Uninsured Motorist carrier served in the case), and a court reporter.

During the deposition session, Respondent engaged in the following conduct:

- Before the start of the depositions, Respondent called Reed's case "crap;"
- Following Basilone's deposition of Volk, Respondent told Basilone he had only asked three pertinent questions during the 45-minute deposition and again referred to the case as "crap;"
- Prior to the start of Respondent's deposition of Reed, Respondent told Basilone he needed to remove his file out of the view of Reed during his deposition. When Basilone declined and explained he was not required to do so, Respondent angrily stated Basilone's position was "nonsense" and "baloney." After further colloquy on the subject, Respondent angrily and sarcastically stated to Basilone "[o]h, I'm sorry if I hurt your feelings" and sarcastically asked if some water would make him feel better; and
- During Respondent's deposition of Reed while impeaching Reed on the accuracy of information he had provided to a health care provider, Respondent stated he was "enjoying this." When Basilone objected, Respondent condescendingly stated to Basilone that he always has to tell him everything twice.

II. NATURE OF MISCONDUCT

Such conduct by Respondent constitutes misconduct in violation of the following provisions of the Rules of Professional Conduct:

RULE 3.4 Fairness To Opposing Party And Counsel

A lawyer shall not:

(j) File a suit, initiate criminal charges, assert a position, conduct a defense, delay a trial, or take other action on behalf of the client when the lawyer knows or when it is obvious that such action would serve merely to harass or maliciously injure another.

RULE 4.4 Respect For Rights Of Third Persons

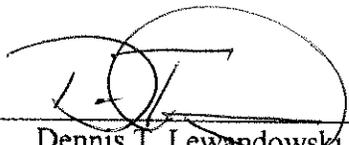
In representing a client, a lawyer shall not use means that have no purpose other than to embarrass, delay, or burden a third person, or use methods of obtaining evidence that violate the legal rights of such a person.

III. PUBLIC REPRIMAND WITHOUT TERMS

Accordingly, having approved the agreed disposition, it is the decision of the Subcommittee to impose a Public Reprimand Without Terms and John George Crandley is hereby so reprimanded.

Pursuant to Part 6, § IV, ¶ 13-9.E of the Rules of the Supreme Court of Virginia, the Clerk of the Disciplinary System shall assess costs.

SECOND DISTRICT SUBCOMMITTEE
OF THE VIRGINIA STATE BAR

By: 
Dennis T. Lewandowski
Chair

CERTIFICATE OF MAILING

I certify that on the 13th day of OCTOBER, 2015, a true and complete copy of the Subcommittee Determination (Public Reprimand Without Terms) was sent by certified mail to John George Crandley, Respondent, at Preston, Wilson & Crandley, PLC, 2404 Potters Rd., Ste. 500, Virginia Beach, VA 23454, Respondent's last address of record with the Virginia State Bar, and by first class mail, postage prepaid to Louis Napoleon Joynes, II, counsel for Respondent, at Joynes, Gaidies, Holadia & Hay, 564 Lynnhaven Parkway, Virginia Beach, VA 23452.


M. Brent Saunders
Assistant Bar Counsel