

# **BROWN BAG SEMINAR**

**Thursday, November 20, 2014**

(third Thursday of each month)

Noon - 1 p.m.

633 17<sup>th</sup> Street

## **12th Floor Conference Room**

**(note different location)**

1 CLE (including .4 ethics)

Presented by

Craig Eley

Manager of Director's Office

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 from

September 11 through November 14, 2014

### **Contents**

#### **Industrial Claim Appeals Office decisions**

Weitzel v. Delta County	2
Whitney v. West Metro Fire Protection	5
Williams v. Colorado Cab	11
Aceves v. Genesis Fixtures	15
Danks v. Rayburn Enterprises	22
Franco v. Denver Public Schools	28
Gebereyes v. Veolia Transportation	37
McMeekin v. Memorial Gardens	43
Meenen v. Boulder County	57
Munoz v. JBS Swift & Co.	64
Osman v. Colorado Cab	71

#### **Colorado Court of Appeals decisions**

Spacecon Specialty Contractors v. Industrial Claim Appeals Office and Ordonez (unpublished)	77
Hoff v. Industrial Claim Appeals Office and Pinnacol	90
Millroy v. Industrial Claim Appeals Office and City of Colorado Springs (unpublished)	131

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-926-816-01

IN THE MATTER OF THE CLAIM OF  
SANDRA WEITZEL,

Claimant,

v.

DELTA COUNTY,

Employer,

and

SELF INSURED,

Insurer,  
Respondent.

ORDER

The respondent seeks review of an order of Administrative Law Judge Mottram (ALJ) dated April 3, 2014, that determined the claimant suffered an occupational disease during the course and scope of her employment, denied the respondent's request for apportionment, and ordered the respondent to pay for reasonable and necessary medical treatment provided by authorized medical providers. We dismiss the petition to review without prejudice.

A hearing was held on a number of the issues including compensability, apportionment pursuant to *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993), and medical benefits. Following the hearing, the ALJ entered an order finding the claimant's claim compensable and making a general award of medical benefits. The ALJ ordered the respondent to pay reasonable and necessary medical treatment provided by authorized providers that are necessary to cure and relieve the claimant from the effects of her occupational disease. The ALJ reserved all matters not determined by the order for future determination.

The respondent has filed a petition to review, raising numerous contentions of error in the ALJ's fact finding, and in his determination that the claimant's carpal tunnel syndrome is related to her employment.

Under §8-43-301(2), C.R.S., a party dissatisfied with an order "which requires any party to pay a penalty or benefits or denies a claimant a benefit or penalty," may file a petition to review. Orders which do not require the payment of benefits or penalties, or deny the claimant benefits or penalties, are interlocutory and not subject to review. *Natkin & Co. v. Eubanks*, 775 P.2d 88 (Colo. App. 1989). Further, orders which determine liability for benefits without determining the amount of benefits, do not award or deny benefits as contemplated by this statute and, therefore, are not subject to review. *Oxford Chemicals, Inc. v. Richardson*, 782 P.2d 843 (Colo. App. 1989); *CF & I Steel Corp. v. Industrial Commission*, 731 P.2d 144 (Colo. App. 1986).

We previously have held that orders determining compensability and containing only a general award of medical benefits are interlocutory, unless the record reveals that specific medical benefits were at issue. *See Gonzales v. Public Service Co. of Colorado*, W.C. No. 4-131-978 (May 14, 1996); *Tilton v. ABC Turf Care*, W.C. No. 3-105-542 (August 18, 1994). Here, the ALJ determined the claimant proved a compensable claim and her entitlement to reasonable and necessary medical benefits. The ALJ, however, did not determine what specific treatment was reasonably necessary. Rather, the ALJ reserved other issues for future determination. Consequently, the order does not award or deny the claimant any particular medical benefit and, is not currently subject to review. *Director of Division of Labor v. Smith*, 725 P.2d 1161 (Colo. App. 1986); *Bollig v. Petco*, W.C. 4-625-226 (October 19, 2005).

**IT IS THEREFORE ORDERED** that the respondent's petition to review the ALJ's order dated April 3, 2014, is dismissed without prejudice.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



Kris Sanko

SANDRA WEITZEL  
W. C. No. 4-926-816-01  
Page 3

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 8/20/2014 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

SANDRA WEITZEL, 650 LEON STREET, DELTA, CO, 81416 (Claimant)  
DELTA COUNTY, C/O: BILL BEVER, 501 PALMER #227, DELTA, CO, 81416 (Employer)  
SELF INSURED, Attn: DEBBIE MCDERMOT, C/O: CTSI, 800 GRANT ST #400, DENVER,  
CO, 802013 (Insurer)  
WITHERS SEIDMAN RICE & MUELLER PC, C/O: SEAN E P GOODBODY ESQ, 101  
SOUTH THIRD ST STE 265, GRAND JUNCTION, CO, 81501 (For Claimant)  
DWORKIN CHAMBERS WILLIAMS YORK BENSON & EVANS PC, C/O: DAVID  
DWORKIN ESQ MARY B PUCELIK ESQ, 3900 EAST MEXICO AVENUE #1300,  
DENVER, CO, 80210 (For Respondents)

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-920-012-01

IN THE MATTER OF THE CLAIM OF

OATFIELD WHITNEY,

Claimant,

v.

**FINAL ORDER**

WEST METRO FIRE PROTECTION  
DISTRICT,

Employer,

and

SELF-INSURED C/O  
COUNTY TECHNICAL  
SERVICES, INC.,

Insurer,  
Respondents.

The claimant seeks review of an order of Administrative Law Judge Cannici (ALJ) dated April 4, 2014, that denied and dismissed the claimant's request for temporary total disability benefits for April 27 and April 28, 2013. We affirm the ALJ's order.

The matter went to hearing on the issue of temporary disability benefits. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant has worked for the respondent employer as a firefighter since 1996. The claimant was admitted to the hospital on April 26, 2013, and was eventually diagnosed with Chronic Lymphocytic Leukemia (CLL). The claimant was scheduled to work on April 27, 2013, and April 28, 2013, but used sick leave because he was unable to work. The claimant received pay for the preceding dates but was charged with two days of sick leave. On May 4, 2013, the employer completed a First Report of Injury reflecting that the claimant's wages would continue pursuant to §8-42-124, C.R.S.

The claimant was also scheduled to work the following dates in 2013; May 3, May 4, May 9, May 10, May 15, May 16, May 21, and May 22. At hearing the claimant explained that he was taken off work due to the CLL and requested temporary total disability benefits for these dates. The ALJ, however, found that during this time period, the claimant had engaged in "trade time agreements" with other firefighters. The trade

time agreements were individual agreements between firefighters to trade shifts so that one firefighter agrees to work for the second firefighter on one day and the second firefighter will work for the first firefighter on another day. Trade time can be used for any reason, whether it's due to a health related issue or simply to take a day off to go skiing. When two firefighters participate in trade time both of them continue to receive regular pay and neither firefighter is charged with any sick leave or vacation time. The trade time agreements result in no impact on the paychecks of either firefighter involved. The employer neither required, requested nor encouraged the claimant to utilize trade time during the period from May 3, 2013, through May 22, 2013, and the claimant's participation was completely voluntary. Since returning to full duty work on June 3, 2013, the claimant has participated in additional trade time agreements and has both covered the shifts of other firefighters and has had other firefighters cover his shift. The claimant did not work and trade time shifts for any of the firefighters who covered his shifts in May of 2013. The claimant testified that he did not expect that he would be requested or required to work the shifts for fellow firefighters who covered his shifts between May 3 and May 22, 2013. The employer continued to pay the claimant his full shift salary and did not charge the claimant with any sick or leave or vacation during this time period. Based on these facts, the ALJ concluded that the claimant was not entitled to temporary total disability benefits because he did not sustain a wage loss. The claimant specifically does not appeal the ALJ's denial of temporary disability benefits during this time period.

The ALJ went on to hold that the claimant was not entitled to temporary disability benefits for April 27 and April 28, 2013. Although the employer erroneously charged the claimant with sick time (*see* §8-42-124(4), C.R.S., claimant's right to receive temporary disability benefits is reinstated if the employer charges the claimant with earned sick time); Tr. at 6 (documenting stipulation), the claimant was not entitled to temporary disability benefits for these two days pursuant to §8-42-103(1), C.R.S. This statute provides that the claimant is entitled to recover temporary disability benefits from the first day the claimant leaves work, only if the period of disability lasts longer than two weeks. The ALJ determined that the claimant had not been disabled for longer than two weeks because he continued to be paid his regular wages. The claimant, therefore, was not entitled to temporary disability benefits for April 27 and April 28, 2013.

The only issue on appeal is the claimant's entitlement to temporary disability benefits for April 27 and April 28, 2013. The claimant contends the ALJ misapplied the three-day waiting period in §8-42-103(1), C.R.S., and argues that because he was restricted from working, he was, "disabled" for longer than two weeks and was entitled to temporary disability benefits despite receiving his full wages for the relevant time period. We are not persuaded the ALJ erred.

In our view, the ALJ used the proper analysis in deciding whether the claimant was entitled to temporary disability benefits for April 27<sup>th</sup> and 28<sup>th</sup>. Section 8-42-103(1)(b), C.R.S., provides that the period of disability must last longer than two weeks, and only then is the disability indemnity "recoverable from the day the injured employee leaves work." The term "disability" as it is used in workers' compensation connotes two distinct elements. The first element is "medical incapacity" evidenced by loss or restriction of bodily function. The second element is loss of wage-earning capacity as demonstrated by the claimant's inability "to resume his or her prior work." *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999); *Hendricks v. Keebler Co.*, W.C. No. 4-373-392 (June 11, 1999). We agree with the ALJ's conclusion that the claimant's "disability" here was not longer than two weeks because he continued to receive his regular wages.

The claimant argues that it is enough under the statute to show that the claimant was physically unable to work even though he was paid wages. We disagree. Section 8-42-103(1), C.R.S. sets forth the claimant's general right to recover temporary disability benefits for the injury. However, §8-42-103(1), C.R.S. expressly states that the right to disability benefits is "subject to" the limitations in subsections (1)(a) through (1)(f). Subsections 1(a) and (b), relevant here, provide in pertinent part:

- (1) If the injury or occupational disease causes disability, a disability indemnity shall be payable as wages pursuant to section 8-42-105(2)(a) subject to the following limitations:
  - (a) If the period of disability does not last longer than three days from the day the injured employee leaves work as a result of the injury, no disability indemnity shall be recoverable...
  - (b) If the period of disability lasts longer than two weeks from the day the injured employee leaves work as a result of the injury disability indemnity shall be recoverable from the day the injured employee leaves work.

To establish an entitlement to temporary disability benefits, the claimant must prove that the industrial injury caused a disability, that he left work as a result of the disability, that he was disabled for more than three regular work days, and that he suffered an actual wage loss. Section 8-42-103(1)(b), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995); *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The period of temporary disability is measured from the day after the employee leaves work as a result of the injury. *See Ralston Purina-Keystone v. Lowry*, 821 P.2d 910 (Colo. App. 1991).

Temporary disability benefits are designed to replace the claimant's actual lost wages during the period he is recovering from the industrial injury. *Broadmoor Hotel v. Industrial Claim Appeals Office*, 939 P.2d 460 (Colo. App. 1996); *PDM Molding, Inc. v. Stanberg, supra*; *Mesa Manor v. Industrial Claim Appeals Office*, 881 P.2d 443 (Colo. App. 1994). We agree with the ALJ that a claimant is not considered “disabled” for purposes of recovering temporary disability benefits if the claimant does not sustain a wage loss from his injury. *See Atencio v. JBQ Allen, Inc.* W.C. No. 4-350-555 (May 19, 2000); *See Matus v. David Matus* W.C. No. 4-740-062 (July 13, 2010)(claimant not entitled to temporary disability benefits where the claimant’s business and financial records supported findings that the claimant did not suffer any actual wage loss); *Hendricks v. Keebler Company, supra* (temporary disability benefits precluded during the time the claimant performed modified duty and earned pre-injury wage.)

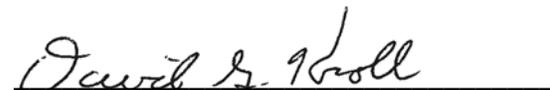
Here, the ALJ found, and the claimant does not contest, that he did not sustain a wage loss during May 2013. The only days the claimant did not receive regular wages were April 27 and April 28. The claimant was “disabled” for purposes of determining entitlement to temporary disability benefits for these two days. However, because the claimant’s period of disability has not yet exceeded two weeks, the first three days are not paid and the claimant is not entitled to temporary disability benefits for April 27 and April 28. Section 8-42-103(1)(a) and (b), C.R.S. We perceive no error in the ALJ’s application of §8-42-103(1).

Additionally, although not raised by either party, we note that the admission filed by the respondent and the subsequent pleadings filed in this case indicate that the admitted date of onset of disability is May 2, 2013. Consequently, the claimant is not entitled to temporary disability prior to the date of onset. *See SCI Manufacturing v. Industrial Claim Appeals Office*, 879 P.2d 470 (Colo. App. 1994)(an occupational disease is not compensable until the "onset of disability.") Moreover, we are unable to determine from the order and the record on appeal whether the claimant has sustained an injury in fact and has standing to bring the appeal. The respondent stipulated that the sick days on April 27 and April 28 will “count towards TTD,” and from the paystubs submitted into evidence, it appears that the claimant was paid his full wages for the days in question. The ALJ also found that the employers’ First Report of Injury reflected that the claimant’s wages will continue pursuant to an §8-42-124, C.R.S. Under these circumstances it does not appear that the claimant is owed any benefits, even if temporary disability benefits were to be awarded for April 27 and 28. If this is indeed the case, the claimant has not sustained an injury in fact and lacks standing to appeal. *See Ainscough v. Owens*, 910 P.3d 851, 855 (Colo. 2004)(standing is premised on the presence of an actual injury to the interests of the appealing party).

**IT IS THEREFORE ORDERED** that the ALJ's order dated April 4, 2014 is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

  
Brandee DeFalco-Galvin

  
David G. Kroll

OATFIELD WHITNEY

W.C. 4-920-012-01

Page 7

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 8/27/2014 \_\_\_\_\_ by \_\_\_\_\_ KG \_\_\_\_\_ .

OATFIELD WHITNEY, 7414 E COSTILLA PLACE, CENTENNIAL, CO, 80012 (Claimant)

WEST METRO FIRE PROTECTION DISTRICT, 485 S ALLISON PARKWAY,

LAKEWOOD, CO, 80216 (Employer)

SELF INSURED c/o CTSI, Attn: LESLIE CAVANAUGH, 800 GRANT ST STE 400,

DENVER, CO, 80203 (Insurer)

LAW OFFICE OF O'TOOLE & SBARBARO PC, C/O: NEIL D O'TOOLE ESQ, 226 WEST

12TH AVE, DENVER, CO, 80204 (For Claimant)

DWORKIN CHAMBERS WILLIAMS YORK BENSON & EVANS PC, C/O: C SANDRA

PYUN ESQ, 3900 E MEXICO AVE STE 1300, DENVER, CO, 80210 (For Respondents)

# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-920-621-01

IN THE MATTER OF THE CLAIM OF

MORGAN WILLIAMS,

Claimant,

v.

FINAL ORDER

COLORADO CAB d/b/a  
DENVER YELLOW CAB,

Employer,

and

OLD REPUBLIC C/O SEDGWICK CMS,

Insurer,  
Respondents.

The pro se claimant seeks review of an order of Administrative Law Judge Lamphere (ALJ) dated March 5, 2014, that ordered his claim for compensation dismissed. We affirm the order of the ALJ.

A hearing was held on the issue of compensability, eligibility for temporary total disability benefits and medical benefits. After hearing, the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant is a cab driver for the employer. The claimant testified he had a regular customer in the person of Merl Mitchell. On May 22, 2013, the claimant and Mr. Mitchell drove around the Denver metro area for several hours with the meter off. The two then stopped off at Tequila's Restaurant for tacos and tequila. Mr. Mitchell expressed an interest in traveling to Paonia, Colorado, to view some land he owned and to rest for several days. The two picked up another, unnamed, passenger and the claimant's dog and set off for Paonia. The cab's meter was still off. After the group passed through the Eisenhower tunnel on Interstate 70, the claimant swerved the cab to avoid a rock. The cab went out of control and rolled several times before it came to rest. The claimant and Mr. Mitchell exited through a car window. The second passenger fled the scene. The claimant was transported to the St. Anthony Summit Medical Center. At the hospital, the claimant was determined to be intoxicated and was treated for several minor injuries. The claimant was then treated at the Concentra Medical Center in Denver. He complained of a left knee injury on May 24. However, X rays were said to be normal and the claimant was released to regular duty. The claimant continued to claim his knee was injured. A subsequent MRI revealed meniscal tears and surgery was recommended. The

respondents denied the compensability of the claim as well as temporary benefits and further medical care.

The respondent employer is a taxi company that provides transportation for fees derived from a meter running in the cab. The employer's witness, Randy Jensen, explained that a meter is used to calculate all fares with the exception of trips to Denver International Airport, the Denver Tech Center and Boulder. Cabs are not allowed to be driven more than 16 miles outside the Denver metro area for the reason that they are fitted with radio transmitting GPS devices which cannot be detected by the employer if driven any further away. The claimant was aware of this policy as it was covered in the orientation training the claimant had completed two months previously. The claimant did not communicate with the employer prior to setting off for Paonia, which is located in Colorado's western slope region. The claimant asserted in his position statement that while he was driving to Paonia off the meter, Mr. Mitchell had agreed to pay him \$500 plus the cost of gasoline for the trip to Paonia.

The ALJ credited the testimony of Mr. Jensen and found the testimony of the claimant unpersuasive. It was determined the claimant and his friend, Mr. Mitchell, were driving to Paonia for a vacation and the claimant was not acting in the course of his occupation as a taxi driver during the trip. Accordingly, the ALJ found the claimant's injuries not compensable. The claimant's request for benefits was denied and dismissed.

On appeal the claimant essentially disputes the evidence and testimony submitted by the respondent and reiterates his version of events. The claimant did not file a brief in support of his petition to review but did make arguments in the petition to review concerning the ALJ's factual findings and credibility determinations. We are not persuaded that the ALJ committed reversible error.

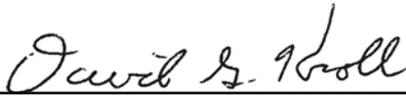
The claimant has the burden to prove a causal relationship between a work-related injury or disease and the condition for which benefits or compensation are sought. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). Whether the claimant sustained his burden of proof is a factual question for resolution by the ALJ. *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). The ALJ's factual determinations must be upheld if supported by substantial evidence and plausible inferences drawn from the record. Section 8-43-301(8), C.R.S. Where, as here, the appealing party fails to procure a transcript of the relevant hearing, we must presume the pertinent findings of fact are supported by substantial evidence. *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988). The ALJ's order here is based in large part on credibility determinations and the ALJ found that the claimant's testimony about the alleged work injury was not credible. Under the substantial evidence standard of review it is the ALJ's sole prerogative to evaluate the credibility of the witnesses and the

probative value of the evidence. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). We may not substitute our judgment for that of the ALJ unless the testimony the ALJ found persuasive is rebutted by such hard, certain evidence that it would be error as a matter of law to credit the testimony. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986). Testimony which is merely biased, inconsistent, or conflicting is not necessarily incredible as a matter of law. *See People v. Ramirez*, 30 P.3d 807 (Colo. App. 2001). Consequently, the ALJ's credibility determinations are binding except in extreme circumstances. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d. 558 (Colo. App. 2000). We perceive no extreme circumstances here.

Although the evidence may have been subject to conflicting inferences, without transcripts, it is presumed that there is substantial evidence in the testimony of the employer's witness to support the ALJ's factual findings and conclusions. Where, as here, the record was subject to conflicting inferences it is left to the ALJ's discretion to resolve those conflicts and to determine the inference to be drawn and we may not substitute our judgment for the ALJ in this regard. *Gelco Courier v. Industrial Commission*, 702 P.2d 295 (Colo. App. 1985).

**IT IS THEREFORE ORDERED** that the ALJ's order dated March 5, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

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

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

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 6/25/2014 \_\_\_\_\_ by \_\_\_\_\_ KG \_\_\_\_\_ .

MORGAN WILLIAMS, 7985 W 51ST AVE, UNIT 1, ARVADA, CO, 80002 (Claimant)  
COLORADO CAB d/b/a DENVER YELLOW CAB, 7500 E 41ST AVE, DENVER, CO,  
80216-4706 (Employer)  
OLD REPUBLIC C/O SEDGWICK CMS, C/O: SHANNON BROWNE, PO BOX 14493,  
LEXINGTON, KY, 40512-4493 (Insurer)  
MOSELEY BUSSEY & APPLETON PC, C/O: SCOTT M BUSSEY ESQ, 300 SOUTH  
JACKSON ST STE 240, DENVER, CO, 80209 (For Respondents)

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-844-271-02

IN THE MATTER OF THE CLAIM OF

JESUS ACEVES,

Claimant,

v.

GENESIS FIXTURES/LEGGETT & PLATT, INC.,

Employer,

and

FIDELITY & GUARANTY INSURANCE COMPANY,

Insurer,

Respondents.

**FINAL ORDER**

The respondents seek review of an order of Administrative Law Judge Felter (ALJ) dated April 22, 2014, that determined the claimant had a reasonable excuse for filing his claim for compensation more than two years but fewer than three years after his date of injury and, therefore, ordered that his claim for compensation and benefits was not barred by the statute of limitations under §8-43-103(2), C.R.S. We affirm.

The ALJ found that the claimant worked as an assembler for the respondent employer when he bent over to pick up cut pallets and felt his lower back pop when straightening. The claimant verbally notified the respondent employer of a lower back sprain or strain on December 17, 2010. The claimant did not indicate whether he was claiming indemnity benefits.

The claimant was treated at Concentra, where Dr. Pineiro became his authorized treating physician. Dr. Pineiro authored a report which opined that the claimant's back pain/strain was work-related. Dr. Pineiro administered a Toradol injection, recommended physical therapy, and assigned a lifting and pushing restriction. Dr. Pineiro prescribed medications and notified the employer's human relations representative of the diagnosis, treatment, plan, and injury.

JESUS ACEVES

W. C. No. 4-844-271-02

Page 2

The respondent employer filed an Employer's First Report of Injury on December 21, 2010. The report included the nature of the claimant's work related injury, but did not indicate whether the claimant was claiming indemnity benefits.

Thereafter, on December 22, 2010, the claimant followed up with Dr. Pineiro. Dr. Pineiro noted that the claimant had not been working because his company had closed. Dr. Pineiro also noted that the claimant was worried because he did not understand the workers' compensation process.

On January 5, 2011, the respondents filed a Notice of Contest, citing the need for further investigation to determine compensability. The Notice also stated that treatment would continue with the workers' compensation doctor until a determination of compensability was made.

Dr. Wunder saw the claimant on January 19, 2011, and diagnosed a lumbar strain, possible sacroilitis, and multilevel lumbar degenerative disk disease. He recommended the claimant continue physical therapy and referred him to a chiropractor for treatment.

Dr. Pineiro followed up with the claimant, and prepared a report dated February 6, 2011, and addressed it to the insurer's claims adjuster. Dr. Pineiro stated that she believed that the claimant's December 17, 2010, injury aggravated his asymptomatic condition, and that any aggravation is considered work related.

The respondents subsequently filed a second Notice of Contest on March 28, 2011, stating that the claimant's injury/illness was not work related. The respondents' Notice of Contest was based on a second report of Dr. Wunder which opined that the claimant's claim was not work related.

In September 2011, the claimant determined that the nature and severity of his condition required that he consult legal counsel. The claimant consulted different attorneys, but was unsuccessful at retaining counsel. Then, on December 4, 2012, two weeks less than two years from the date of the original injury of December 17, 2010, the claimant's present counsel entered his appearance.

Subsequently, on May 17, 2013, the claimant filed an application for hearing, listing average weekly wage and TTD as issues. At no time prior to this, did the claimant file a Worker's Claim for Compensation.

After the hearing, the ALJ found that the negligence of the claimant's counsel in failing to file a claim within the two week window before the two year statute of limitations was exceeded, established that the claimant had a reasonable excuse for failing to timely file his claim under §8-43-103(2), C.R.S. The ALJ also found that the claimant gave notice of a claimed lost time injury within three years by virtue of his counsel filing an Application for Hearing on May 17, 2013. The ALJ therefore concluded that the claimant gave notice of his claim before expiration of the extended three year period enunciated in §8-43-103(2), C.R.S. The ALJ also found that there was no credible evidence that the respondent employer was prejudiced by the claimant's delayed filing of notice of a lost time injury. The ALJ specifically reasoned that the respondents' actions from the outset revealed that they were treating the claimant's situation as a lost time claim. The ALJ found that the employer filed a First Report of Injury shortly after the December 17, 2010, incident, and filed two Notices of Contest.

On appeal, the respondents argue that the claimant's claim is barred by the statute of limitations enunciated in §8-43-103(2), C.R.S. The respondents contend that the ALJ erred in determining the claimant had shown a reasonable excuse for his failure to file the claim within two years. The respondents argue that ignorance of the law regarding the compensability of the claimant's claim does not toll the statute of limitations. The respondents also contend that they were prejudiced by the claimant's delay in filing his claim. Under the particular circumstances of this case, we conclude that the ALJ did not abuse his discretion in determining that the claimant's claim is not time-barred under §8-43-103(2), C.R.S.

Section 8-43-103(2), C.R.S., provides in pertinent part as follows:

. . . [T]he right to compensation and benefits provided by said articles shall be barred unless, within two years after the injury or after death resulting therefrom, a notice claiming compensation is filed with the division. This limitation shall not apply to any claimant to whom compensation has been paid or if it is established to the satisfaction of the director within three years after the injury or death that a reasonable excuse exists for the failure to file such notice claiming compensation and if the employer's rights have not been prejudiced thereby, and the furnishing of medical, surgical, or hospital treatment by the employer shall not be considered payment of compensation or benefits within the meaning of this section; but, in all cases in which the employer has been given notice of an injury and fails, neglects, or refuses to report said injury to the division as required by the provisions of said articles, this statute of limitations shall not begin to run

against the claim of the injured employee or said employee's dependents in the event of death until the required report has been filed with the division.

Initially, we agree with the respondents that a claimant's mistake or ignorance concerning the time period for filing his claim, is not an excuse for his failure to file within the applicable statute of limitations. A claimant is presumed to know his legal rights, and a mistake in this regard does not constitute an excuse for filing a claim after the statute of limitations has run. *See Paul v. Industrial Commission*, 632 P.2d 638 (Colo. App. 1981)(parties are presumed to know the law); *Ramos v. Sears Roebuck Co.*, W.C. No. 4-156-827 (February 10, 1994). Thus, a claimant's misunderstanding of his legal rights does not provide a basis for establishing a "reasonable excuse" for extending the statute of limitations under §8-43-103(2), C.R.S. *Patt v. City of Wheat Ridge*, W.C. No. 4-180-739 (July 24, 1997).

Our Colorado Supreme Court previously has held, however, that the negligence of a claimant's attorney can constitute a "reasonable excuse" for not filing a timely claim for compensation. *State Compensation Insurance Fund v. Foulds*, 167 Colo. 123, 445 P.2d 716 (1968). The ALJ has wide discretion in determining whether the claimant presented a "reasonable excuse" for failure to file a claim within the two year statute of limitations. Further, a determination that the claimant has a reasonable excuse will not be set aside except on a showing of fraud or abuse of discretion. *Industrial Commission v. Canfield*, 172 Colo. 18, 469 P.2d 737 (1970). The appellate standard on review of an alleged abuse of discretion is whether the ALJ's order exceeds the bounds of reason. *See Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993).

Under the particular circumstances here, we cannot say the ALJ abused his discretion in finding that the failure of the claimant's counsel to file a claim within the applicable two year statute of limitations constituted a "reasonable excuse" thereby extending the statute to three years. Section 8-43-103(2), C.R.S. The ALJ found, with record support, that prior to the expiration of the two year statute enunciated in §8-43-103(2), C.R.S., the claimant recognized the nature and severity of his condition and consulted with other attorneys before retaining his present counsel. Tr. (March 24, 2014) at 21-23, 37. The claimant's present counsel entered his appearance on December 4, 2012, which is less than two years from the date of the claimant's injury of December 17, 2010. Consequently, at the time the claimant retained his present counsel, he had two weeks within which to file a claim, but this did not happen. Instead, the claimant's counsel filed an Application for Hearing on May 17, 2013, which was filed more than two years but less than three years after the claimant's date of injury. We conclude that this constitutes substantial evidence to support the ALJ's finding of a reasonable excuse

JESUS ACEVES

W. C. No. 4-844-271-02

Page 5

under §8-43-102(2), C.R.S. *See Butler v. Memorial Gardens Cemetery*, W.C. No. 4-589-950 (Nov. 9, 2005); §8-43-301(8), C.R.S.

Additionally, the respondents' argument notwithstanding, we do not view the holding in *Emrich v. Jackson Hewitt Tax Service*, W.C. No. 4-241-443 (Oct. 27, 1998) as requiring a different result. In *Emrich*, the claimant had hired an attorney to represent her in a personal injury claim and did not file a claim for workers' compensation within the two-year statute of limitations, but did within three years of the injury. The ALJ dismissed the claim, finding that the statute of limitations had run and that the claimant had failed to establish a reasonable excuse for extending the statute by one year. The ALJ expressly relied upon the fact that the Division had sent to the claimant correspondence specifically advising her to "file a notice of claim to preserve her right to benefits." Given that specific advice to the claimant to file a claim in order to preserve her rights, the ALJ reasonably could have inferred that any other factors tending to excuse the claimant were overridden by the Division's letter.

The respondents further argue that the ALJ failed to perform a negligence analysis regarding counsel's representation of the claimant, and they also contend that the claimant failed to present any evidence of his counsel's negligence. Contrary to the respondents' argument, however, we do not view the record as being devoid of analysis or evidence. The ALJ is not held to a standard of absolute clarity when issuing findings of fact and conclusions of law. It is only necessary that the basis of the order is apparent from the findings which are entered. When considering an order, we may note findings which, although not expressly contained in the order, are necessarily implied by it. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.2d 385 (Colo. App. 2000). As detailed above, the ALJ found that prior to the running of the two year statute of limitations, the claimant consulted with other attorneys, and then found his present counsel, who had entered his appearance two weeks prior to expiration of the two year statute of limitations. Tr. (March 24, 2014) at 21-23, 37. The ALJ found that counsel did not file a Worker's Claim for Compensation within this time frame, but, rather, waited until May 17, 2013, to file an Application for Hearing. This finding makes it clear that it was the failure of the claimant's counsel to file a claim prior to expiration of the two year statute, which constituted the basis of the ALJ's finding of a reasonable excuse.

The respondents also argue that they have been prejudiced by the claimant's delay in filing his claim. They argue that the timely filing of a claim would have resulted in a prompt decision on compensability. According to the respondents, had the claim been found compensable at an earlier date, then medical treatment could have been rendered, thereby possibly avoiding the need for surgery, which is now being considered. As noted

JESUS ACEVES

W. C. No. 4-844-271-02

Page 6

above, however, the ALJ expressly found that the respondents failed to establish by a preponderance of the evidence that they had been prejudiced by the claimant's failure to file a claim within the two year statute of limitations under §8-43-301(2), C.R.S. We agree with the ALJ that the respondents' actions from the outset demonstrate that they were treating the claimant's December 17, 2010, injury as though it were a lost time injury. The respondents filed two Notices of Contest, one on January 5, 2011, and the other on March 28, 2011. The respondents' January 5, 2011, Notice of Contest specifically provides that liability was being contested so that they could conduct further investigation to determine compensability. The respondents' mere speculation or the possibility of how they could be prejudiced does not warrant a reversal of the ALJ's order. *Cf. Youngs v. White Moving & Storage, Inc.*, W.C. No. 4-648-693 (Jan. 24, 2012)(quoting *People v. Rodriguez*, 209 P.3d 1151, 1162 (Colo. App. 2008) for proposition that more than mere speculation concerning the possibilities of prejudice must be demonstrated to warrant reversal) *aff'd Youngs v. Industrial Claim Appeals Office*, 316 P.3d 50 (Colo. App. 2013); *cf. Industrial Commission v. Havens*, 136 Colo. 111, 314 P.2d 698 (1957)(awards cannot be denied as the result of speculation or conjecture, nor upon evidence not in record). Consequently, we will not disturb the ALJ's order on this ground.

**IT IS THEREFORE ORDERED** that the ALJ's order dated April 22, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



Kris Sanko

JESUS ACEVES  
W. C. No. 4-844-271-02  
Page 8

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 11/14/2014 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

THE LAW FIRM OF JESS PEREZ, P.C., Attn: JESS PEREZ, ESQ., 1717 MADISON AVENUE, #2, LOVELAND, CO, 80538 (For Claimant)  
RITSEMA & LYON, P.C., Attn: ELIOT J. WEINER, ESQ., 999 18TH STREET, SUITE 3100, DENVER, CO, 80202 (For Respondents)

## INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-770-978-01

IN THE MATTER OF THE CLAIM OF

RYAN DANKS,

Claimant,

v.

FINAL ORDER

RAYBURN ENTERPRISES, INC.,

Employer,

and

PINNACOL ASSURANCE,

Insurer,  
Respondents.

The respondents seek review of an order of Administrative Law Judge Allegretti (ALJ) dated April 3, 2014, that denied their request for an offset or credit for combined temporary disability payments and permanent partial disability payments in excess of the applicable \$150,000 statutory cap set forth in §8-42-107.5, C.R.S. We reverse.

The parties presented this case to the ALJ for a decision based upon stipulated facts. Pursuant to the stipulation, the claimant's date of injury is September 15, 2008, and, therefore, benefits payable are subject to the maximum benefits rates in effect for injuries occurring between July 1, 2008, to June 30, 2009. Thus, the claimant's claim is subject to the \$150,000 cap in combined indemnity benefits and a maximum disfigurement award of \$8,348. The respondents previously paid the claimant disfigurement benefits totaling \$300.

The claimant received temporary total disability (TTD) benefits from September 16, 2008, through August 26, 2013, for a total of 258 weeks. The benefits were paid at a rate of \$576.07 per week, so the claimant was paid a total of \$148,626.06 in TTD benefits. The respondents filed a Final Admission of Liability (FAL) on December 13, 2010, admitting liability for permanent partial disability (PPD) benefits totaling \$10,562.46. This amount was paid to the claimant.

RYAN DANKS

W. C. No. 4-770-978-01

Page 2

The ALJ made additional findings of fact. She found that on January 3, 2011, Dr. Castro reported that the claimant was not at maximum medical improvement (MMI) because he was in need of a surgical consultation and possible surgery for his ankle and great toe. On January 19, 2011, the respondents filed a General Admission of Liability, remarking that per the attached report of Dr. Castro, the claimant was not at MMI.

The respondents subsequently filed a FAL dated September 27, 2013, which admitted for TTD benefits from September 16, 2008, through August 26, 2013. The claimant was placed at MMI by Dr. Castro on August 27, 2013, with a 29% whole person impairment rating.

The parties stipulated that the respondents have paid a total of \$161,657.39 in TTD and PPD benefits to the claimant, which exceeds the statutory cap by \$11,657.39.

The issues for hearing were whether the combined temporary disability payments and permanent partial disability payments that the respondents paid to the claimant in excess of the statutory cap under §8-42-107.5, C.R.S. constitute an “overpayment” under §8-40-201(15.5), C.R.S., and if so, whether the respondents could take an offset for the overpayment of disability benefits against the disfigurement benefits due and owing to the claimant in the amount of \$8,048. The ALJ ultimately determined that there was no overpayment pursuant to §8-40-201(15.5), C.R.S. Relying on the Colorado Court of Appeals’ opinions in *United Airlines v. Industrial Claim Appeals Office*, 312 P.3d 235 (Colo. App. 2013), and *Cooper v. Industrial Claim Appeals Office*, 109 P.3d 1056 (Colo. App. 2005), the ALJ concluded that the respondents paid PPD and TTD benefits to the claimant when due and pursuant to statute and, therefore, there was no overpayment since the claimant had a right to these benefits.

On review, the respondents argue that the ALJ erred in ruling that there was no overpayment pursuant to §8-40-201(15.5), C.R.S. The respondents contend that the combined TTD and PPD benefits they paid to the claimant exceed the \$150,000 statutory cap on indemnity benefits under §8-42-107.5, C.R.S. by \$11,657.39. The respondents argue that since neither *United Airlines* nor *Cooper* involved combined TTD and PPD benefits, they are distinguishable and do not mandate the conclusion that there was no overpayment. We agree with the respondents.

Section 8-40-201(15.5), C.R.S. provides as follows:

"Overpayment" means money received by a claimant that exceeds the amount that should have been paid, or which the claimant was not entitled

to receive, or which results in duplicate benefits because of offsets that reduce disability or death benefits payable under said articles. For an overpayment to result, it is not necessary that the overpayment exist at the time the claimant received disability or death benefits under said articles.

Thus, §8-40-201(15.5), C.R.S. provides for three categories of possible overpayment: (1) a claimant receives money "that exceeds the amount that should have been paid"; (2) money received that a "claimant was not entitled to receive"; and (3) money received that "results in duplicate benefits because of offsets that reduce disability or death benefits" payable under articles 40 to 47 of Title 8. *See Simpson v. Industrial Claim Appeals Office*, 219 P.3d 354 (Colo. App. 2009), *rev'd in part on other grounds, Benchmark/Elite, Inc. v. Simpson*, 232 P.3d 777 (Colo. 2010).

Additionally, §8-42-107.5, C.R.S. caps combined temporary and permanent payments at \$150,000 for a claimant whose impairment rating is greater than twenty-five percent. That statute provides in pertinent part as follows:

. . . No claimant whose impairment rating is greater than twenty-five percent may receive more than one hundred fifty thousand dollars from combined temporary disability payments and permanent partial disability payments.

The intent of the General Assembly, as expressed in the language of the statute, is effectuated by considering the statutory scheme as a whole and giving a consistent, harmonious, and sensible effect to each individual section. Section 2-4-201(1)(b), C.R.S.; *see Zab, Inc. v. Berenergy Corp.*, 136 P.3d 252, 255 (Colo. 2006)(citing *Charnes v. Boom*, 766 P.2d 665, 667 (Colo. 1988)). Further, when determining the intent of a statute, we must presume that "[a] just and reasonable result is intended." Section 2-4-201(1)(c), C.R.S.

Here, when reading together §8-40-201(15.5), C.R.S. and §8-42-107.5, C.R.S., as we are required to do, it is clear that the combined TTD and PPD benefits that the respondents paid to the claimant in excess of the applicable \$150,000 statutory cap constitute an "overpayment." As stated above, "overpayment" is defined as money received by a claimant that exceeds the amount that should have been paid. Section 8-40-201(15.5), C.R.S. Pursuant to §8-42-107.5, C.R.S., a claimant whose impairment rating is greater than twenty-five percent, as is the case here, may not receive combined temporary and permanent payments exceeding \$150,000. Since the claimant here received more than \$150,000 in combined temporary disability payments and permanent

RYAN DANKS

W. C. No. 4-770-978-01

Page 4

partial disability payments, he has received money that exceeds the amount that should have been paid. The circumstances here, therefore, satisfy the statutory definition of “overpayment” as set forth in §8-40-201(15.5), C.R.S.

Additionally, our holding is not contrary to the holdings in either *United Airlines* or *Cooper*. In neither case did the claimant receive combined temporary disability payments and permanent partial disability payments that exceeded the statutory cap. In *United Airlines*, the Court held that the claimant did not receive an overpayment of temporary benefits and, therefore, the applicable \$75,000 cap enunciated in §8-42-107.5, C.R.S. did not apply to the \$99,483 in temporary benefits she received. The Court explained that the claimant received only benefits to which she was entitled, and the benefits she received were solely for her temporary disability. Importantly, the Court concluded that since the claimant exceeded the cap before an award of permanent benefits was made, she never received combined permanent and temporary benefits exceeding the cap:

Here, the benefits claimant received were solely for her temporary disability; because she exceeded the cap before an award of permanent benefits was made, none of the benefits paid to her was compensation for permanent impairment. Thus, she never received combined permanent and temporary benefits exceeding the cap.

*Id.* at 239. Conversely, here, the parties stipulated that the claimant received both PPD and TTD benefits exceeding the applicable \$150,000 statutory cap enunciated in §8-42-107.5, C.R.S.

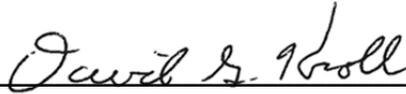
Further, in *Cooper*, the respondent attempted to recover an alleged overpayment of PPD benefits. The respondent asserted that as a result of the decedent's subsequent death, a portion of the lump sum payment automatically became an "overpayment" because she no longer suffered a loss of future earning capacity. The Court disagreed, holding that the lump sum payment was a vested right and not subject to recoupment by an employer or its insurer upon the subsequent death of the employee. The *Cooper* Court specifically construed §8-42-107(8)(d), C.R.S., which pertains exclusively to PPD medical impairment benefits. Because PPD benefits are not wage replacement benefits they were held to become “vested” as of the date of MMI, and the claimant’s subsequent death was of no significance to their payment in a lump sum. These are not qualities shared by temporary or permanent total benefits, and the *Cooper* decision had no occasion to deal with the combined benefits cap. Since the claimant in that case was deceased, the circumstance of a reopening or of a reduced PPD impairment award due to a subsequent

DIME review played no role in the *Cooper* Court's analysis. Conversely, here, the respondents are attempting to recover an overpayment of combined TTD and PPD benefits in excess of the applicable \$150,000 statutory cap under §8-42-107.5, C.R.S.

Consequently, we conclude that pursuant to §8-40-201(15.5), C.R.S., the claimant received an overpayment totaling \$11,657.39. As such, the respondents may offset the entire overpayment against their liability for the unpaid disfigurement benefits awarded to the claimant. *See generally Donald B. Murphy Contrs. v. Industrial Claim Appeals Office*, 916 P.2d 611 (Colo. App. 1995)(petitioners entitled to offset permanent partial benefits paid against temporary total disability benefits); *see also generally* §8-43-303, C.R.S.

**IT IS THEREFORE ORDERED** that the ALJ's order dated April 3, 2014, is reversed.

INDUSTRIAL CLAIM APPEALS PANEL

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

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

RYAN DANKS  
W. C. No. 4-770-978-01  
Page 7

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 9/10/2014 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

RYAN DANKS, 11050 WEBB AVE, CONFIER, CO, 80433 (Claimant)  
RAYBURN ENTERPRISES, INC., C/O: JERRILYN RAYBURN, PO BOX 1113, BAILEY,  
CO, 80421 (Employer)  
PINNACOL ASSURANCE, C/O: HARVEY FLEWELLING ESQ, 7501 E LOWRY BLVD,  
DENVER, CO, 80230 (Insurer)  
ELEY LAW FIRM, C/O: CLIFFORD E ELEY ESQ, 2000 S COLORADO BLVD NO 2-740,  
DENVER, CP, 80222 (For Claimant)  
RITSEMA & LYON PC, C/O: JOEL POLLACK, 999 18TH ST NO 3100, DENVER, CO,  
80202 (For Respondents)

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-818-579-05

IN THE MATTER OF THE CLAIM OF

ANN FRANCO,

Claimant,

v.

DENVER PUBLIC SCHOOLS,

Employer,

and

SELF INSURED,

Insurer,  
Respondents.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Allegretti (ALJ) dated May 12, 2014, that found the claimant had received an overpayment of benefits and directed repayment in installments. We affirm the order of the ALJ.

This matter was previously before us. On April 23, 2013, we affirmed several findings of the ALJ but remanded the matter for additional findings pertinent to a burden of proof issue. In response to the order of remand, the ALJ entered a new order on June 5, 2013. The new order came to the same conclusions and result as the ALJ's original order. Neither party appealed the June 5, 2013, order.

In the order of June 5, 2013, the ALJ resolved the parties' dispute regarding an award of permanent partial disability (PPD) benefits. The claimant sustained a work injury on December 1, 2009. The claimant was placed at maximum medical improvement (MMI) on October 17, 2011. The claimant's treating physician provided a permanent impairment rating of 23% of the upper extremity and 11% of the lower extremity. The respondent submitted a final admission of liability (FA) on October 31, 2011, which awarded PPD benefits pursuant to these ratings. The claimant filed an application for a hearing seeking to have the upper extremity rating converted to that of a whole person. At the hearing convened on May 9, 2012, the respondent argued the claimant's upper extremity symptoms were not actually related to a work injury. The ALJ authored an order of October 15, 2012, which found the claimant had failed to show

that a whole person rating applied and also held that the upper extremity was not injured at work such that no PPD was owed by the respondent for an upper extremity rating. The claimant appealed the October 15 order of the ALJ.

In our decision of April 23, 2013, we observed the respondent was not constrained by its FA to the extent it could challenge its own PPD award once that award was made the subject of a hearing by the claimant. We also concluded the respondent could challenge the causation element of a PPD award in the absence of a Division Independent Medical Exam (DIME). The PPD award at issue consisted solely of scheduled impairments. This schedule of impairments appears in § 8-42-107(2). However, the provisions for a DIME review of an impairment rating are specified by § 8-42-107(8)(a) and (c) to apply only to body parts and ratings not listed on the § 8-42-107(2) schedule. Our order noted the respondent appropriately placed at issue for the hearing the question of the causation of the claimant's upper extremity impairment. We did determine the ALJ was not sufficiently definite as to whether she had properly placed the burden of proof on the respondent pertinent to this issue of causation. Accordingly, the matter was remanded for an additional determination in regard to this last finding.

The ALJ wrote in her June 5, 2013, order that the respondent had sustained its burden of proof pertaining to causation. Consequently, the order adopted the ALJ's rulings from her previous order of October 15, 2012. Subsequently, the respondent filed a second FA on July 11, 2013. This FA corresponded to the ALJ's order which limited the respondent's PPD liability solely to 11% of the claimant's left lower extremity. The claimant filed an application for hearing on August 8 endorsing for hearing the respondent's asserted overpayment of PPD benefits in the amount of \$12,154.23. No hearing was scheduled in regard to this application. The respondent submitted its own application for hearing on October 18, 2013, pertinent to the same issue and requesting an order for the repayment of overpaid PPD benefits. A hearing on this application commenced on February 20, 2014.

At the conclusion of the February hearing, the ALJ deemed the claimant was overpaid in the amount of \$12,154.23. The claimant was ordered to repay this sum but due to the claimant's financial circumstances she was allowed to pay at the rate of \$200 per month for 60 months, § 8-42-113.5(1)(a) and (c).

On appeal, the claimant contends there is not an overpayment in this case, and that the respondent is barred by the doctrine of laches from pursuing an overpayment order.

I.

The claimant asserts that in other circumstances where respondents have requested repayment of previously paid benefits the Court of Appeals has denied the request. However, the case authority cited by the claimant features the construction of specific statutes which do not apply in this matter.

The term ‘overpayment’ is defined in § 8-40-201(15.5):

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

The claimant argues the Court of Appeals ruled in *Rocky Mountain Cardiology v. Industrial Claim Appeals Office*, 94 P.3d 1182 (Colo. App. 2004), that retroactive recovery of an overpayment may only be allowed when the claimant was found guilty of misconduct. It should be noted that in *Rocky Mountain Cardiology*, the court held that in the context of a *suspension* of temporary benefits due to a failure of the claimant to attend a rescheduled medical appointment, the respondents are obligated to reinstate temporary benefits once the claimant returns to see his treating physician. In addition, the respondents had contended at hearing that they should be allowed to withdraw their admission of liability because they now believed the claimant did not sustain an injury at work. While the ALJ agreed and allowed a withdrawal of the admission, the withdrawal was held to be effective as of the date of the hearing. The Court of Appeals affirmed and held that because the respondents had filed an admission of liability awarding temporary benefits prior to the ALJ’s decision, they were required to pay temporary benefits up to the date of the ALJ’s order. However, the failure to make the withdrawal retroactive was premised in the acknowledgement by the Court that “... the record here shows that employer sought relief only as of the date of hearing and did not seek retroactive relief.” The court then, was asked to rule only on the nature of ‘suspended’ benefits, and their

need to be repaid pursuant to § 8-42-105(2)(c), rather than on whether an overpayment was required to be repaid pursuant to § 8-40-201(15.5).

The claimant also cites to *Cooper v. Industrial Claim Appeals Office*, 109 P.3d 1056 (Colo. App. 2005), which held that a lump sum payment made pursuant to § 8-72-107(8)(d) need not be paid back even in the event the claimant dies shortly after the lump sum payment. The situation in *Cooper* is distinct from that in this case because, as the court noted, there was in *Cooper* a specific statutory provision setting forth the requirement to pay a lump sum in a specified amount without reference to the result of subsequent developments in the claim. Here, an award of PPD benefits through a final admission may be challenged via an application for a hearing to an ALJ. Once a hearing is requested within 30 days of the FA, awards that are in dispute will not close until the dispute is resolved. Section 8-43-203(2)(b)(II) and (d). Unlike the statutory statement in § 8-72-107(8)(d) relevant to lump sums which was construed in *Cooper*, the procedure in § 8-43-203(2)(b)(II) pertaining to an FA does not indicate a vesting of an award until further procedures have been exhausted.

Finally, the claimant relies on the decision in *United Airlines v. Industrial Claim Appeals Office*, 312 P.3d 235 (Colo. App. 2013). *United Airlines* also dealt with circumstances distinct from those featured here. In *United Airlines*, the Court was asked to determine if temporary benefits received in excess of the \$75,000 cap for combined temporary and permanent partial benefits referenced in § 8-42-107.5, could be seen as an overpayment subject to recovery by the respondents. The Court ruled that temporary benefits in that category were not an overpayment. This was based on the conclusion that the benefits cap is generally a limitation on PPD benefits and not on temporary benefits. The Court pointed out that § 8-42-105(3) is written to insist that temporary benefits “shall” be paid until one of the conditions to stop benefits is present (*i.e.* attainment of MMI, a return to work, an offer of employment or a release to regular employment). The terms of the cap however, only applied to *combined* temporary and PPD benefits. It applied then, only to the eligibility for benefits, of either kind, after MMI is attained. In *United Airlines* then, the claimant’s receipt of temporary benefits prior to the date of MMI was never affected by the benefits cap. Those benefits therefore, were not an ‘overpayment’ when received, and would never be an overpayment at any point. This result however, was due to a construction of § 8-42-107.5, and not because of any analysis of § 8-40-201(15.5).

In this case, the benefits in question consist entirely of PPD benefits. Section 8-43-203(b)(II)(A) provides that when a final admission is filed, the claimant must file an application for a hearing on disputed issues within 30 days (or request a DIME review in

the case of non-scheduled ratings). This would include PPD benefits. The determination of the amount of a PPD award is then subject to an ALJ's decision. There is no other statutory section which justifies payment of a greater amount of PPD benefits to the claimant. Unlike in *United Airlines*, there is no tension between discrete sections of the statute.

As we previously held in *Mattorano v. United Airlines*, W.C. No. 4-861-379 (July 25, 2013), the overpayment of PPD benefits is more aptly controlled by the decision in *Simpson v. Industrial Claim Appeals Office*, 219 P.3d 354 (Colo. App. 2009), *rev'd in part on unrelated grounds*, 232 P.3d 777 (Colo. 2010). In *Simpson* the Court pointed to the 1997 statutory amendments to § 8-43-303(1) & (2)(a) and to the definition of 'overpayment' in § 8-40-201(15.5). The amendment to § 8-43-303(1) and (2)(a) stated that upon a showing the claimant received overpayments, an award could be reopened "and repayment shall be ordered". As noted, the term 'overpayment' is defined in § 8-40-201(15.5). That section refers to three circumstances which constitute an 'overpayment.' The term covers "money received by a claimant that exceeds the amount that should have been paid." It also encompasses money "which the claimant was not entitled to receive." Finally, it includes money received "which results in duplicate benefits because of offsets that reduce disability or death benefits payable under said articles". The section concludes with the direction that "for an overpayment to result, it is not necessary that the overpayment exist at the time the claimant received disability or death benefits under said articles." These amendments were in response to the decision in *Lewis v. Scientific Supply Co.*, 897 P.2d 905 (Colo. App. 1995), which had held the statute barred the retroactive recovery of an overpayment prior to the 1997 amendments.

In *Simpson*, the respondents asserted an overpayment had occurred because of duplicate payments of temporary benefits and because of the lump sum payment of PPD benefits in excess of the amounts the claimant was owed when he later qualified for permanent total benefits. The Court found the amendments pertaining to reopening allowed for the retroactive recovery of an overpayment. This was due to the statement in that statute specifying that a reopening would not affect an earlier award as to money already paid "except in cases of overpayment." The definition provision was held to refer to these three distinct types of overpayments connected as they were by the disjunctive use of the word "or". The court also referenced the category describing as 'over paid' money received that a claimant was not entitled to receive. Finally, the court observed the definition is explicit that an 'overpayment' could be found even when there would not have been an overpayment "at the time the claimant received ... benefits." The respondents were therefore allowed to recover the past overpayments by reducing the future payments to the claimant. The *Simpson* analysis however, is consistent with the

ALJ's here and with the Panel's determination in *Mattorano* that PPD benefits paid pursuant to a final admission can be ordered retroactively repaid to the respondents when an appeal of that award results in a reduction of the PPD benefits. *See also Haney v. Shaw, Stone & Webster*, W.C. No. 4-796-763 (July 28, 2011); *Grandestaff v. United Airlines*, W.C. No. 4-717-644 (December 12, 2013); *Marquez v. Americold Logistics*, W.C. No. 4-896-504 (August 7, 2014).

In *Mattorano*, the respondents filed a FA for PPD benefits pursuant to the treating doctor's impairment rating. The claimant sought a DIME review which resulted in a lower impairment rating. The claimant was unsuccessful at hearing in overcoming the DIME's rating. Accordingly, the ALJ determined the claimant had been overpaid PPD benefits when the respondents had paid PPD according to their original FA. Although the overpayment did not exist "at the time the claimant received disability ... benefits under the articles," § 8-40-201(15.5) specifies that circumstance does not prevent a determination there is an overpayment. As a result, the panel affirmed the ALJ's ruling that the reduction in the impairment rating caused an overpayment which was ordered to be repaid by the claimant.

Here, similar to *Mattorano*, we perceive no error in the ALJ's determination that the claimant received an overpayment. The claimant requested a hearing pertinent to the impairment rating so as to increase the PPD award. The PPD award then, did not become final prior to a hearing on this issue before the ALJ. The ultimate effect of the hearing process resulted in a lower impairment rating and entitlement to PPD benefits less than what the respondent previously admitted in its original FA. As found by the ALJ, the mere fact that the respondent filed a FA did not result in a vested right to receive any specific amount of PPD benefits once the claimant initiated the hearing process. The ALJ then, committed no error in ordering the excess PPD benefits be repaid to the respondent.

## II.

The claimant argues the respondent is barred by the equitable doctrine of laches from pursuing its request for an overpayment. The respondent correctly points out this issue was not raised by the claimant previously and therefore should not be considered in this appeal. *Monolith Portland Cement*, 772 P.2d 688 (Colo. App. 1989). It does however, appear the claimant has only relabeled an argument she submitted previously at the time of our original order of remand in this matter. In the May 9, 2012, hearing, the claimant complained the respondent was not moving to withdraw its final admission and therefore was not putting before the ALJ the issue of causation for the upper extremity

injury. In our previous order we held that the record showed this position by the claimant was not actually a problem of notice pursuant to standards of procedural due process. The claimant's counsel explained the steps she needed to take to respond to the causation issue and the ALJ allowed her request to cross-examine the respondent's medical witness after the hearing. We concluded then, that the claimant's objection did not constitute a violation of procedural due process due to this mitigation of any prejudice by the ALJ.

Here, the claimant complains again that because the respondent did not state it wished to withdraw its previous FA, the claimant was misled into believing she would not be required to repay any overpayment of PPD benefits. The claimant argues that after the ALJ made her June 5, 2013, order following our remand, the claimant did not choose to appeal that order because she was not aware she would be required to repay the overpayment. We do not find this argument compelling.

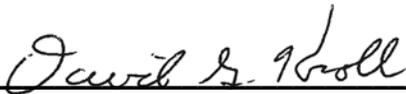
The respondent had paid the PPD award for the upper extremity in full prior to the May 9, 2012, hearing. If the respondent was not seeking to recover an overpayment as the claimant asserts, it is not clear why it would have submitted the issue of causation at the hearing. If it had simply made a successful response to the claimant's contention that a whole person rating applied to the upper extremity, it would have achieved the same result as it had when it filed its FA. However, the respondent did succeed in its defense pertinent to the claim for a whole person rating but it did not withdraw its causation issue after our order of remand had affirmed the denial of the whole person conversion. Our order approved the ALJ's ruling that conversion to a whole person rating was not shown to apply. However, we remanded the matter specifically to allow the ALJ to explain how the burden of proof was allocated in regard to the finding that the upper extremity was not related to the work injury. If repayment of an overpayment was not a possibility, such a remand would have been unnecessary. The ALJ entered her order of June 5, 2013, which again made two separate findings. First, the ALJ stated conversion to a whole person rating had not been established. Second, the ALJ concluded the respondent had shown the upper extremity injury was not work related and the claimant was therefore "not entitled to PPD benefits related to the wrist and shoulder" and the "liability of the respondents" for PPD benefits "is accordingly reduced from the admission contained in the final admission ... so as to exclude liability for that portion of the impairment rating ...". The ALJ obviously felt there was a need to rule on both issues. She did not reason that a ruling on the first obviated the need for a ruling on the second. Accordingly, the claimant was adequately placed on notice by the ALJ's order, and by our order of remand, that recovery of an overpayment was a clear likelihood.

By the time the ALJ entered her June 5, 2013, order, the Court of Appeals' decision in *Simpson v. Industrial Claim Appeals Office, supra*, and our decision in *Haney* had been reported. Holdings then, that a finding reducing an admission for a PPD award could lead to an order for repayment, were at that point an explicit part of the case law.

In addition, claimant has made arguments on this appeal that would also have been pertinent to an appeal of the June 5, 2013, ALJ order. The claimant has not indicated there were any other arguments she could have made had she appealed the June 5 order that she was precluded from presenting at this juncture. Therefore, even if the claimant was misled about the need to appeal earlier, that failure to appeal would have constituted a harmless error due to the absence of any prejudice to the claimant's position.

**IT IS THEREFORE ORDERED** that the ALJ's order issued May 12, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

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

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

ANN FRANCO  
W. C. No. 4-818-579-05  
Page 10

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 11/13/2014 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

THE LAW OFFICES OF BARBARA J. FURUTANI, P.C., Attn: PENNY MERKEL, ESQ.,  
1732 RACE STREET, DENVER, CO, 80206 (For Claimant)  
RITSEMA & LYON, P.C., Attn: T. PAUL KRUEGER, ESQ., 999 18TH STREET, SUITE  
3100, DENVER, CO, 80202 (For Respondents)

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-880-828-02

IN THE MATTER OF THE CLAIM OF

ASCHALEW GEBEREYES,

Claimant,

v.

FINAL ORDER

VEOLIA TRANSPORTATION,

Employer,

and

OLD REPUBLIC INSURANCE CO,

Insurer,  
Respondents.

The claimant seeks review of an order of Administrative Law Judge Jones (ALJ) dated April 25, 2014, that determined the respondents overcame the Division Independent Medical Examination (DIME) physician's impairment rating and denied medical maintenance benefits. We affirm the ALJ's order.

This matter went to hearing on the issue of overcoming the DIME physician's impairment rating and the claimant's entitlement to ongoing medical maintenance benefits. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant worked for the respondent-employer as a diesel mechanic. He sustained an admitted injury to his back on February 5, 2012, after a slip and fall at work. The claimant had previously injured his low back in December 2011 in a non-work-related motor vehicle accident.

The claimant was treated for the work injury by Dr. Beatty and initially presented with complaints of cervical and lumbar spine, right ribs and radicular symptoms. The claimant did not advise Dr. Beatty of his 2011 motor vehicle accident. Although the claimant's cervical spine and right rib symptoms completely resolved early in the treatment of the claim, the claimant continued to complain of pain and loss of feeling in the left leg.

Dr. Beatty placed the claimant at maximum medical improvement (MMI) on August 27, 2012. According to Dr. Beatty there were no objective findings to support the claimant's subjective symptoms and, therefore, he concluded that there was no ratable permanent impairment. Dr. Beatty did, however, place permanent restrictions limiting the claimant's ability to lift, carry and push and pull. Dr. Beatty did not recommend any further maintenance beyond home exercise and over-the-counter pain medication as needed.

The claimant was involved in another non-work-related motor vehicle accident on September 21, 2012, which resulted in new injuries to his neck and back. The claimant underwent a DIME with Dr. Ksiazek on February 7, 2013. The claimant was still involved with treatment for the non-work-related motor vehicle accident at this time. The DIME physician rated the claimant with a five percent whole person impairment based on Table 53 for sacroiliac dysfunction. The DIME physician also found there was loss of range of motion but determined that apportionment was appropriate for a final rating of five percent whole person impairment.

Dr. Beatty testified that there is no objective testing to support the DIME physician's Table 53 findings of spinal pathology. In Dr. Beatty's opinion, the MRI findings merely establish degenerative changes that pre-existed the work injury as evidenced by the MRI findings from the December 2011 motor vehicle accident. Consequently, without a Table 53 rating, there is no impairment for range of motion. The ALJ found Dr. Beatty's opinion credible and persuasive and concluded that the respondents had shown by clear and convincing evidence that the DIME physician's rating was most probably incorrect. Relying on Dr. Beatty's assessment, the ALJ found that the claimant did not sustain any permanent impairment as a result of the February 5, 2012, work injury. The ALJ also determined that the claimant failed to sustain his burden to prove that he is entitled to maintenance medical benefits.

On appeal the claimant calls into question the ALJ's credibility determinations and argues that the ALJ's determination that the respondents overcame the DIME is not supported by substantial evidence. We are not persuaded the ALJ committed reversible error.

The DIME physician's medical impairment rating is binding unless overcome by "clear and convincing evidence." Section 8-42-107(8)(c), C.R.S.; *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). "Clear and convincing evidence" is evidence which proves that it is "highly probable" the DIME physician's opinion is incorrect. *Id.* The question of whether the DIME physician's rating has been

overcome by "clear and convincing evidence" is a matter of fact for determination by the ALJ. *Id.* The standard of review is whether the ALJ's findings of fact are supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. Substantial evidence is that quantum of probative evidence which a rational fact finder would accept as adequate to support a conclusion without regard to the existence of conflicting evidence. *Metro Moving & Storage Co. v. Gussert, supra.* This standard of review is deferential and the scope of our review is "exceedingly narrow." *Id.*

The ALJ here credited the opinions of Dr. Beatty to determine that the respondents overcame the DIME physician's findings. The record supports the ALJ's factual findings and consequently we are bound by those findings. Section 8-43-301(8), C.R.S. The claimant contends that Dr. Beatty is not credible, pointing to the fact that the ALJ initially found Dr. Beatty not credible in her summary order. However, it is the ALJ's specific findings of fact and conclusions of law, not the Summary Order, which is the subject of our review. It is the ALJ's order dated April 25, 2014, that was appealed to us and because it is the order which we review, any inconsistency between this order and the summary order is of no consequence. *See, Krauth v. Great West Life*, W.C. No. 4-744-278 (September 25, 2009); *Gaskins v. Golden Automotive Group, LLC*, W. C. No. 4-374-591 (August 06, 1999); *see also, Reed v. Industrial Claim Appeals Office*, 13 P.3d 810 (Colo. App. 2000) (if there is a conflict between oral and written findings, it is the written order that controls).

The claimant argues that the ALJ must reject the allegedly inconsistent findings of Dr. Beatty who determined that the claimant had no permanent impairment but, nonetheless, imposed permanent work restrictions. Contrary to the claimant's assertion, the existence of work restrictions is not dispositive of the claimant's entitlement to permanent medical impairment. In any event, the claimant's second functional capacities evaluation (FCE) in 2013 demonstrated that the claimant was able to work without restriction. Dr. Beatty testified the 2013 FCE demonstrated that the claimant's pain was not permanent and had resolved completely and that this supported his conclusion that the claimant did not sustain any permanent impairment. Dr. Beatty Depo. at 70-71, ALJ Order at 7-8 ¶24.

The claimant also alleges that Dr. Beatty was biased in his capacity as the respondents' choice of physician. These arguments however, do not compel the ALJ to find Dr. Beatty's opinions not credible, but rather, go to the weight the ALJ chose to assign to his opinions. Weighing the medical evidence is the sole prerogative of the ALJ and we may not substitute our opinion for that of the ALJ. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *City of Durango v.*

*Dunagan*, 939 P.2d 496 (Colo. App. 1997) (weight and credibility to be assigned expert testimony is a matter within the sole discretion of the ALJ and we may not substitute our judgment for that of the ALJ). Because Dr. Beatty's opinions provide substantial evidence and valid support for the ALJ's determination that the respondents overcame the findings of the DIME physician, we have no basis to disturb the ALJ's order on review. Section 8-43-301(8), C.R.S.

## II.

The claimant finally asserts that the ALJ lost jurisdiction to issue a summary order<sup>1</sup> when she failed to issue the order within the time prescribed by §8-43-215, C.R.S. This statute provides, in pertinent part:

No more than fifteen working days after the conclusion of a hearing, the administrative law judge or director shall issue a written order allowing or denying the claim. The written order must either be a summary order or a full order. A full order must contain specific findings of fact and conclusions of law. If compensation benefits are granted, the written order must specify the amounts thereof, the disability for which compensation benefits are granted, by whom and to whom such benefits are to be paid, and the method and time of the payments. A certificate of mailing and a copy of the written order shall be served by regular or electronic mail or by facsimile to each of the parties in interest or their representatives, the original of which is a part of the records in the case. If an administrative law judge has issued a summary order, a party dissatisfied with the order may make a written request for a full order within ten working days after the date of mailing of the summary order. The request is a prerequisite to review under section 8-43-301. If a request for a full order is made, the administrative law judge has ten working days after receipt of the request to issue the order. A full order shall be entered as the final award of the administrative law judge or director subject to review as provided in this article.

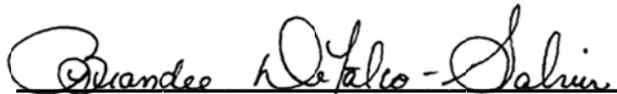
---

<sup>1</sup> The claimant refers to the April 25 full order of the ALJ alternately as a 'summary order' or as a 'supplemental order.' It is neither. Those are terms of art provided by either § 8-43-315 or § 8-43-301(5). The ALJ had previously submitted a 'summary' order on March 11. Her subsequent order was pursuant to the requirement in § 8-43-315 to follow the summary order with a 'full' order. A 'supplemental' order is described in § 8-43-301(5) as an amended order after the filing of a petition to review. As of April 25, no petition to review had been submitted.

Here, the hearing was held on December 11, 2013, but the record was kept open until February 18, 2014, to allow submission of a deposition. The ALJ issued her summary order awarding permanent disability benefits based on the DIME physician's rating on March 11, 2013, 21 days after the record was closed. The respondents filed a request for specific findings on March 20, 2014, and 36 days later the ALJ issued the specific findings of fact and conclusions of law now under review. Although the ALJ's orders were outside the timeframes set forth under §8-43-215, C.R.S., the court of appeals has said that the time limits to issue orders in this section are not jurisdictional and have rejected the argument set forth by the claimant. *Langton v. Rocky Mountain Health Care Corp.*, 937 P.2d 883, 885 (Colo. App. 1996) (statute stating that ALJ "shall" enter written order within fifteen days after conclusion of hearing is directory and not mandatory.) We are bound by published decisions of the court and, therefore, have no authority to disturb the ALJ's order on this basis. *See* C.A.R. 35(f).

**IT IS THEREFORE ORDERED** that the ALJ's order issued April 25, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

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

  
\_\_\_\_\_  
David Kroll

ASCHALEW GEBEREYES  
W. C. No. 4-880-828-02  
Page 7

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 9/23/2014 \_\_\_\_\_ by \_\_\_\_\_ KG \_\_\_\_\_ .

ASCHALEW GEBEREYES, 1095 SABLE BLVD, AURORA, CO, 80011-6822 (Claimant)  
VEOLIA TRANSPORTATION, C/O: SANDY ROSENWINKEL, 720 E BUTTERFIELD RD  
STE 300, LOMBARD, IL, 60148 (Employer)  
OLD REPUBLIC INSURANCE CO, Attn: SHANNON BROWNE, C/O: SEDGWICK CMS,  
PO BOX 14493, LEXINGTON, KY, 40512 (Insurer)  
LAW OFFICE OF FRANCIS K CULKIN, C/O: FRANCIS K CULKIN ESQ, 3801 E FLORIDA  
AVE STE 400, DENVER, CO, 80210 (For Claimant)  
THOMAS POLLART & MILLER LLC, C/O: BRAD J MILLER ESQ, 5600 S QUEBEC ST  
STE 220-A, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-384-910

IN THE MATTER OF THE CLAIM OF

JANE MCMEEKIN,

Claimant,

v.

MEMORIAL GARDENS,

Employer,

and

RELIANCE NATIONAL INDEMNITY,

Insurer,  
Respondents.

FINAL ORDER

The claimant and respondents seek review of an order of Administrative Law Judge Walsh (ALJ) dated May 14, 2014, that awarded the claimant \$1,323.10 for attorney fees and costs for filing an application for hearing on an unripe issue. We set aside the ALJ's order.

This matter previously was before us. In an October 19, 2011, order the ALJ made factual findings pertinent to the September 6, 2011, hearing in this matter. The claimant sustained an admitted injury on March 3, 1997. The respondents filed a final admission of liability on March 5, 2003, admitting for a 36 percent whole person impairment and admitting for "Grover type medical care 'per attached division IME report by Dr. Beatty dated August 27, 2002.'" The respondents later stipulated to reimburse the claimant for prescriptions and agreed to directly pay for the prescriptions in the future. In addition, the ALJ determined that the respondents formally stipulated to the claimant's need for such medical care.

On April 27, 2011, the respondents filed an application for hearing seeking to terminate maintenance medical benefits, specifically stating that the claimant's condition "as is right now" does not require narcotic medications as "it's laid out in Beatty's report." Tr. at 17. The respondents' requested that "everything be cut off based on the causation defense and based on the fact that it's not reasonable and necessary." Tr. at 21.

The respondents also endorsed the issue of apportionment and authorized treating physician.

The ALJ considered the respondents to be challenging the reasonableness and necessity of the claimant's current medical care. The ALJ credited the opinion of the claimant's authorized treating physician, Dr. Meyer, indicating that the claimant's current medical treatment resulted from her work-related injury. The ALJ concluded that the claimant had established her entitlement to her current treatment as prescribed by Dr. Meyer. Consequently, the ALJ denied the respondents' request to terminate the claimant's current medical treatment regimen.

The ALJ went on to determine that the issues of apportionment and authorized treating provider endorsed by the respondents were not ripe under §8-43-211(2)(d), C.R.S. The ALJ granted the claimant's request for attorney fees and costs and directed the claimant to submit an affidavit of fees and costs. The ALJ stated that he would “issue a separate order concerning the attorney fees and costs that will approve, deny or approve in part the submitted attorney fees and costs.”

The claimant's attorney submitted an affidavit for attorney fees and costs in the amount of \$26,462.00 which was the attorney fees and costs for the entire proceeding. In an order dated February 3, 2012, the ALJ concluded that the claimant was entitled to only 10 percent of the amount of attorney fees and costs delineated in the claimant's affidavit and, therefore awarded \$2,646.20. The ALJ rejected the claimant's argument that she was entitled to attorney fees and costs for the entire proceeding. Instead, the ALJ reasoned that the only unripe issues were apportionment and authorized treating provider and that assessing fees and costs against the opposing party for that portion of the hearing that is ripe was not legally or logically reasonable for purposes of §8-43-211(2)(d), C.R.S. Both parties appealed to the Industrial Claims Appeals Office. (Panel)

In an order dated November 15, 2012, the Panel reversed the findings of the ALJ that determined that the apportionment issue was not ripe for hearing, leaving only the issue of authorized treating provider as an unripe issue and subject to attorney fees and costs. The matter was remanded to the ALJ to determine attorney fees and costs appropriate for the single unripe issue of authorized treating provider. On remand the ALJ found that the claimant's counsel's October 2011 Affidavit of Attorney Fees and Costs was deficient in that it failed to delineate the attorney fees and costs that are attributable to only the unripe issue of authorized treating provider. The ALJ nonetheless found it reasonable to assess attorney fees and costs of five percent of the amount

delineated in the claimant's affidavit noting that the claimant's post-hearing statement devotes only a single paragraph of four sentences to the unripe issue of authorized treating provider, in a position statement that is otherwise ten pages in length. The ALJ, therefore, awarded the claimant \$1,323.10 in attorney fees and costs pursuant to §8-43-211, (2)(d), C.R.S. Both the respondents and the claimant appealed the May 14, 2014, order.

On appeal the respondents argue that the ALJ erred in determining that the issue of authorized treating provider was unripe for purposes of §8-43-211(2)(d), C.R.S. and that the ALJ erred in determining that any attorney fees and costs were reasonable. The claimant argues on appeal that she is entitled to the entire amount of attorney fees and costs despite the fact that there was only one unripe issue listed on the application for hearing. We hereby revise our previous analysis of the applicability of §8-43-211(2)(d) and reverse the ALJ's order.

#### I.

Section 8-43-211(2)(d), C.R.S., as it existed at the time the respondents' application for hearing was filed, provides that if any person requests a hearing or files a notice to set a hearing on issues which are not ripe for adjudication at the time such request or filing is made, such person shall be assessed the reasonable attorney fees and costs of the opposing party in preparing for such hearing or setting. The statute was amended in 2014 by Senate Bill 13-285, ch. 301, p. 1594, § 5, and the amendments are not pertinent here.

"An issue is ripe for hearing when it is real, immediate, and fit for adjudication." *Youngs v. Industrial Claim Appeals Office*, 297 P.3d 964, 969 (Colo. App. 2012)(quoting *Olivas-Soto v. Industrial Claim Appeals Office*, 143 P.3d 1178 (Colo. App. 2006)). The term "fit for adjudication" refers to a disputed issue concerning which there is no legal impediment to immediate adjudication. See *Maestas v. Wal Mart Stores, Inc.*, W.C. 4-717-132 (Jan. 22, 2009)(quoting *Olivas-Soto v. Genesis Consolidated Services*, W. C. No. 4-518-876) (November 02, 2005), *aff'd Olivas-Soto v. Industrial Claim Appeals Office, supra*). Whether an issue is ripe for review is a legal question that an appellate court reviews *de novo*. *Youngs v. Industrial Claim Appeals Office, supra*.

We note that although the Workers' Compensation Act formerly provided for the assessment of attorney fees in frivolous actions, that section was repealed effective March 1, 1996, and attorney fees are not generally available as a sanction for endorsing an issue without merit. Colo. Sess. Law 1991, ch. 219, § 8-43-216(1) at 1321. We also

specifically recognize that an issue that lacks merit does not necessarily lack ripeness. The two concepts are distinct and a frivolous or meritless claim may nonetheless be ripe for adjudication. See *Younger v. Merritt Equipment Company*, W.C. No. 4-326-355 (December 30, 2009).

## II.

The claimant contends the respondents breached the requirements of § 8-43-211(d) when they submitted a request for a hearing which included the issue of “authorized provider.” The claimant asserts the respondents did not possess evidence with which to support their claim in regard to this issue when they filed their request. As a result, the claimant argues that the respondents requested a hearing in regard to an issue that was not ‘ripe for adjudication’ and are liable to pay the claimant’s corresponding attorney fees.

Conversely, the respondents argue the issue was ripe for the reason that there was no legal impediment to submitting the issue to a hearing. They argue that an issue which is without evidentiary support is distinct from the circumstance that the issue might be barred by a legal impediment. They point to our previous decision in *Younger*, which held that the likelihood of success on the merits of an issue is a consideration discrete from that of ripeness for adjudication. That latter requirement turns on the absence of a legal barrier pertinent to the issue requested for hearing. We agree with the respondents and therefore set aside the ALJ’s award of attorney fees.

In his order of October 19, 2011, the ALJ concluded the issue of ‘authorized provider’ was not ripe for adjudication at the time the application for a hearing was filed. The ALJ’s findings in this regard was that the respondents “have not put forth evidence of that issue nor have they argued the issue.” The ALJ also cited to the decision in *Olivas-Soto v. Industrial Claim Appeals Office*, 143 P.3d 1178 (Colo. App. 2006), as support. The ALJ noted the court in *Olivas-Soto* described an issue ripe for adjudication as one which is “real, immediate, and fit for adjudication.”

However, the fact that a party determines to abandon an issue at the point of a hearing is not germane to that issue’s integrity at the point the request for a hearing was made several months previously. The ALJ has also misconstrued the holding in *Olivas-Soto*. The court in *Olivas-Soto* sought to interpret § 8-43-203(2)(b)(II). That section requires that a claimant seeking to challenge a final admission of liability made by an insurer must file within 30 days of the admission a request for a hearing on “any disputed issues that are ripe for a hearing.” In *Olivas-Soto*, the claimant had filed an application for a hearing on several issues within 30 days of the admission. That application

however, did not include the issue of permanent total disability benefits. When the claimant later submitted an amended application which did list the issue, the respondents objected the issue was untimely and it was closed. The court agreed stating: “the issue of PTD was legally ripe for adjudication when claimant filed his first application for hearing. The FAL and the DIME placing claimant at MMI removed any legal impediment to a determination of his eligibility for PTD benefits ...” *Id.* at 1180. Because it was legally ripe, the failure to include the issue on the application caused it to be closed. The claimant argued the court’s analysis was illogical because the inclusion of an issue when the party may not currently possess sufficient evidence to justify the pursuit of that benefit would force both parties to incur significant costs even though the issue may not need to be decided at the time of a hearing. The court found that argument to be notwithstanding: “... despite the potential for additional cost, the result we reach promotes judicial economy because it requires early identification of the disputed issues ...” *Id.* In *Olivis-Soto*, the court described the test of ‘ripeness’ generally as whether “an issue is real, immediate, and fit for adjudication.” However, the holding of the decision was that the statute’s reference to ‘ripeness’ meant “ripe for adjudication” because there was no longer a “legal impediment” to the issues’ determination at a hearing.

The opinion in *Olivis-Soto* followed a similar analysis in *Perego v. Industrial Claims Appeals Office*, 87 P.3d 261 (Colo. App. 2004). The court in *Perego* also was required to construe § 8-43-203(2)(b)(II). The claimant in that case had filed an application for a hearing within 30 days of the respondents’ final admission but had not listed any issues for hearing. The claimant argued she sought to reserve the litigation of permanent partial disability benefits to a later point when she could present evidence of a dispute to the PPD benefits awarded in the respondents’ admission. The opinion noted the claimant “contends that an issue is not ripe for hearing until it is ready for adjudication, both legally and factually.” The court observed “that claimant’s argument strains the statutory language ...” *Id.* at 264. The decision found the requirement that an issue be listed in the request for hearing within 30 days of the admission was a rational method to “provide time limitation on a claimant’s right to contest closure.” *Id.* at 265. The court explicitly made the distinction between a contest of an issue through filing an application for a hearing, and the concept of ‘prevailing’ at a hearing. “To contest an aspect of an FAL, a claimant must be able to state the benefits to which he or she is entitled.” *Id.* at 264. However, “to prevail at the hearing, the claimant must overcome the DIME by clear and convincing evidence.” *Id.* In both *Olivas-Soto* and in *Perego*, the court found that the provision requiring a claimant to file a request for hearing on an issue ‘ripe for adjudication’ had nothing to do with the amount, or lack, of evidence pertinent to the issue when a request for a hearing was filed. An issue was said to be

‘ripe’ when any legal impediment was absent. A clear distinction was present between the merits of the issue and its ripeness. The latter had nothing to do with the former.

Citing to *Olivis-Soto*, our decision in *Younger v. Merritt Equipment*, W.C. 4-326-355 (December 30, 2009), applied that concept of ripeness to § 8-43-211(2)(d). In *Younger*, the respondents sought an award of attorney fees when the claimant listed as an issue for hearing temporary disability benefits. The respondents contended a previous decision by an ALJ had resolved the temporary benefits issue against the claimant. The respondents argued *res judicata* was a legal barrier to a hearing on the issue. Our decision noted that *res judicata* was an affirmative defense required to be raised by the respondents. Accordingly, at the time the request for a hearing was made, there was no legal impediment to the issue. The argument of the respondents was characterized as being aimed at the likelihood of success for the issue, and not on whether it was ripe for adjudication when filed. The claim for attorney fees was denied. The decision noted: “And, an issue that lacks merit does not necessarily lack ripeness. The two concepts are distinct and a frivolous or meritless claim may nonetheless be ripe for adjudication.”

We applied this analysis from *Younger* subsequently in *Ferry v. City Glass Co.*, W.C. 4-741-385 (May 7, 2010)(failure to specifically plead the basis for a penalty is not cause for an attorney’s fee award); *Martin v. El Paso School Dist.* W.C. 3-979-487 (June 6, 2012)(challenge to medical benefits in a partially settled case not legally precluded) and in *Meacham v. American Blue Ribbon Holdings*, W.C. 4-885-416 (July 18, 2014)(if a party was successful on one issue, the need for the resolution of additional issues would no longer be barred). To the extent that *Silvera v. Colorado Springs Health Partners*, W.C. 4-502-555 (November 8, 2011), and *McMeekin v. Memorial Gardens*, W.C. 4-384-910 (November 15, 2012), express a contrary view, we decline to follow those decisions.

In this matter, the claimant and the ALJ are also confusing the standard of ‘merit’ with that of ‘ripe for adjudication’ due to an absence of a legal impediment. The only pertinent findings by the ALJ state that at the hearing the respondents did not present evidence or argument relating to the authorized provider issue. This determination indicates that the respondents may have abandoned the issue by that point, but it does not reveal any insight as to whether the issue was ripe for adjudication several months earlier when the application for a hearing was submitted. Similarly, the claimant argues the respondents did not have any evidence at the hearing, or probably at the time of application, to support the issue. However, that is a dispute as to the merits of the issue. It does not implicate the legal ability to have the issue adjudicated at hearing. The ALJ’s reference to the standard cited in *Olivas-Soto*, that ripe for adjudication means an issue

must be “real, immediate, and fit for adjudication” ignores the holding in that case that the issue of PTD benefits was “ripe for adjudication” when the finding of MMI by a DIME “removed any legal impediment to a determination of his eligibility for PTD benefits” regardless of whether PTD was an issue that “may not need to be decided.” *Id.* at 1180. Neither the ALJ nor the claimant point to a legal barrier that would make impossible a hearing pertaining to ‘authorized provider.’

Because there was no legal impediment to the presentation of the issue of authorized provider extant at the time the respondents included the issue on their application for hearing, the issue was ‘ripe for adjudication’ and there was no violation of §8-43-2011(2)(d). The status of the evidentiary merits of that issue is notwithstanding. The claimant, therefore, is not entitled to an award of attorney fees or costs.

The construction of § 8-43-211(2)(d) suggests it is not aimed generally at categories of frivolous litigation. It applies only to issues requested for hearing and limits its focus to the date the issue was requested. It does not apply to issues at any other juncture in the litigation process, including at hearing. Therefore, an issue presented to an ALJ supported by a paucity or absence of evidence is beyond the scope of the section. As noted, the statute previously allowed for attorney fees in the case of frivolous actions, but that section was repealed by the General Assembly as of March 1, 2006, Colo. Sess. Law 1991, ch 219, § 8-43-216. In 2013, § 8-43-211(2)(d) was amended to preclude an award of attorney fees against *pro se* litigants and to require a party requesting fees to first seek relief from a prehearing ALJ and specified the fees awarded must be limited to those directly caused by the unripe issue. S.B. 13-285, ch301, pg. 1594 (effective July 1, 2013). This history suggests the General Assembly has sought to minimize the attorney fees remedy for perceived frivolous litigation in workers’ compensation claims.

The statutory and regulatory scheme governing workers’ compensation claims often requires a very speedy request for a hearing in order to prevent an issue from being resolved by default. An insurer must request a hearing to challenge a DIME finding within 20 days of the finding, § 8-42-107.2(4)(c). A claimant will need to contest any final admission of liability within 30 days, § 8-43-203(2)(b)(II). A response to an application for hearing with any additional issues is due within 30 days of the application, OAC Rule 8 (G). An insurer is deemed to have agreed to a medical preauthorization request absent a contrary medical review unless a hearing is requested within seven days, WC Rule 16-10(E)(1). These and other situations require requests for hearing often before any significant evidence can be obtained by the requesting party. If it was required that the issue be suitable for presentation at a hearing on the date a hearing

request became due, the parties would be forced to choose between their right to a hearing or waiving that right to avoid an expensive assessment of fees should they guess wrong about the possible strength of their claim. The reason for the deadlines is to keep the process moving in an efficient manner. The deadlines are not to discourage parties from presenting their disputes to a judge.

The final difficulty presented by the determination of the ALJ in this matter pertinent to the award of attorney fees derives directly from the finding that the issue of “authorized provider” was without evidentiary support and was therefore, on that basis, not fit for adjudication. The ALJ made a finding that “there existed a ‘justiciable issue,’ that being: ‘whether or not the current medical maintenance care is related and reasonably necessary’”. The issue designated as “authorized provider” is not very specific and allows for a variety of evidentiary issues to be included within its realm. The respondents’ application for hearing also revealed that the respondents sought to argue: “whether claimant continues to require maintenance medical treatment for her work related injury; whether any need for medical treatment is related solely to claimant’s non-occupational medical conditions’ which medical treatment, if any, is reasonable, necessary, and related to claimant’s work-related injury.” While ‘authorized provider’ can refer to whether a medical care giver is authorized by the parties, it may also be seen to refer to the scope of a referral. In *Steele v. Berardi*, W.C. 4-441-620 (June 15, 2001), payment for surgery was denied when it was determined the referral to the surgeon by an authorized treater was limited to an evaluation for an impairment rating and did not include surgery. The scope of the referral is a question of fact for resolution by the ALJ. *City of Durango v. Dunagn*, 93 P.2d 496 (Colo. App. 197); *Suetrack USA v. Industrial Claim Appeals Office*, 902 P.2d 854 (Colo. App. 1995). To the extent the respondents in this case presented the issue of whether continued maintenance care was related, the issue does implicate the scope of the referral to the authorized provider. The respondents are arguing the authorized provider may be exceeding the scope of his authorization by treating symptoms not related to the work injury.

Because the application of § 8-43-211(2)(d) is subject to a de novo review, we are not constrained by the ALJ’s findings of fact that the designation of ‘authorized provider’ was not submitted for adjudication at the September 6, 2011, hearing. Given the dispute over the work relatedness of continuing medical maintenance benefits, the more persuasive conclusion is that issue was part of the respondents’ case presented at the hearing.

Accordingly, the ALJ's order awarding attorney fees to the claimant under §8-43-211(2)(d) is set aside. This follows from our analysis that the issue of authorized provider was ripe for adjudication due to an absence of any legal impediment at the point a hearing was requested. It is also for the reason that the issues submitted at hearing, and adjudicated, included 'authorized provider' and, as such, is evidence that issue was indeed present at the time the respondents filed their application for a hearing.

**IT IS THEREFORE ORDERED** that the ALJ's order dated May 14, 2014, is set aside and the claimant's request for an award of attorney's fees is denied.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

**Dissent:**

**Examiner DeFalco-Galvin dissents.**

Although I agree with the majority's order insofar as it generally sets forth the law, I disagree with its application in this case. In my view, the ALJ did not err in his determination that the issue of authorized treating physician was unripe under the circumstances of this case.

The respondents' endorsement of the authorized treating provider issue in this case did not present an actual controversy between the parties that was sufficiently real and immediate. Contrary to the respondents' arguments, this is not a case where the issue of

authorized treating provider may have simply lacked merit or was frivolous. Nor is this a case where the respondents are being assessed attorney fees and costs because they presented scant or no evidence on the issue. Rather, this is a case where there was no disputed issue concerning the authorized treating provider at the time the application for hearing was filed. The fact that the respondents did not present any evidence on this issue is merely indicative of the fact that at the time the application for hearing was filed there was no real and immediate controversy that was capable of litigation on the issue of the authorized treating provider.

It is true that the prior panel orders addressing the issue of ripeness have discussed the concept in terms of there being “no legal impediment.” This, however, is not the only factor to be considered in a ripeness determination. As recognized by the Supreme Court, “ripeness is an amorphous legal concept subject to many ‘subtle pressures including the appropriateness of the issues for decision by this Court and the actual hardship to the litigants of denying them the relief sought.’” *Carstens v. Lamm*, 543 F. Supp. 68 (D. Colo.1982)(citing *Poe v. Ullman*, 367 U.S. 497, 508, 81 S. Ct. 1752, 1758, 6 L. Ed. 2d 989 (1961)). The central concern of a ripeness inquiry is “whether there is a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality” to warrant the attention of the Court. *Id*; *Lake Carriers Ass'n. v. MacMullan*, 406 U.S. 498, 506, 92 S. Ct. 1749, 1755, 32 L. Ed. 2d 257 (1972) (quoting *Maryland Cas. Co. v. Pacific Coal & Oil Co.*, 312 U.S. 270, 273, 61 S. Ct. 510, 512, 85 L. Ed. 826 (1941)); *National Park Hospitality Assn. v. Department of Interior*, (02-196) 538 U.S. 803 (2003)(issue unripe because no concrete dispute about a particular concession contract).

The case law from the Colorado Supreme Court and Court of Appeals also sets forth a more comprehensive analysis rather than just looking at whether there is a legal impediment. Ripeness tests where an issue is *real, immediate and fit for adjudication*. *Bd. of Directors, Metro Wastewater Reclamation District v. Nat'l Union Fire Ins. Co.*, 105 P.3d 653 (Colo. 2005). Thus, ripeness also requires that there be an actual case or controversy between the parties that is sufficiently immediate and real so as to warrant adjudication. *Metal Management West, Inc. v. State* 251 P.3d 1164 (Colo. App. 2010); *Jesse v. Farmers Ins.* 147 P.3d 56 (Colo. App 2006); *Beauprez v. Avalos*, 42 P.3d 642 (Colo. 2002). The doctrine of ripeness recognizes that courts will not consider uncertain or contingent future matters because the injury is speculative and may never occur. *Dicocco v. Nat'l Gen. Ins. Co.*, 140 P.3d 314 (Colo. App. 2006); *See Stell v. Boulder County Department of Social Services*, 92 P.3d 910 (2004). In all of these cases, the court’s analysis does not resolve the issue based on whether there was a legal impediment, but rather, the opinions discuss whether the facts of the case give rise to an actual dispute or controversy that is real and immediate.

Even in *Olivas-Soto*, cited in the majority order, the court referred to the opinion of the Colorado Supreme Court in *Nat'l Union Fire Ins. Co.*, 105 P.3d 653 (Colo. 2005). In *Nat'l Union*, the court noted that judicial review generally requires “*actual controversies based on real facts*” and that “[r]ipeness tests whether the issue is *real, immediate,*” in addition to being “fit for adjudication” (emphasis added). The court reiterated that “[c]ourts should refuse to consider uncertain or contingent future matters that suppose speculative injury that may never occur.” *Nat'l Union*, 105 P.3d at 656.

In order to determine whether an issue is ripe for adjudication at the time the application for hearing was filed, it is instructive to look at how the parties handled the issue in question during the course of the hearing proceedings. *See Franz v. Industrial Claims Appeals Office*, (Colo. App. 2010)(Court looked at the ALJ’s characterization of the issue and responses to interrogatories to determine issue was ripe). In this case, based on the respondents’ handling of the authorized treating provider issue during the course of the hearing, it was reasonable for the ALJ to conclude that there was no real and immediate controversy between the parties on the issue of authorized treating provider at the time the respondents filed the application for hearing. In October of 2007, the respondents stipulated to ongoing medical treatment provided by the authorized treating provider, Dr. Meyer. October 19, 2011, order at 3 ¶9; Claimant’s Exhibit at 60-61. The respondents then filed an application for hearing in 2011, on the issue of authorized treating provider. When the ALJ confirmed that this was the issue for hearing, the respondents did not disagree. Tr. at 3. There were no medical bills at issue and no request for treatment at issue for the hearing. The respondents never stated who was authorized or whose authorization they were contesting. Moreover, the respondents’ counsel acknowledged at hearing that the authorized treating physician, Dr. Meyer, was providing ongoing treatment and did not ever challenge his authorization throughout the hearing. Tr. at 14 and 15. The respondents’ post hearing submission and proposed findings of facts make no mention of the authorized treating physician issue.

In the brief in support, the respondents state that the authorized treating provider issue was, “ultimately abandoned and was not presented at hearing.” Respondents’ Brief at 9. However, the respondents never notified the claimant or the ALJ that they were withdrawing the issue of authorized treating provider. *See Office of Administrative Courts Rule of Procedure (OACRP) 15* (Application for hearing may not be withdrawn except on agreement of the parties or upon order of a judge). The record provides ample support in the record to make a plausible inference that there was not a real and immediate controversy or any type of dispute concerning the authorized treating provider at the time the respondents filed the application for hearing.

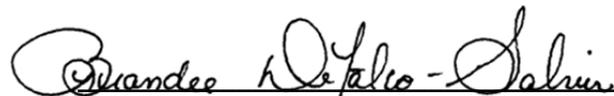
The respondents contend that the authorized treating provider issue is inextricably intertwined with medical benefits and apportionment of medical benefits and if those issues were ripe, the issue of authorized treating physician must be ripe as well. The majority order similarly discusses the authorized treating provider issue as essentially related to the provision of medical benefits. I disagree. It is well settled that a provider's authorization is a separate and distinct issue from determining the reasonableness, necessity and relatedness of medical benefits. *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999). This is especially true as evidenced in this case by the respondents who choose to contest the causation of the medical benefits but ultimately decided to abandon the issue of authorized treating provider. The issues are not dependent or necessarily related to each other. *Compare Meacham v. American Blue Ribbon Holdings*, W.C. No. 4-885-416 (July 18, 2014) (issues of overpayment, offsets and caps to be determined in conjunction with compensation benefits). There is nothing in the record to suggest that the respondents would have waived the issue of authorized treating provider had they not listed in conjunction with the issues on medical benefits.

Under these circumstances, the respondents sought a hearing on a matter that was not ready to be heard because at the time of applying for the hearing there was not an actual controversy that was real and immediate concerning the issue of authorized treating provider. The fact that the respondents can fashion a set of hypothetical facts on appeal and contend that "it was likely" or "probable" that the claimant was "receiving treatment from her personal care physician for injuries and accidents which the claimant suffered at home or outside of the work environment," does not mean that there was a justiciable issue here. See Respondents' Brief in Support at 7. The respondents' contention is purely speculative and therefore, unripe. *Sheridan Redevelopment Agency v. Knightsbridge Land Co. L.L.C.* 166 P.3d 259 (Colo. App. 2007) (issue of attorney fees was not ripe because outcome of case was unknown); *see also Developmental Pathways v. Ritter*, 178 P.3d 524 (Colo. 2008)(First amendment challenge was not ripe because statute had not been applied).

The majority order in this case similarly sets forth a hypothetical scenario under which the respondents could have been contesting the "scope of the referral" by listing the issue of authorized treating provider. The respondents, however, do not make this contention and there is nothing in the record to suggest that this was the case. The idea that facts *could have* arisen during the course of a hearing on the causation of medical benefits is purely speculative and, therefore, could not have been real and immediate at the time the application for hearing was filed. This is especially true in light of the fact that there were no medical bills from Dr. Meyer at issue or any treatment from Dr. Meyer that had been specifically contested. If the respondents discovered facts during the hearing process that actually gave rise to a dispute on the authorized treating provider,

OACRP 12 provides a mechanism to add issues for hearing. Moreover, in order for the authorized treating provider issue to even arise, the respondents would have had to first been successful on their claim that the medical benefits the claimant was receiving were not related to the industrial injury. This arguably constitutes a legal impediment to trying the issue of authorized treating provider and, therefore, the issue was not fit for adjudication, in addition to not being real and immediate.

Thus, in my view, the ALJ did not commit reversible error in awarding attorney fees and costs for this issue. *See Silveira v. Colorado Springs Health Partners*, W.C. No. 4-502-555 (November 8, 2011)(award of attorney fees and costs appropriate where the party files an application without a real and immediate controversy) *aff'd Silveira v. Industrial Claim Appeals Office*, Colo. App. No. 11CA2396 & 11CA2397, November 8, 2012, *not selected for publication*.

  
Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 9/30/2014 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

JANE MCMEEKIN, 7139 PALMER PARK BLVD., COLORADO SPRINGS, CO, 80915  
(Claimant)

MEMORIAL GARDENS, 3825 AIRPORT ROAD, COLORADO SPRINGS, CO, 80910  
(Employer)

RELIANCE NATIONAL INDEMNITY, Attn: MELISSA RYAN - CLAIMS  
REPRESENTATIVE, C/O: GALLAGHER BASSETT SERVICES, INC., P O BOX 4068,  
ENGLEWOOD, CO, 80155 (Insurer)

STEVEN U. MULLENS, P.C., Attn: STEVEN U. MULLENS, ESQ., P O BOX 2940,  
COLORADO SPRINGS, CO, 80901 (For Claimant)

THOMAS, POLLART & MILLER, LLC, Attn: BRAD J. MILLER, ESQ., 5600 S. QUEBEC  
STREET, SUITE 220A, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-898-245-02

IN THE MATTER OF THE CLAIM OF  
DENNIS MEENEN,

Claimant,

BOULDER COUNTY,

Employer,

and

SELF INSURED,

Insurer,  
Respondents.

ORDER OF REMAND

The respondent seeks review of an order of Administrative Law Judge Allegretti (ALJ) dated March 4, 2014, that found the claimant sustained a compensable injury, awarded medical and temporary disability benefits and penalties in the amount of \$4,600.00 against the respondent for failure to comply with §8-42-101(1)(a), C.R.S., §8-43-404(5)(a)(I)(A), C.R.S. and Workers' Compensation Rule of Procedure (WCRP) 8-2(a)(1). We dismiss, without prejudice, the respondent's appeal of temporary disability benefits for lack of a final order and remand the matter to the ALJ for further findings on the issue of penalties.

The claimant was employed as a seasonal forest technician with the employer's parks and recreation division. During the 2012 season the claimant worked at a community sort yard for the employer where the residents of the community would bring wood and slash as part of the fire mitigation efforts. The ALJ credited the claimant's description of the lifting motions and techniques he used at work to conclude that the claimant's job required heavy lifting, bending and twisting. As a result of these activities the ALJ determined that the claimant sustained an occupational disease to his lumbar spine.

The claimant completed a workers' compensation injury report dated September 11, 2012, which was marked as received on September 18, 2012, by Andrea Bell, the

claims administrator for the employer. The ALJ found that the employer failed to provide the claimant with the designated provider list. The claimant went ahead with back surgery performed by Dr. Smith on September 26, 2012. The ALJ concluded that the right to select a physician passed to the claimant when the employer did not provide the list of designated physicians in the first instance or as of September 11, 2012, when the claimant reported the injury. Dr. Hinman and Dr. Smith were determined to be the claimant's authorized treating physicians and the respondent was ordered to pay for their treatment. The ALJ also awarded temporary disability benefits from August 29, 2012 through December 21, 2012.

The ALJ denied the respondent's request for penalties against the claimant for failure to timely report the injury. The ALJ, however, awarded penalties against the respondent pursuant to §8-43-304(1), C.R.S., finding that the respondent violated §8-42-101(1)(a), C.R.S., §8-43-404(5)(a) and W.C.RP 8-2 (a)(1), C.R.S. The ALJ determined that the employer's claims administrator was aware on September 11, 2012, that the claimant was actively receiving medical care and had reported a workers' compensation injury but failed to provide the claimant with a designated provider list. The ALJ imposed a penalty of \$50 per day from September 20, 2012, until December 21, 2012, the date that the claimant was released from care. This was a period of 92 days resulting in a total penalty of \$4600.00.

On appeal the respondent does not contest the ALJ's determination of compensability or the award of medical benefits. The respondent appeals the ALJ's award of temporary disability benefits but asserts that the issue is not final for purposes of appeal. The respondent also contends that the ALJ's findings on the issue of penalties are insufficient to permit appellate review because the ALJ failed to specify the amount of the penalty apportioned to each violation. We agree with the respondent.

## I.

Under §8-43-301(2), C.R.S., a party dissatisfied with an order "which requires any party to pay a penalty or benefits or denies a claimant a benefit or penalty," may file a petition to review. Orders which do not require the payment of benefits or penalties, or deny benefits or penalties are interlocutory and not subject to review. *Natkin & Co. v. Eubanks*, 775 P.2d 88 (Colo. App. 1989). An order may be partially final and reviewable and partially interlocutory. *Bestway Concrete v. Industrial Claim Appeals Office*, 984 P.2d 680 (Colo. App. 1999). Without a determination of average weekly wage, an order awarding temporary total disability benefits is interlocutory and not

subject to review. *Oxford Chemicals, Inc. v. Richardson*, 782 P.2d 843 (Colo. App. 1989); *Tooley v. Johnson and Sons Trucking*, W.C. No. 4-376-713 (January 28, 2000).

Here, the ALJ ordered temporary disability benefits to be paid to the claimant based on a percentage of the hours owed to the claimant using the claimant's regular wages and a percentage using the claimant's overtime wage. The ALJ made these findings due to her inference from the claimant's testimony that he was responsible for the loss of his job. *See*, § 8-42-105(4)(a). He testified he only would ever work a specified number of days in each calendar year so as not to affect his PERA pension benefits. The number of hours the claimant had already worked prior to his injury thereby allowed the ALJ to calculate the date by which wage loss would no longer be "attributable to the on the job injury." *Gutierrez-Delgado v. North Star Foods*, W.C. No. 4-857-384 (December 19, 2012).

However, both parties on appeal state that the issue of average weekly wage was not an issue for hearing and was specifically reserved for future determination. Tr. at 29 and 95. Because temporary disability benefits are based on the average weekly wage, temporary disability benefits cannot be ascertained without a determination of average weekly wage. Consequently, to the extent the ALJ ordered a specific amount of temporary disability benefits to be paid to the claimant, the ALJ erred.<sup>1</sup> Thus, we agree with the respondent that the ALJ's order of temporary disability benefits is interlocutory and not currently subject to review.

## II.

The ALJ awarded penalties against the respondent in the amount of \$50 per day, for 92 days, for violation of §8-42-101(1)(a), C.R.S., §8-43-404(5)(a), C.R.S. and WCRP 8-2(a)(1), for the employer's failure to provide a designated provider list in the first instance. We conclude that the ALJ's findings of fact are insufficient to permit appellate review and the conflicts are not resolved in the evidence. We, therefore remand the matter to the ALJ for additional findings and entry of a new order.

Under §8-43-304(1), C.R.S., penalties may be imposed against an insurer who "violates any provision" of the Workers' Compensation Act (Act) or "fails or refuses to perform any duty lawfully enjoined" for which no penalty is specifically provided. *Pueblo School District No. 70 v. Toth*, 924 P.2d 1094 (Colo. App. 1996). Case law has held that an insurer's failure to comply with a rule of procedure constitutes the

---

<sup>1</sup> It is also not clear the issue of responsibility for termination of employment was endorsed as an issue for determination by the ALJ and the parties therefore may not have had sufficient notice of its applicability.

failure to perform a duty lawfully enjoined or the violation of an order within the meaning of §8-43-304(1), C.R.S. See *Diversified Veterans Corporate Center v. Hewuse*, 942 P.2d 1312 (Colo. App. 1997); *Fera v. Industrial Claim Appeals Office*, 169 P.3d 231 (Colo. App. 2007)(violation of WCRP 16-10(F), is a violation of an “order”).

The determination of whether an insurer is subject to penalties under § 8-43-304(1), C.R.S., requires a two-step analysis. *Allison v. Industrial Claim Appeals Office*, 916 P.2d 623 (Colo. App. 1995). First, the ALJ must find a violation of the Act or an order. Second, the ALJ must determine whether the challenged conduct was unreasonable as measured by an objective standard. *Pueblo School District No. 70 v. Toth, supra*. The reasonableness of the insurer's actions depends upon whether the actions were predicated on a rational argument based on law or fact. *Diversified Veterans Corporate Center v. Hewuse, supra*.

As the respondent points out, the ALJ's order did not allocate specific penalties to specific violations of the Act. The order generally found that a \$50 per day penalty was warranted for violations of §8-42-101(1)(a), C.R.S., §8-43-404(5)(a) and WCRP 8-2(a)(1). We agree with the respondent that without an exact amount attributed to each particular violation, the order is not sufficiently clear to permit appellate review as we are unable to determine whether the ALJ intended to find violations for each of the statutes listed or whether there were multiple reasons for a violation of one of the provisions listed.

Moreover, if the award of penalties was predicated on the violation of §8-42-101, (1)(a), C.R.S., the order is in error. The record indicates that the respondent timely denied the claim. Respondent Exhibit L. While it is true that §8-42-101, C.R.S. provides that every employer shall furnish such medical treatment as may reasonably be needed at the time of the injury and thereafter during the disability to cure and relieve the employee from the effects of the injury, the claimant's entitlement to medical care under in §8-42-101 is premised upon the establishment of a compensable injury. *Urtusuastegui v. JBS*, W.C. No. 4-795-733 (November 8, 2010). We are not aware of any authority for the proposition that a penalty under § §8-43-304 may be imposed on a respondent for failure to provide benefits on a denied claim. The claimant's arguments notwithstanding, §8-42-101(1)(a), does not create an implied duty to offer medical care in contravention of the respondent's right to contest a claim. See *Allison v. Industrial Claim Appeals, supra*, (ALJ must look to the express duties and prohibitions imposed by the statutory language, and should not create implied duties and responsibilities). Accordingly, there can be no violation of §8-42-101(1)(a), C.R.S. under these circumstances.

In addition, the respondent argues that in regard to a violation of § 8-43-404(5)(a)(I)(A), C.R.S., a penalty may not be assessed pursuant to § 8-43-304(1) because another penalty has been “specifically provided.” That other penalty is argued to be the surrender to the claimant of the right to select the treating physician. However, the presence of this same surrender of physician selection in WCRP 8-2 (D) would not have that effect because the clause in § 8-43-304(1) pertinent to other ‘specifically provided’ penalties does not apply to “any lawful order made by the director” which includes regulations. *See, Fera v. Industrial Claim Appeals Office, supra* and *Holiday v. Bestop, Inc.*, 23 P.3d 700 (Colo. 2001).

The obligations in § 8-43-404(5)(a)(I)(A) and in Rule 8-2 (A)(1) are not interchangeable. They are, in fact, mutually exclusive. Section 8-43-404(5)(a)(I)(A) requires a list of medical providers be submitted to the claimant at “the first instance” (i.e. at the time an injury is reported to the employer). WCRP 8-2 (A)(1) however, only applies where the list of providers was offered to the claimant either by a preinjury posting or verbally when the injury was reported. *Marcelli v. Echostar Dish Network*, W.C. No. 4-776-535 (March 2, 2010). In that circumstance the employer has seven business days to also supply a written list of providers. Consequently, a violation of the rule only occurs when a provider list was given in “the first instance” (albeit verbally or via poster). Hence, when there is a violation of the statute, the rule does not apply. Here, the ALJ made reference to the penalty period beginning seven business days subsequent to notice being given to the employer. This suggests the ALJ determined the rule was breached. This would also lead to the conclusion there was compliance with the statute. However, the findings of fact by the ALJ pertain solely to a violation of the statute and say nothing as to an oral discussion of providers or a posted provider list. This inherent paradox must be reconciled.

The ALJ also determined the penalty should be assessed for a 92 day period. The 92 days was measured from a date seven business days after the employer received notice of the injury until the date of MMI. Both the statute in § 8-43-404(5)(a)(III)(A), and the rule in 8-5 (A), provide that the purpose of the provider list is to allow the claimant to make an initial choice of physician and to determine who they may select in the situation where they desire a change of physician. Both the selection of a physician and the change of physician must be accomplished before either the claimant reaches MMI or within 90 days of the date of injury. The ALJ determined the date of onset for the claimant’s occupational disease was September 10, 2012, but awarded temporary benefits beginning August 29, 2012, which is a logical impossibility. In addition, since the date of MMI on December 21 is more than 90 days after the September 10 date of onset (as well

as the date of August 29) it is not clear why the ALJ found the provider list only became moot as of the date of MMI. This confusion, as well as the specific violation being penalized must be addressed by the ALJ.

We also note that although the ALJ's order makes reference to applying the two-step analysis in awarding penalties, the order does not make any specific findings concerning the reasonableness of the respondent's actions which resulted in the alleged violation or violations. The ALJ appears to find to the contrary because the order states that there was credible evidence presented that the employer's representatives mistakenly believed that the required information was actually provided to the claimant. (ALJ Order at 23). Although this finding might support a conclusion that the respondent's actions were objectively reasonable, it does not compel it. Therefore, we cannot resolve the issue as a matter of law and the matter must be remanded to the ALJ for entry of a new order which resolves the conflict in the evidence. On remand the ALJ shall enter specific findings of fact concerning which of the respondent's actions resulted in which violations and whether the respondent's actions were objectively unreasonable.

In view of our remand, it is premature to consider the respondent's remaining contentions concerning the award of penalties.

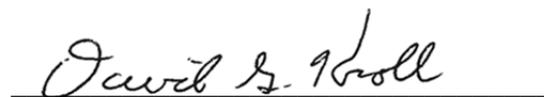
**IT IS THEREFORE ORDERED** that the respondent's petition to review the issue of temporary disability benefits in the ALJ's March 4, 2014, order is dismissed without prejudice.

**IT IS FURTHER ORDERED** that the ALJ's order concerning the award of penalties against the respondent is set aside and remanded for entry of a new order consistent with the views expressed herein. The order is otherwise affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



David G. Kroll

DENNIS MEENEN  
W. C. No. 4-898-245-02  
Page 8

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 9/09/2014 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

DENNIS MEENEN, 3103 MEGAN WAY, BERTHOUD, CO, 80513 (Claimant)  
BOULDER COUNTY, C/O: ANDREA BELL, PO BOX 471, BOULDER, CO, 80306  
(Employer)  
TAUSSIG & TAUSSIG PC, C/O: JOHN G TAUSSIG ESQ, 5377 MANHATTAN CIR STE  
203, BOULDER, CO, 80303 (For Claimant)  
RITSEMA & LYON PC, C/O: NANCY C HUMMEL ESQ, 999 18TH ST STE 3100,  
DENVER, CO, 80202 (For Respondents)  
ALJ ALLEGRETTI, % OFFICE OF ADMINISTRATIVE COURTS, ATTN: RONDA  
MCGOVERN, 1525 SHERMAN STREET, 4<sup>TH</sup> FLOOR, DENVER, CO 80203

## INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-780-871-03

IN THE MATTER OF THE CLAIM OF

JESUS MUNOZ,

Claimant,

v.

FINAL ORDER

JBS SWIFT & CO. USA, LLC,

Employer,

and

ZURICH AMERICAN INSURANCE CO.,

Insurer,  
Respondents.

The claimant seeks review of an order of Administrative Law Judge Allegretti (ALJ) dated May 19, 2014, that denied the claimant's request for post maximum medical improvement (MMI) medical treatment. We affirm the order of the ALJ

The claimant was injured at work on August 25, 2008, while cutting bones with manual scissors over a period of three days. He developed pain in his right shoulder. An MRI revealed a large tear of the claimant's rotator cuff. The claimant received a surgical consultation from Dr. Gray. The doctor was of the opinion that such a large tear was not likely to be improved by surgery. There was, in fact, a significant chance a surgical procedure would actually make the claimant's condition worse. Surgery was not performed and the claimant was referred to Dr. Laura Caton for further treatment. Dr. Caton placed the claimant at MMI on January 9, 2009, and assigned a permanent impairment rating of 22% of the upper extremity. The respondents filed a Final Admission of Liability (FAL) on January 26, 2009. The FAL admitted for maintenance medical benefits after MMI that were reasonable, necessary and related to the injury. After prolonged litigation, the claimant's request for a Division Independent Medical Examination was denied. The claimant returned to work after MMI with the employer performing a light duty job. The claimant retired from the employer in November, 2011.

The claimant returned to see Dr. Caton in June and July, 2013. On July 16, 2013, Dr. Caton noted the claimant was complaining of continued pain in the right shoulder.

She recommended an MRI arthrogram and an EMG study to determine if there were any interventions that may assist the claimant with his shoulder symptoms. The respondents denied authorization for the recommendations. The claimant was sent by the respondents for a second opinion evaluation by Dr. Kathy D'Angelo.

The respondents applied for a hearing in regard to the reasonableness and necessity for maintenance medical care. No hearing was held as the parties agreed to submit the evidence to the ALJ through the submission of written medical reports. The ALJ authored an order of January 28, 2014, which relied principally upon the June 14, 2013, report of Dr. D'Angelo. The ALJ completed a supplemental findings and order on May 19, 2014. This subsequent order determined the ALJ's denial of the request for medical benefits was based on a finding that a preponderance of the evidence submitted showed the symptoms and injury for which the claimant sought benefits was not causally related to the September 25, 2008, work accident. The ALJ concluded no "future medical treatment will be reasonably necessary to relieve the effects of the August 25, 2008 injury or to prevent further deterioration of his condition."

Dr. D'Angelo was noted by the ALJ to have been without the advantage of any medical reports created between 2009 and June, 2013. The doctor noted in her examination the claimant had surgical scars on his neck. Upon inquiry, the claimant described to the doctor that he had surgery on his neck in 2011 due to a work injury. He then offered that the surgery was treatment for arthritis and it was the reason he left work in November, 2011. The claimant asserted yet a third reason for leaving work which was a result of his return to Mexico to assist his ill parents. The claimant described weakness in his legs and his low back. This caused him difficulty in standing and walking. Dr. D'Angelo had observed significant muscle atrophy in the claimant's right arm. The claimant reported that he developed numbness and pain in the right arm shortly before he experienced pain in his neck. Dr. D'Angelo diagnosed the claimant as suffering from diabetes, asthma, cervical arthritis, osteoarthritis, degenerative changes in the right shoulder, cervical radiculopathy and cervical spine stenosis with lower extremity motor signs. It was the impression of Dr. D'Angelo that the claimant's symptoms were not related to the 2008 work injury. They were attributed instead, to degenerative changes associated with arthritis and to cervical myelopathy addressed by the 2011 cervical surgery. The doctor's opinion was that none of the medical treatment appropriate for the claimant was made necessary by the work injury of 2008. The ALJ found the views of Dr. D'Angelo to be credible and persuasive. It was decided a preponderance of the evidence established the need for the medical care recommended by Dr. Caton to be due to intervening conditions. Consequently, the ALJ denied the claimant's request for medical benefits as not causally related to the work injury.

It is well settled that where the respondents file a final admission admitting for maintenance medical benefits pursuant to *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988), the respondents are not precluded from later contesting their liability for a particular treatment. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). Moreover, when the respondents contest liability for a particular medical benefit, the claimant must prove that such contested treatment is reasonably necessary to treat the industrial injury and is related to that injury. *See Grover v. Industrial Commission, supra; Snyder v. Industrial Claim Appeals Office, supra.*

Where, however, the respondents attempt to modify an issue that previously has been determined by an admission, they bear the burden of proof for such modification. Section 8-43-201(1), C.R.S.; *Dunn v. St. Mary Corwin Hospital*, W.C. No. 4-754-838 (Oct. 1, 2013); *see also Salisbury v. Prowers County School District*, W.C. No. 4-702-144 (June 5, 2012); *Barker v. Poudre School District*, W.C. No. 4-750-735 (July 8, 2011). Section 8-43-201(1), C.R.S. was added to the statute in 2009 and provides, in pertinent part:

...a party seeking to modify an issue determined by a general or final admission, a summary order, or a full order shall bear the burden of proof for any such modification.  
(2) The amendments made to subsection (1) of this section by Senate Bill 09-168, enacted in 2009, are declared to be procedural and were intended to and shall apply to all workers' compensation claims, regardless of the date the claim was filed.

The principal aim of the 2009 amendment to § 8-43-201(1), C.R.S. was to reverse the effect of *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo. App. 2001). That decision held that while the respondents could move to withdraw a previously filed admission of liability, the respondents were not actually assessed the burden of proof to justify that withdrawal. The amendment to § 8-43-201(1), C.R.S. placed that burden on the respondents and made such a withdrawal the procedural equivalent of a reopening. The statute serves the same function in regard to maintenance medical benefits. The Supreme Court in *Grover v. Industrial Commission*, 759 P.2d 705, 712 (Colo. 1988), provided that after the respondents had admitted for maintenance medical benefits “the employer retains the right to file a petition to reopen, ... for the purpose of either terminating the claimant’s right to receive medical benefits or reducing the amount of benefits available to the claimant.” The amendments to § 8-43-201(1), C.R.S., then, require that when the respondents seek a ruling at hearing that would serve as “terminating the claimant’s right to receive medical benefits,” they are seen as seeking to reopen that admission and the burden is theirs. In *Salisbury v. Prowers County School District, supra*, we held that

where the effect of the respondents' argument is to terminate previously admitted maintenance medical treatment, the respondents have the burden pursuant §8-43-201(1), C.R.S., to prove that such treatment is not reasonable, necessary or related.

In her supplemental order, the ALJ made corresponding findings which alternated the burden of proof between the claimant and the respondents. As to the findings both in respect to the specific treatment recommendations of Dr. Caton and the contention of the respondents that no future treatment is related to the work injury, the ALJ found the claimant had failed to satisfy his burden of proof while the respondents succeeded in achieving theirs'. The ALJ concluded a preponderance of all the evidence established that no further medical treatment was necessary to treat the claimant's work injury.

On appeal, the claimant contends his attorney has not prevailed in a workers' compensation case in the previous 15 years. He also estimates his attorney will never prevail in such a case in the future. He blames this futility on physicians that are paid to examine claimants, on a workers' compensation system which continually becomes more difficult for claimants to apply, and to judges, both at the in the Office of Administrative Courts and at the Industrial Claim Appeals Office, who are drawn from backgrounds featuring work at either the Attorney General's office or as attorneys representing respondents. He concludes that "Respondents will always prevail, as they have 100% of the time in the undersigned's experience during the last 15 years or so..."

The ALJ correctly noted in her supplemental order that these arguments by the claimant were not helpful in analyzing his claim. In order to impose liability for medical treatment, the ALJ must find the need for treatment was proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(b), C.R.S. The determination of whether the claimant proved causation is one of fact for the ALJ. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000). To prove causation, it is not necessary to establish that the industrial injury was the sole cause of the need for treatment. Rather, it is sufficient if the injury is a "significant" cause of the need for treatment in the sense that there is a direct relationship between the precipitating event and the need for treatment. *Reynolds v. U.S. Airways, Inc*, W. C. Nos. 4-352-256, 4-391-859, 4-521-484 (May 20, 2003). Thus, if the industrial injury aggravates or accelerates a preexisting condition so as to cause a need for treatment, the treatment is compensable. *Joslins Dry Goods Co. v. Industrial Claim Appeals Office*, 21 P.3d 866 (Colo. App. 2001); *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *Seifried v. Industrial Commission*, 736 P.2d 1262 (Colo. App. 1986).

Consequently, we must uphold the ALJ's order if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. In this regard, it was the prerogative of the ALJ to assess the weight and credibility of the medical records offered on the issue of causation. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). The ALJ did find more credible the reports of Dr D'Angelo than those of Dr. Caton. Given that the record consisted only of the reports from these two doctors completed in 2013, which arrived at opposing conclusions, the ALJ was compelled to find one more authoritative than the other and direct the outcome of her order in a corresponding manner. The medical report of Dr. D'Angelo represents substantial evidence to support the findings of the ALJ. As a result, we perceive no persuasive reason to question the ALJ's findings or conclusions.

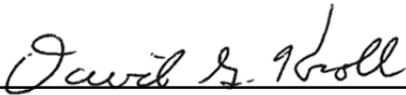
Insofar as the claimant asserts the workers' compensation system is biased against him as a characteristic unconstitutional breach of substantive due process, his contention is difficult to understand. A cursory review of ALJ and Panel orders issued in the past 15 years reveals claimants routinely prevailing in their claims. Decisions favoring the position of the claimant have been rendered by ALJs and Panel examiners regardless of their professional experience prior to appointment to the bench. General arguments that the statute is in breach of standards of procedural and substantive due process have been rejected by the Colorado Supreme Court, *Colorado AFL-CIO v. Donlon*, 914 P.2d 396 (Colo. 1995); *Duran v. Industrial Claim Appeals Office*, 883 P.2d 477 (Colo. 1994). Despite the fact that the claimant's attorney has been unsuccessful in his workers' compensation practice for the previous 15 years we cannot construe his attorney's misfortune as an objective basis for finding error with the ALJ's decision in this matter.

Accordingly, we find no compelling reason to attribute error to the decision of the ALJ and therefore affirm that decision.

**IT IS THEREFORE ORDERED** that the ALJ's order issued May 19, 2014, is affirmed.

JESUS MUNOZ  
W. C. No. 4-780-871-03  
Page 6

INDUSTRIAL CLAIM APPEALS PANEL

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

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

JESUS MUNOZ  
W. C. No. 4-780-871-03  
Page 8

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 10//7/2014 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

JESUS MUNOZ, 1415 5TH STREET, GREELEY, CO, 80631 (Claimant)  
JBS SWIFT & COMPANY, Attn: ROXIE GARCIA, P O BOX 1450, GREELEY, CO, 80632-1450 (Employer)  
ZURICH AMERICAN, C/O: SEDGWICK CMS, P O BOX 14493, LEXINGTON, KY, 40512-4493 (Insurer)  
LAW OFFICES OF RICHARD K BLUNDELL, Attn: RICHARD K. BLUNDELL, ESQ., 1233 EIGHTH AVENUE, GREELEY, CO, 80631 (For Claimant)  
CLIFTON & BOVARNICK, P.C., Attn: CLIFTON BOVARNICK, ESQ., 789 SHERMAN STREET, SUITE 500, DENVER, CO, 80203 (For Respondents)

## INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-905-869-01

IN THE MATTER OF THE CLAIM OF

MOHAMED ABDI OSMAN,

Claimant,

v.

COLORADO CAB COMPANY,

Employer,

and

OLD REPUBLIC INSURANCE COMPANY,

Insurer,  
Respondents.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Cannici (ALJ) dated May 6, 2014, that determined his average weekly wage (AWW) was \$162.56. We affirm.

This matter went to hearing over the claimant's AWW. After the hearing, the ALJ found that the claimant, a taxi cab driver, executed a contract with Colorado Cab Company (Colorado Cab). Pursuant to this contract, the claimant indefinitely agreed to lease a taxi cab from Colorado Cab for \$700.00 per week. The claimant also was responsible for additional costs, penalties, and fees assessed by Colorado Cab, including credit card and other processing fees, costs associated with accidents and repairs, fees and penalties associated with accidents, pass through of traffic and parking tickets, and other items.

The ALJ found that the claimant did not earn a salary from the respondent employer because he was an independent contractor. Instead, the claimant earned income by collecting fares from customers.

On December 6, 2012, the claimant was involved in a motor vehicle accident while operating his cab. The claimant filed a claim for compensation seeking an AWW of \$1,500. On December 27, 2012, the respondents filed a General Admission of Liability, acknowledging liability for medical benefits and an AWW of \$1.00.

The claimant continued to operate his cab and received medical care through Concentra Medical Centers. On October 7, 2013, authorized treating physician, Dr. Hattem, determined the claimant had reached maximum medical improvement (MMI), and concluded the claimant had suffered a 13% whole person impairment rating as a result of the automobile accident. The respondents filed a Final Admission of Liability (FAL) consistent with Dr. Hattem's impairment and MMI determinations. The FAL specified that the claimant earned an AWW of \$162.56 with an accompanying permanent partial disability rate of \$108.37. This revised AWW figure reflected the average net revenue generated by the claimant during the pertinent time frame. The claimant objected to the FAL, and filed an Application for Hearing.

Prior to the hearing, the parties filed a partial stipulation. Pursuant to this partial stipulation, the parties agreed that the claimant represented in a 1099 form that he was self-employed for income tax purposes. The parties also stipulated that the claimant's gross income from May 25, 2012, until December 31, 2013, totaled \$26,438.24, and the claimant incurred accompanying expenses of \$21,259.63. The parties agreed, therefore, that the claimant had a net income of \$5,178.61, an average of \$162.56 per week.

The ALJ ultimately found and concluded that the claimant worked as an independent contractor for Colorado Cab and earned an AWW of \$162.56. In making his AWW determination, the ALJ deducted the claimant's business expenses from his gross earnings, and determined that this was a fair approximation of his wage loss and diminished earning capacity. The ALJ held that the pertinent case law, including *Elliott v. El Paso County*, 860 P.2d 1363 (Colo. 1993), *Sneath v. Express Messenger*, 881 P.2d 453 (Colo. App. 1994), and *Hunterson v. Colorado Horseracing Association*, W.C. Nos. 4-552-585, 4-576-683 (Sept. 29, 2004), demonstrated that when a claimant is an independent contractor, expenses may be deducted from gross income if they bear a logical relationship to his ability to earn money. The ALJ found that all of the claimant's delineated expenses bore a logical relationship to his ability to earn money.

On appeal, the claimant argues that the ALJ abused his discretion in deducting his business expenses from his gross earnings in order to determine his AWW. The claimant asserts that AWW for both employed and self-employed workers must be based on gross income. The claimant contends that his expenses increase his gross income and, therefore, should be credited for purposes of calculating average weekly wage. The claimant asserts that an employer working with an independent contractor should not be allowed to disadvantage an independent contractor by being able to reduce gross wages by deducting reasonable business expenses paid by the independent contractor to run his

business. According to the claimant, this puts workers in a particularly vulnerable situation. We do not perceive an abuse of discretion.

Section 8-42-102(2), C.R.S, sets forth the method for calculating the average weekly wage. The overall purpose of the statutory scheme is to calculate "a fair approximation of the claimant's wage loss and diminished earning capacity." *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993). As such, §8-42-102(3), C.R.S., grants the ALJ substantial discretion to calculate the average weekly wage if any of the statutorily prescribed methods will not "fairly compute" the average weekly wage. Because the statute affords such discretion, we may not interfere with the ALJ's order unless an abuse is shown. An abuse of discretion exists if the ALJ's order is beyond the bounds of reason, as where it is contrary to law or unsupported by the evidence. *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867 (Colo. App. 2001).

Further, the ALJ's findings must be upheld if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires us to defer to the ALJ's resolution of conflicts in the evidence, his credibility determinations, and the plausible inferences he drew from the evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

Our appellate courts have held that if the claimant is paid a "wage" by his employer, then the AWW is to be calculated based on the gross wages without regard to expenses the claimant might have incurred to earn the wage. See *Sneath v. Express Messenger*, 881 P.2d 453 (Colo. App. 1994); *Fillipone v. Industrial Commission*, 41 Colo. App. 322, 590 P.2d 977 (1978). In *Elliott v. El Paso County*, 860 P.2d 1363 (Colo. 1993), however, the court held that depreciation claimed on a self-employed truck driver's tax return could be considered in calculating the driver's AWW. The court reasoned that the "cost of earnings must be considered in measuring those earnings." *Id.* at 1366. The *Elliott* court also held that it was not establishing a "per se rule of depreciation deduction for the simple reason that it would be manifestly unjust to require any depreciation deduction taken on a claimant's income tax return to be considered" when computing the AWW. Rather, the *Elliott* court held the "depreciation deduction must bear some logical relationship to a self-employed claimant's actual diminution in earnings as a result of capital expenditures." *Id.* at 1366.

The Panel subsequently issued *Hunterson v. Colorado Horseracing Assoc.*, W.C. Nos. 4-552-585, 4-576-683 (Sept. 29, 2004). In *Hunterson*, the Panel remanded the matter for the ALJ to determine whether the claimant was a wage earning employee of the Colorado Horseracing Association or was self-employed. The Panel held that if the

ALJ determined the claimant was self-employed, then the ALJ may consider the claimant's expenses in calculating her AWW. Consistent with the holding in *Elliott*, however, the Panel noted that the ALJ was not under an automatic obligation to treat every expense claimed on the tax return as a deduction from the claimant's gross earnings when calculating the AWW. Rather, the Panel explained that there must be a logical relationship between the deduction and the claimant's expenditures to earn money as a trainer/exerciser of horses. *See also Tozer v. Scott Wetzel Services, Inc.*, 883 P.2d 496 (Colo. App. 1994).

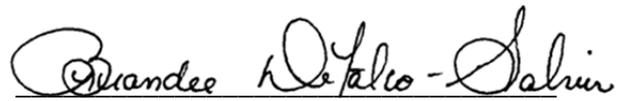
A review of the decisions issued in other states have held consistent with *Hunterson*. Those decisions have considered the appropriate method for determining a self-employed individual's wages for the purpose of calculating workers' compensation benefits. None has determined that a self-employed individual's average weekly wage should be based on gross income without taking into consideration the individual's business expenses. *See Vite v. Vite*, 377 S.W.3d 453 (Ark. App. 2010); *Florida Timber Products v. Williams*, 459 So. 2d 422 (Fla. App. 1984); *Hull v. Aetna Ins. Co.*, 541 N.W.2d 631 (Neb. 1996); *Appeal of Carnahan*, 821 A.2d 1122 (N.H. 2003); *Christian v. Riddle & Mendenhall*, 450 S.E.2d 510 (N.C. App. 1994); *State ex rel. Richards v. Indus. Comm.*, 673 N.E.2d 667 (Ohio App. 1996); *Meredith Construction Co. v. Holcombe*, 466 S.E.2d 108 (Va. App. 1996).

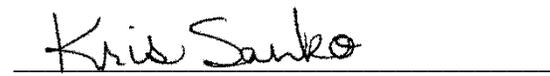
Here, as detailed above, neither party disputes that the claimant is self-employed. Pursuant to the parties' partial stipulation, the parties agreed that during all relevant periods, the claimant operated the cab using his own discretion subject to the terms of the lease and in accordance with controlling federal, state, and local law. The parties stipulated that the claimant is not paid wages by Colorado Cab, but instead is self-employed and collects fares from paying customers. Additionally, neither party disputes that the claimant is covered by the pertinent workers' compensation insurance policy issued by the respondent insurer. Although it is unclear why Colorado Cab is listed as the employer on this claim, in view of the parties' stipulations concerning the employment relationship, this is not an issue here. *See* §40-11.5-102(5)(a), C.R.S. Further, in his order, the ALJ held that all of the claimant's delineated expenses bore a logical relationship to his ability to earn an income as a cab driver. The claimant does not appear to dispute this finding. Further, there is substantial support for the ALJ's factual finding in this regard. Section 8-43-301(8), C.R.S. Thus, consistent with the holding in *Hunterson*, under the particular circumstances here, we conclude that the ALJ did not abuse his discretion in deducting the claimant's expenses from his gross wages when calculating his AWW. *See Tozer v. Scott Wetzel Services, Inc.*, *supra*. Consequently, we will not disturb the ALJ's order.

We are not otherwise persuaded by the claimant's remaining arguments on appeal.

**IT IS THEREFORE ORDERED** that the ALJ's order dated May 6, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

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

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

MOHAMED ABDI OSMAN  
W.C. No. 4-905-869-01  
Page 7

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 10/30/2014 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

THE GAIENNIE LAW OFFICE LLC, Attn: OZZIE A. MENDOZA, ESQ./MEREDITH A. QUINLIVAN, ESQ., 3801 E. FLORIDA AVE., STE 100, DENVER, CO, 80210 (For Claimant)  
MOSELEY, BUSSEY & APPLETON, P.C., Attn: SCOTT M. BUSSEY, ESQ., 300 SOUTH JACKSON STREET, SUITE 240, DENVER, CO, 80209 (For Respondents)

13CA1991 Spacecon v. ICAO 08-21-2014

COLORADO COURT OF APPEALS

DATE FILED: August 21, 2014  
CASE NUMBER: 2013CA1991

---

Court of Appeals No. 13CA1991  
Industrial Claim Appeals Office of the State of Colorado  
WC No. 4-792-073-03

---

Spacecon Specialty Contractors, LLC and Tristar Risk Management,

Petitioners,

v.

Industrial Claim Appeals Office of the State of Colorado and Erasmo Ordonez,

Respondents.

---

ORDER AFFIRMED

Division I  
Opinion by JUDGE KAPELKE\*  
Bernard and Navarro, JJ., concur

**NOT PUBLISHED PURSUANT TO C.A.R. 35(f)**

Announced August 21, 2014

---

Lee & Kinder, LLC, Francis M. Cavanaugh, Denver, Colorado, for Petitioners

No Appearance for Respondent Industrial Claim Appeals Office

Marra & Leavitt, LLC, Teresa A. Marra, Arvada, Colorado, for Respondent  
Erasmo Ordonez

\*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art. VI, § 5(3), and § 24-51-1105, C.R.S. 2013.

In this workers' compensation action, employer, Spacecon Specialty Contractors, LLC, and its insurer, Tristar Risk Management, seek review of a final order of the Industrial Claim Appeals Office (Panel) which affirmed the order of an administrative law judge (ALJ) awarding claimant, Erasmo Ordonez, medical benefits, as well as temporary and permanent total disability (TTD and PTD) benefits. We conclude that substantial evidence supports the ALJ's determination, and therefore affirm the Panel's order.

### I. Background

Claimant sustained an admitted, work-related injury to his back in 2008. His pain did not improve and instead spread to the big toe on his right foot. He also developed severe depression, which his psychologist believed was causally related to his work injury. The psychologist opined that claimant's pain and severe depression rendered him unable to work. The parties stipulated that claimant reached maximum medical improvement (MMI) in August 2010.

Claimant sought medical, PTD, and TTD benefits. During the ensuing hearing, employer questioned claimant's immigration

status. In response, claimant invoked his Fifth Amendment privilege against self-incrimination, choosing not to answer the question. Employer also inquired whether claimant had applied for social security disability benefits. The parties stipulated that claimant had not applied for social security disability benefits because he believed he would be ineligible.

Later in the hearing, a vocational evaluator retained by employer testified that claimant indicated he was ineligible for social security benefits because he did not have “papers.” The vocational evaluator took this response to mean that claimant was not legally in this country. Based on this testimony, and on claimant’s invocation of the Fifth Amendment privilege, employer argued that claimant was not entitled to PTD benefits because his immigration status, not his work-related injuries, prevented him from working.

The ALJ disagreed, however, finding instead that claimant’s work-related physical and mental disabilities rendered him unable to work. The ALJ therefore awarded claimant TTD benefits for the period before claimant reached MMI; PTD benefits “for the rest of

[c]laimant’s natural life”; and all causally related and reasonably necessary post-MMI medical maintenance care. Over employer’s objection, the ALJ declined to draw a negative inference from claimant’s invocation of the Fifth Amendment privilege, finding instead that there was “no evidence whatsoever” demonstrating that claimant had ever provided false documentation to obtain employment.

The Panel concluded that substantial evidence supported the ALJ’s decision, and therefore affirmed. This appeal followed.

## II. Analysis

Employer raises two arguments on appeal: (1) that claimant improperly invoked the Fifth Amendment and the ALJ failed to properly weigh the applicable Fifth Amendment factors; and (2) that the ALJ should have considered claimant’s immigration status in determining whether claimant is entitled to PTD benefits. We are not persuaded that any error occurred.

### A. Substantial Evidence Supports the ALJ’s Order

A claimant is entitled to PTD benefits if he or she is “unable to earn any wages in the same or other employment. Except as

provided in paragraph (b) of this subsection (16.5), the burden of proof shall be on the employee to prove that the employee is unable to earn any wages in the same or other employment.” § 8-40-201(16.5), C.R.S. 2013. “[A] claimant cannot obtain PTD benefits if he or she is capable of earning wages in any amount.” *Weld Cnty. Sch. Dist. RE-12 v. Bymer*, 955 P.2d 550, 556 (Colo. 1998).

“The determination whether a claimant is permanently and totally disabled is made on a case by case basis and varies according to the particular abilities and circumstances of the claimant.” *Holly Nursing Care Ctr. v. Indus. Claim Appeals Office*, 992 P.2d 701, 703 (Colo. App. 1999).

[I]n making a PTD determination, the ALJ may consider the effects of the industrial injury in light of the claimant’s human factors, including, *inter alia*, the claimant’s age, work history, general physical condition, and prior training and experience. . . . The crux of the test is the “existence of employment that is reasonably available to the claimant under his or her particular circumstances.”

*Joslins Dry Goods Co. v. Indus. Claim Appeals Office*, 21 P.3d 866, 868 (Colo. App. 2001) (quoting *Bymer*, 955 P.2d at 558.)

Whether a claimant is entitled to PTD benefits is a question of

fact for determination by the ALJ. *Joslins Dry Goods Co.*, 21 P.3d at 868-69. Therefore, if the ALJ's PTD determination is supported by substantial evidence in the record, we are bound by it. *Christie v. Coors Transp. Co.*, 919 P.2d 857, 860 (Colo. App. 1995), *aff'd*, 933 P.2d 1330 (Colo. 1997).

Here, the ALJ determined that claimant's physical and psychological injuries rendered him permanently and totally disabled and incapable of earning wages. He therefore awarded claimant PTD and other benefits. In reaching his conclusion, the ALJ found the opinions of claimant's psychologist and occupational therapist/vocational evaluator credible and persuasive. The psychologist and the occupational therapist took claimant's mental state into consideration when they opined that claimant was unable to work because of his work-related injuries. Conversely, the ALJ rejected the opinions of employer's vocational evaluator, partly because the evaluator did not rely on the opinion of any psychologist in reaching his conclusion, and partly because the evaluator conceded at hearing that if he had relied on claimant's psychologist, he would have found claimant unable to earn wages.

The weight to be given expert testimony is within the sound discretion of the ALJ. *Rockwell Int'l v. Turnbull*, 802 P.2d 1182, 1183 (Colo. App. 1990). We may not disturb the ALJ's credibility determinations absent a showing that the overwhelming weight of the evidence rebuts the opinion. *See Youngs v. Indus. Claim Appeals Office*, 2012 COA 85M, ¶ 46 ("Nor may we set aside a ruling dependent on witness credibility where the testimony has not been rebutted by other evidence."); *Arenas v. Indus. Claim Appeals Office*, 8 P.3d 558, 561 (Colo. App. 2000); *Rockwell Int'l*, 802 P.2d at 1183.

Although employer may disagree that the ALJ considered all relevant factors in weighing claimant's request for PTD benefits, the evidence in the record supports the ALJ's findings and conclusions. Because the evidence does not overwhelmingly rebut the ALJ's findings, and, to the contrary, supports them, we may not disturb the ALJ's credibility determinations. *See Youngs*, ¶ 46; *Arenas*, 8 P.3d at 561. Accordingly, because we conclude that substantial evidence supports the ALJ's determination that claimant was permanently and totally disabled, we find no error in the Panel's decision affirming the ALJ's order. *See Christie*, 919 P.2d at 860.

B. Because Substantial Evidence Supports the ALJ's Findings,  
Claimant's Immigration Status Was Irrelevant

Although the evidence supports the ALJ's findings and conclusions, employer contends that the ALJ erred by disregarding claimant's immigration status. Employer argues here, as it did before the Panel and the ALJ, that if claimant lacks legal authority to work in the United States, his immigration status creates a legal impediment which prevents him from earning wages. Thus, it claims, because claimant's legal status, and not his disability, may be the cause of his inability to work, the ALJ erred by disregarding claimant's immigration status.

A division of this court has held, however, that a worker's immigration status does not create a legal disability that precludes a claimant "as a matter of law from proving an entitlement to temporary disability benefits." *Champion Auto Body v. Indus. Claim Appeals Office*, 950 P.2d 671, 673 (Colo. App. 1997). Under *Champion Auto Body*, an individual illegally residing in this country may still recover workers' compensation benefits if injured on the job. Employer suggests, however, that *Champion Auto Body* does not foreclose consideration of immigration status.

We need not reach this question, however, because substantial evidence in the record, particularly the opinions of claimant's psychologist and occupational therapist, supports the ALJ's conclusion that claimant could not work, regardless of his immigration status. Indeed, the ALJ found that claimant would be permanently and totally disabled whether he lived in the United States or Mexico. Because substantial evidence supports the award of PTD benefits to claimant, we agree with the ALJ and the Panel, that claimant's immigration status is essentially irrelevant in this case.

C. Any Error Committed in Considering Claimant's Fifth Amendment Plea Was Harmless

Lastly, employer argues that the ALJ erred by permitting claimant to invoke the Fifth Amendment privilege without considering the requisite factors. We conclude that even if an error was committed, it was harmless given that substantial other evidence in the record supports the ALJ's decision.

As pertinent here, the Fifth Amendment to the United States Constitution provides as follows:

No person shall be held to answer for a capital

or otherwise infamous crime, unless on a presentment or indictment of a grand jury, except in cases arising in the land or naval forces, or in the militia, when in actual service, in time of war or public danger; . . . nor shall be compelled, in any criminal case, to be a witness against himself. . . .

U.S. Const. amend. V. When a party invokes his or her Fifth Amendment privilege against self-incrimination in a civil action, an ALJ, like a trial court,

must engage in a three-part balancing test before determining what adverse consequences, if any, will flow from that invocation.

Specifically, when confronted with the tension between the plaintiff's invocation of the privilege and the defendant's need for discovery, a trial court must determine: (1) whether the defendant has a substantial need for the information withheld; (2) whether the defendant has an alternative means of obtaining the information; and (3) whether any effective, alternative remedy, short of dismissal, is available. In applying the third prong of this analysis, the trial court must ensure that "the detriment to the party asserting [the privilege is] no more than is necessary to prevent unfair and unnecessary prejudice to the other side."

*Steiner v. Minnesota Life Ins. Co.*, 85 P.3d 135, 141 (Colo. 2004)

(quoting *SEC v. Graystone Nash, Inc.*, 25 F.3d 187, 192 (3d

Cir.1994)).

Employer contends that the ALJ failed to engage in the requisite inquiry before permitting claimant to invoke the Fifth Amendment privilege when asked about his immigration status. Upon review of the exchange between the ALJ and the parties, it is evident that the ALJ suggested that claimant might wish to invoke his privilege against self-incrimination. The ALJ advised the parties:

[T]his is a tough one, because I think you have the right to – and I’ve noticed something in the record, to advise [claimant] to be in the country illegally is a criminal offense. He should be advised of his [F]ifth [A]mendment right not to say something. . . . It shouldn’t come out of his lips. Do you want to advise your client of the [F]ifth [A]mendment rights not to say anything that will incriminate him?

In response, claimant’s counsel affirmatively answered that she did wish to so advise her client, after which claimant expressly stated that he was “taking my rights – assuming my rights under the [F]ifth [A]mendment.” The exchange makes clear that the ALJ did not engage in the three-part analysis mandated by *Steiner*.

Nevertheless, we conclude that employer’s contention that the

Fifth Amendment was improperly invoked and ruled upon provides no basis for setting aside the Panel's order. In light of the substantial evidence supporting the ALJ's findings and conclusions any error the ALJ committed was harmless. See § 8-43-310, C.R.S. 2013; *L.E.L. Constr. v. Goode*, 849 P.2d 876, 883 (Colo. App. 1992) (admission of report which may have contained inadmissible statement was harmless in light of testimony establishing assertions contained in report), *rev'd on other grounds*, 867 P.2d 875 (Colo. 1994); *Featherstone v. Loomix, Inc.*, 726 P.2d 246, 249 (Colo. App. 1986) (any error in the fact-finding process was harmless and not prejudicial where issue was resolved by legal question).

The testimony and opinions of claimant's psychologist and occupational therapist amply support the ALJ's finding that claimant's work-related mental and physical injuries prevented him from working and rendered him permanently and totally disabled.

Whether claimant is in this country legally and whether he is legally able to work does not change his physical and mental inability to work. The ALJ concluded, with record support, that

claimant's disability, not his immigration status, caused his loss of earning capacity. Consequently, inquiring into the bases for claimant's invocation of the Fifth Amendment, or analyzing the legal and evidentiary consequences of doing so would not have altered the outcome of the case. As employer concedes, even if claimant is in this country illegally, his immigration status does not bar him from receiving workers' compensation benefits. *See Champion Auto Body*, 950 P.2d at 673.

We therefore conclude that any error the ALJ may have committed in addressing or analyzing claimant's Fifth Amendment privilege against self-incrimination was harmless. *See* § 8-43-310.

The order is affirmed.

JUDGE BERNARD and JUDGE NAVARRO concur.

---

Court of Appeals No. 13CA1798  
Industrial Claim Appeals Office of the State of Colorado  
WC No. 4-850-627-03

---

DATE FILED: October 9, 2014  
CASE NUMBER: 2013CA1798

Norma Patricia Hoff,

Petitioner,

v.

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

Respondents.

---

ORDER SET ASIDE IN PART AND CASE  
REMANDED WITH DIRECTIONS

Division II

Opinion by JUDGE DAILEY

Casebolt, J., concurs in part and dissents in part  
Berger, J., concurs in part and dissents in part

Announced October 9, 2014

---

Scott A. Meiklejohn, LLC, Scott A. Meiklejohn, Denver, Colorado; Law Office of  
Worstell & Associates, David Worstell, Denver, Colorado, for Petitioner

No Appearance for Respondents Industrial Claim Appeals Office; Hernan  
Hernandez; MDR Roofing, Inc.; and Alliance Construction & Restoration, Inc.

Harvey D. Flewelling, Denver, Colorado, for Respondent Pinnacol Assurance

¶ 1 In this workers' compensation insurance coverage dispute, petitioner, Norma Patricia Hoff, seeks review of a final order of the Industrial Claim Appeals Office (Panel) affirming the order of an administrative law judge (ALJ). The ALJ's order awarded claimant, Hernan Hernandez, medical and disability benefits, and held Hoff (a statutory employer), MDR Roofing, Inc. (MDR) (claimant's direct employer), and the general contractor, Alliance Construction (Alliance), jointly liable for claimant's benefits. The Panel held that Hoff lacked standing to challenge the ALJ's ruling that MDR was not covered by an insurance policy issued by Pinnacol Assurance (Pinnacol) to MDR when claimant sustained serious work-related injuries.

¶ 2 We conclude that Hoff has standing.<sup>1</sup> We also conclude as a matter of law that the cancellation provision of the certificate of insurance issued by Pinnacol's agent required that notice of cancellation be given to Alliance, and that no such notice was

---

<sup>1</sup> This division is unanimous that Hoff has standing.

given.<sup>2</sup> We finally conclude that there are issues of fact that the ALJ must address in applying the law and, thus, a remand is required.<sup>3</sup> In addition, the Panel misconstrued the applicable law concerning estoppel; thus, we correct that interpretation.

Accordingly, we set aside the Panel's order as it relates to the liability of Hoff and Pinnacol, and remand for further proceedings.

### *I. Background*

¶ 3 Hoff owns a house that she uses as a rental property. After sustaining hail damage to the roof, Hoff and her husband engaged Alliance to negotiate with their insurance company to resolve their damage claim. Following a successful resolution, she and her husband contracted with Alliance to repair the roof. Without the Hoff's knowledge, Alliance verbally subcontracted the roofing job to MDR. Claimant was employed by MDR as a roofer.

---

<sup>2</sup> Judge Dailey and Judge Berger concur in this holding. Judge Casebolt dissents for the reasons set forth in his concurring and dissenting opinion.

<sup>3</sup> Judge Dailey and Judge Casebolt concur in this remand. Judge Berger dissents from this remand for the reasons set forth in his concurring and dissenting opinion.

¶ 4 While working on the Hoff roof in March 2011, claimant fell approximately twenty-five feet to the ground from the top of a ladder, sustaining serious injuries.

¶ 5 Claimant sought medical and temporary total disability (TTD) benefits for his work-related injuries. However, Pinnacol, MDR's insurer, denied the claim because MDR's policy had lapsed for failure to pay the premiums. Neither Alliance nor Hoff carried workers' compensation insurance.

¶ 6 The following facts are pertinent to the coverage issue. In October 2010, before starting the roofing job on the Hoff property, Alliance obtained a certificate of insurance (certificate) from Pinnacol's agent, Bradley Insurance Agency (Bradley), which verified that MDR had worker's compensation insurance through Pinnacol.

¶ 7 On February 10, 2011, Pinnacol sent a certified letter to MDR advising it that the policy was going to be cancelled if payment of a past due premium was not received by March 2, 2011. A relative of MDR's owner signed for the letter. However, MDR's owner testified he never received the letter and was not informed of its delivery. A copy of the letter was also mailed to and received by Bradley, as evidenced by the entry in Bradley's computerized log of

events. Alliance did not receive notice of the pending cancellation of MDR's workers' compensation insurance from Bradley or Pinnacol.

¶ 8 MDR did not pay the outstanding premium. The policy was therefore cancelled effective March 3, 2011. Pinnacol sent letters to MDR and Bradley advising of the policy's cancellation, but not to Alliance.

¶ 9 Claimant was injured on the job on March 10, 2011. On March 11, 2011, MDR's owner went to Bradley's office seeking to reinstate the policy. The agent advised him that the policy could be reinstated if he paid the past due premium, paid a reinstatement fee, and signed a no-loss letter. A no-loss letter is a statement by the insured that no injuries have occurred since the cancellation of the policy. Although the owner knew claimant had been injured since the policy's cancellation, he signed and submitted the no-loss letter. He did not inform Bradley about the accident.

¶ 10 Pinnacol reinstated the policy on March 11, 2011. Shortly thereafter, MDR's owner returned to Bradley's offices to report claimant's injuries. Bradley contacted a Pinnacol underwriter to advise her of the claim. Pinnacol contested the claim on coverage grounds, and subsequently cancelled the policy.

¶ 11 After conducting a hearing on the matter, the ALJ determined that the owner's failure to disclose claimant's injuries when he signed the no-loss letter to reinstate the policy was a material misrepresentation. He further found that the reinstated policy was void because of MDR's misrepresentation. Finding claimant was temporarily and totally disabled and concluding that no workers' compensation insurance policy was in effect insuring any of them, the ALJ held MDR, Alliance, and Hoff jointly liable for claimant's medical and TTD benefits. The Panel agreed and affirmed.

¶ 12 Hoff now appeals.<sup>4</sup> She contends that Pinnacol is estopped from denying benefits to claimant because

- Bradley, acting as Pinnacol's agent, issued the certificate to Alliance;
- the issuance of the certificate obligated Pinnacol or Bradley to notify Alliance that MDR's policy was being cancelled; and,
- she and Alliance relied on the certificate; and
- neither Bradley nor Pinnacol sent notice of cancellation to Alliance.

---

<sup>4</sup> MDR and Alliance have not appeared in this appeal.

¶ 13 Pinnacol contends that we need not reach this issue because Hoff has no standing to challenge the cancellation of MDR’s policy. Addressing, first, the issue of standing, we reject Pinnacol’s argument. Addressing Hoff’s contention, we agree in part, and remand the matter to the ALJ for further consideration.

## *II. Standing*

¶ 14 As Pinnacol points out, we lack jurisdiction to decide an issue unless the party seeking review has standing to assert it. See *Ainscough v. Owens*, 90 P.3d 851, 855 (Colo. 2004) (“In order for a court to have jurisdiction over a dispute, the plaintiff must have standing to bring the case. Standing is a threshold issue that must be satisfied in order to decide a case on the merits.”). If Hoff lacks standing to challenge Pinnacol’s cancellation procedures then her “case must be dismissed.” *First Comp Ins. v. Indus. Claim Appeals Office*, 252 P.3d 1221, 1222 (Colo. App. 2011).

¶ 15 To establish standing, a plaintiff must demonstrate (1) that she has sustained an injury in fact, and (2) that the injury is to a legally protected interest. *Id.* at 1223; see also *City of Greenwood Village v. Petitioners for Proposed City of Centennial*, 3 P.3d 427, 437 (Colo. 2000). “Whether the plaintiff’s alleged injury was to a legally

protected interest ‘is a question of whether the plaintiff has a claim for relief under the constitution, the common law, a statute, or a rule or regulation.’” *Barber v. Ritter*, 196 P.3d 238, 246 (Colo. 2008) (quoting *Ainscough*, 90 P.3d at 856). The question of “[w]hether a plaintiff has standing to sue is a question of law that we review de novo.” *Id.* at 245.

¶ 16 The first prong of the standing test is met in this case. The liability imposed on Hoff by the ALJ and the Panel exceeds \$300,000. Neither Alliance nor MDR has appeared in this court, and it is unclear from the record whether either is able to compensate claimant for his medical expenses and lost wages. But even if MDR and Alliance are able to contribute, unless Pinnacol is held liable for claimant’s benefits, a substantial liability must be borne by Hoff. Therefore, Hoff has demonstrated sufficient injury in fact to satisfy this requirement. *See O’Bryant v. Pub. Utils. Comm’n*, 778 P.2d 648, 653 (Colo. 1989) (“[T]he injury-in-fact element of standing does not require that a party undergo actual injury, as long as the party can demonstrate that the administrative action ‘threatens to cause’ an injury-in-fact.”).

¶ 17 The second prong of the standing test asks whether the plaintiff's alleged injury is to a legally protected interest. In concluding that Hoff did not have standing, the Panel relied on *First Comp*, 252 P.3d at 1224. There, the court held the insurer of a statutory employer liable for the decedent's funeral expenses. The insurer for the decedent's direct employer, Pinnacol, had cancelled the direct employer's policy for nonpayment of premium. Relying on *Chevron Oil Co. v. Industrial Commission*, 169 Colo. 336, 456 P.2d 735 (1969), a division of this court held that the statutory employer's insurer, First Comp, could not challenge Pinnacol's cancellation procedures because it was "outside the class of entities and persons the cancellation requirements are arguably intended to protect." *First Comp*, 252 P.3d at 1224.

¶ 18 In *Chevron*, the supreme court had held that workers' compensation insurance cancellation procedures are "for the protection of the claimant entitled to compensation." *Chevron*, 169 Colo. at 342, 456 P.2d at 738. Thus, another insurer or party, who could become liable for workers' compensation if the policy of the direct employer lapsed for nonpayment of premium, "is . . . not a

proper party to complain of non-compliance” with the statutory cancellation procedures. *Id.* at 342-43, 456 P.2d at 738.

¶ 19 Both *First Comp* and *Chevron* are distinguishable from this case. Hoff does not contend that she has standing to claim that Pinnacol breached the cancellation provisions of the policy that it issued to MDR, or that Pinnacol violated the statutory cancellation mandates set forth in section 8-44-110, C.R.S. 2014. If she had so claimed, both *First Comp* and *Chevron* would be dispositive of the standing issue. Instead, Hoff contends that she is a beneficiary of specific promises (external to the Pinnacol policy) made by Pinnacol or Bradley, its agent, to Alliance (and thus indirectly to her) that there was a workers’ compensation policy issued to MDR that was in force on the dates stated in the certificate. Thus, the source of Hoff’s claim for relief is neither the Pinnacol policy, nor the Workers’ Compensation Act (Act) itself, but promises allegedly made by Pinnacol or its agent to Alliance. This claim arises independently of any provisions of the Pinnacol policy or of the requirements of the Act, and thus this case is distinguishable from the claims adjudicated in both *First Comp* and *Chevron*.

¶ 20 Additionally, *First Comp* and *Chevron* are distinguishable because, unlike the parties in those cases, Hoff is not an insurer. First Comp sued Pinnacol directly in the former case, and in *Chevron*, “[t]he sole question at issue [was]: Which of the insurers [was] liable for the payment of benefits.” *Chevron*, 169 Colo. at 339, 456 P.2d at 736. Here, the Act anticipates that Hoff, as a statutory employer, is a party who must carry insurance. Indeed, it anticipates her inclusion within the group protected by workers’ compensation insurance by requiring persons who contract for the performance of construction work to either have workers’ compensation insurance or require proof of such insurance by obtaining a certificate of insurance from their contractor. See § 8-41-404(1)(a), C.R.S. 2014; see also § 8-40-102(1), C.R.S. 2014 (stating the intent of the General Assembly that the Act be interpreted so as to assure benefits to injured workers “at a reasonable cost to employers”).

¶ 21 Because the legislature intended that the Act not only protect and compensate workers but also protect remote employers, Hoff falls within the scope of persons or entities the Act covers, whereas the insurance companies in *First Comp* and *Chevron* did

not. Accordingly, the question whether Hoff has standing to assert the claim that Pinnacol is estopped from denying coverage is not governed by the principles set forth in *First Comp* and *Chevron*.

¶ 22 The substantive claim asserted by Hoff is promissory estoppel. In *Vigoda v. Denver Urban Renewal Authority*, 646 P.2d 900, 905 (Colo. 1982), the supreme court adopted the principles articulated in section 90(1) of the Restatement (Second) of Contracts, and thus recognized the quasi-contractual claim of promissory estoppel. The doctrine of promissory estoppel “encourages fair dealing in business relationships and discourages conduct which unreasonably causes foreseeable economic loss because of action or inaction induced by a specific promise.” *Kiely v. St. Germain*, 670 P.2d 764, 767 (Colo. 1983). Section 90(1) of the Restatement provides:

A promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee *or a third person* and which does induce such action or forbearance is binding if injustice can be avoided only by enforcement of the promise. The remedy granted for breach may be limited as justice requires.

Restatement (Second) of Contracts § 90(1) (1981) (emphasis added).

¶ 23 An indirect beneficiary of a promise, such as Hoff, may assert a promissory estoppel claim. *See Galie v. RAM Assocs. Mgmt.*

*Servs., Inc.*, 757 P.2d 176, 178 (Colo. App. 1988) (“[T]hird [parties], whom the promisor should reasonably expect to act as a result of the promise, may recover for a breach of that promise.”). While Pinnacol may not have known Hoff’s identity, it is certainly charged with knowledge that under the Act, a person may be liable for workers’ compensation benefits for a worker on a construction project if the contractors in the chain of the work do not obtain the requisite coverage and thus fail to comply with the Act. *See* § 8-41-402, C.R.S 2014. Thus, it was foreseeable that the owner of the property, whether or not known to Pinnacol, might rely upon the certificate.

¶ 24 Consequently, the facts of this case are sufficient to confer standing upon Hoff because she has a claim for relief under the common law and thus her injury in fact is to a legally protected interest. Whether Hoff can prove her claim of promissory estoppel is a separate question; we must not conflate the requirement for standing with a determination of the merits of the claim. *See In re B.B.O.*, 2012 CO 40, ¶ 14.

### *III. Promissory Estoppel*

¶ 25 Having determined that Hoff has standing to assert that Pinnacol is estopped from denying coverage for claimant's injuries, the next question is whether a remand is required. Hoff contends that the facts are essentially undisputed and that we should hold, as a matter of law, that Pinnacol is estopped. For a number of reasons, we disagree.

#### *A. Issue of Law or Issue of Fact?*

¶ 26 First, whether the elements of promissory estoppel have been proved generally presents a question of fact for the fact finder to resolve. *See Alexander v. McClellan*, 56 P.3d 102, 106 (Colo. App. 2002). Further, where more than one inference could be drawn from evidence adduced at a hearing, the issue must be determined by the trier of fact and cannot be determined as a matter of law. *Reynolds v. Farber*, 40 Colo. App. 467, 471, 577 P.2d 318, 320 (1978).

¶ 27 Here, the ALJ made no findings whatsoever concerning estoppel, although the Panel concluded that Hoff had properly raised that issue. In our view, except as set forth below, the ALJ should first address the issue as the fact finder, especially because

determining which of several inferences might be drawn from the evidence may prove crucial in deciding whether Hoff prevails on her promissory estoppel claim.

*B. What Law Should Be Applied?*

¶ 28 Second, even though the ALJ did not make any findings relative to estoppel, the Panel stated that

[N]o evidence was introduced substantiating Hoff's insinuation that she relied upon a certificate of insurance issued by Pinnacol regarding MDR's insurance coverage. In his order the ALJ instead found that a certificate of insurance was requested by, and provided to, the general contractor, Alliance, from Bradley. . . . The ALJ made no finding that a certificate of insurance was requested by Hoff from Pinnacol or that one was issued to Hoff from Pinnacol or from Bradley, on behalf of Pinnacol . . . . Hoff testified she never had heard of MDR prior to the claimant's fall. Hoff testified she had no idea that Alliance was not going to perform the actual roofing work . . . but, rather, she thought Alliance would be doing the work. . . .

[B]oth promissory estoppel and equitable estoppel require proof of a reasonable and detrimental reliance by one party on a representation by another party which was made with the intent of inducing action or forbearance. Since Hoff does not allege, and there is no evidence demonstrating that a certificate of insurance was issued to Hoff by Pinnacol or Bradley . . . then the elements of reliance and promise cannot be shown.

¶ 29 But there are several problems with the Panel's view of the law. Whether Pinnacol or Bradley (as Pinnacol's agent) should have

reasonably expected any promises set forth in the certificate to induce action or forbearance could relate to *either* Alliance or Hoff. *See Galie*, 757 P.2d at 178 (third parties, whom the promisor should reasonably expect to act as a result of the promise, may recover). Hoff might be the indirect beneficiary (a third person, as noted in *Galie*) of the promise, or Alliance could be the beneficiary, acting as Hoff's agent. Thus, contrary to the Panel's view, Hoff does not need to demonstrate that the certificate was issued to her or that she personally relied on it.

¶ 30 In addition, the Panel's statement that a representation must be made by another party with the intent of inducing action or forbearance is incorrect. Actual intent is not required. Instead, the test is whether the promisor reasonably should have expected that the promise would induce action or forbearance by the promisee. *Kiely*, 670 P.2d at 767; Restatement (Second) of Contracts § 90(1).

### *C. Promises and Disclaimers*

¶ 31 We also conclude that, as a matter of law, (1) the certificate required notice to Alliance; and (2) the disclaimers and exculpatory language in the certificate are invalid.

¶ 32 Alliance indisputably sought and obtained a certificate from Pinnacol's agent to protect itself and its customer, Hoff, from precisely the type of liability that has been assessed against Hoff by the Panel.

¶ 33 The legal meaning of the certificate, like any other legal writing, is a question of law. *Colo. Div. of Ins. v. Auto-Owner's Ins. Co.*, 219 P.3d 371, 376 (Colo. App. 2009).

¶ 34 The certificate, on its face, states that it was issued to Alliance. Directly adjacent to the portion of the certificate in which Alliance's name is affixed, there is a provision that addresses notification of any attempted cancellation of the policy. That provision reads as follows: "SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS."

¶ 35 The cancellation provision does not specify to whom notice of cancellation must be given by Pinnacol. But the language of the provision and its physical location on the certificate strongly suggest that Pinnacol or the agent that issued the certificate was required to give notice to Alliance of any termination of the policy.

¶ 36 Pinnacol, however, asks us to construe the cancellation provision to provide that the notice that Pinnacol undertakes to give is only notice to the policy holder, MDR, not the certificate holder. For the following reasons, we decline to do so.

¶ 37 A court must interpret a writing in its entirety, harmonizing and giving effect to all provisions so that none will be rendered meaningless. *Copper Mountain, Inc. v. Indus. Sys., Inc.* 208 P.3d 692, 697 (Colo. 2009). In our view, Pinnacol’s proffered interpretation does not give reasonable meaning to the words of the provision or the physical composition of the certificate, especially because Pinnacol was already required, by the terms of the policy, to give notice of termination to MDR.

¶ 38 Further, even if, as Judge Casebolt would hold in his dissenting opinion, the notice provision were ambiguous, the legal result would be the same. Under long-established principles, any “ambiguity in the policy language [of an insurance contract] is construed against the drafter and in favor of the insured.” *USAA Cas. Ins. Co. v. Anglum*, 119 P.3d 1058, 1060 (Colo. 2005); *see also Auto-Owner’s Ins. Co.*, 219 P.3d at 377. Because the certificate at issue here plays the same role as an insurance contract — to

protect the holder against liability — to the extent that there is any ambiguity in the cancellation provision, we conclude that the provision required that notice of cancellation be given to Alliance, the holder of the certificate.<sup>5</sup>

¶ 39 Further, courts may not enforce provisions of contracts that are contrary to public policy. *F.D.I.C. v. Am. Cas. Co.*, 843 P.2d 1285, 1290 (Colo. 1992). “A contractual provision is void if the interest in enforcing the provision is clearly outweighed by a contrary public policy.” *Huizar v. Allstate Ins. Co.*, 952 P.2d 342, 344 (Colo. 1998) (quoting *Am. Cas. Co.*, 843 P.2d at 1290). This principle extends to “conditions and terms of an insurance contract

---

<sup>5</sup> In addition, to the extent there is any ambiguity in the language used, courts may look to the conduct of the parties in construing an ambiguous writing. See Restatement (Second) of Contracts § 220(1) (1981) (“An agreement is interpreted in accordance with a relevant usage if each party knew or had reason to know of the usage and neither party knew or had reason to know that the meaning attached by the other was inconsistent with the usage.”); see also *id.* at § 219 (“Usage is habitual or customary practice.”). In this respect, we observe that the record discloses that when Pinnacol directly issues a certificate of insurance (as opposed to when a certificate is issued by Pinnacol’s agent), it gives notice to the certificate holder as a matter of course. Because it is undisputed that Bradley acted as Pinnacol’s agent in issuing the certificate to Alliance, it is legally immaterial that the certificate in this case was issued by Bradley and not directly by Pinnacol. Thus Pinnacol’s own course of conduct fully supports a determination that the certificate required notice to Alliance.

that undermine legislatively-expressed public policy.” *Id.*

¶ 40 The General Assembly has specifically recognized the role that certificates of insurance play in the workers’ compensation scheme. The Act expressly contemplates that a person or entity in the chain of contract or work on a construction contract may obtain a certificate of workers’ compensation insurance to protect itself from the types of liabilities at issue here. Section 8-41-404(5)(c) provides that a certificate of insurance constitutes proof that a complying workers’ compensation policy is in effect, and section 8-41-402(2) immunizes an owner from liability to an injured employee when a contractor or subcontractor has complying workers’ compensation insurance. Thus, by legislative mandate, certificates of insurance play a critical role in the workers’ compensation system — a critical role that would be wholly undermined if, as Pinnacol argues, either (1) notices of termination need not be provided to certificate holders or (2) various disclaimers and exculpatory language like that found in the certificate<sup>6</sup> could immunize insurers from any liability arising

---

<sup>6</sup> The certificate provides that it “is issued as a matter of information only and confers no rights upon the certificate holder” and “does not constitute a contract between the issuing insurer’s authorized representative . . . and the certificate holder.”

from the issuance of the certificate.

¶ 41 Colorado’s public policy, as described in the Act, requires that courts give effect to the reasonable meaning and purpose of certificates of insurance. To give effect to the role that the General Assembly contemplated certificates of insurance would play in the workers’ compensation system, we must (1) construe the certificate as requiring notice to the certificate holder of termination of coverage, and (2) disregard any language and disclaimers that would impede the certificate from fulfilling its statutorily-prescribed purpose.<sup>7</sup>

¶ 42 Pinnacol argues otherwise, relying on *Broderick Investment Co. v. Strand Nordstrom Stailey Parker, Inc.*, 794 P.2d 264, 266 (Colo. App. 1990), in which a division of this court held generally that a certificate of insurance is subject to the terms of the underlying

---

<sup>7</sup> For example, at oral argument, counsel for Pinnacol acknowledged that if this court were to give effect to the disclaimers contained in the certificate, the insurance coverage noted in the certificate could dissipate one minute after its issuance without any notice to the certificate holder. Thus, as construed by Pinnacol, the certificate is a meaningless document, which undermines both the express requirements and purposes of the Act. See §§ 8-41-402(2), 8-41-404(1)(a), (5)(c), C.R.S. 2014. This court, and the ALJ and Panel on remand, are prohibited by law from acquiescing in such an interpretation of the certificate.

policy, does not constitute a binder or contract of insurance, and does not create a duty to inform a certificate holder of changes in circumstances. Pinnacol's reliance upon *Broderick*, however, is misplaced. Although the disclaimers and exculpatory language in the certificate of insurance at issue in *Broderick* were similar to that of the certificate in this case, *Broderick* did not involve a certificate of insurance issued under the Act. As we explained above, certificates of insurance play an important role in the statutory scheme established by the Act: the Act specifically recognizes certificates of insurance as a mechanism to protect an owner from precisely the types of liabilities imposed on Hoff in this case. See §§ 8-41-402, 8-41-404(5)(c). Because *Broderick* was not a workers' compensation case, the division had no occasion to address the special role that certificates of insurance play in the workers' compensation area.

¶ 43 For the forgoing reasons, we conclude that Alliance (and thus Hoff indirectly) was entitled to rely on the substance of the certificate, free of the disclaimers and exculpatory language. Thus, Pinnacol was required to notify Alliance of the cancellation of MDR's policy. It is undisputed that neither Pinnacol nor its agent, Bradley,

did so.

#### *D. Remaining Factual Issues*

¶ 44 We do agree, however, that the fact finder must resolve all remaining factual issues relating to Hoff’s promissory estoppel claim — specifically, whether Alliance or Hoff relied upon the promises contained in the certificate, as we have construed them. In this respect, we disagree with Judge Berger that we may decide that issue as a matter of law. To the contrary, there is more than one reasonable inference that may be drawn from the facts, and in such circumstances, it is for the fact finder, not an appellate court, to determine what, if any, inferences should be drawn from the evidence presented.

#### *IV. Conclusion*

¶ 45 The order is set aside in part, and the case is remanded to the Panel for remand to the ALJ to resolve all remaining factual issues relating to Hoff’s promissory estoppel claim—specifically, whether (1) Alliance or Hoff relied upon the promises contained in the certificate, as we have construed them in this opinion; and (2) whether circumstances exist such that injustice can be avoided only by enforcement of the promises contained in the certificate. In

his discretion, the ALJ may conduct an additional hearing and allow submission of additional evidence.

JUDGE CASEBOLT concurs in part and dissents in part.

JUDGE BERGER concurs in part and dissents in part.

JUDGE CASEBOLT concurring in part and dissenting in part.

¶ 46 I fully concur that petitioner, Norma Patricia Hoff, has standing to challenge the ALJ's order and the Panel's conclusion that MDR was not covered by the insurance policy issued by Pinnacol to MDR. Therefore, I join in part II of the majority opinion. I also agree that the Panel misconstrued the law of promissory estoppel and that the case must be remanded to the ALJ to address whether a promise made by Pinnacol and Bradley induced action or forbearance and whether injustice can be avoided only by enforcement of the promise. Hence, I also join in subsections A, B, and D of part III of the majority opinion. However, I do not agree that the certificate, as a matter of law, promised that Pinnacol and Bradley would give notice to Alliance of any cancellation of coverage; nor do I agree that the disclaimers and exculpatory language in the certificate are invalid as a matter of law. Instead, I conclude that the promise in the certificate is ambiguous and I would therefore remand that issue to the ALJ for further consideration. Accordingly, I respectfully dissent from subsection C of part III of the majority opinion.

### *A. Issue of Fact or Law?*

¶ 47 As the majority correctly notes, whether the elements of promissory estoppel have been proved generally presents a question of fact for the fact finder to resolve, *see Alexander v. McClellan*, 56 P.3d 102, 106 (Colo. App. 2002), and where more than one inference could be drawn from evidence adduced at a hearing, the issue must be determined by the trier of fact and cannot be determined as a matter of law. *Reynolds v. Farber*, 40 Colo. App. 467, 471, 577 P.2d 318, 320 (1978).

### *B. Who Determines the Meaning of a Written Agreement?*

¶ 48 The legal meaning of a written agreement generally presents a question of law for a court to decide. *Colo. Div. of Ins. v. Auto-Owner's Ins. Co.*, 219 P.2d 371, 376 (Colo. App. 2009). However, when a written document contains a promise that is central to the dispute and the promise is ambiguous, the fact finder must determine the meaning of the promise in the same manner as other questions of fact. *Dorman v. Petrol Aspen, Inc.*, 914 P.2d 909, 912 (Colo. 1996); *Preserve at the Fort, Ltd. v. Prudential Huntoon Paige Assocs.*, 129 P.3d 1015, 1017-18 (Colo. App. 2004).

### *C. When Is a Document Ambiguous and What May Be Considered?*

¶ 49 Whether a contract or document is ambiguous presents a question of law for the court. *See Nat'l Cas. Co. v. Great Sw. Fire Ins. Co.*, 833 P.2d 741, 744-47 (Colo. 1992). The provisions of a document are ambiguous when they are susceptible to more than one reasonable interpretation. *See Union Ins. Co. v. Houtz*, 883 P.2d 1057, 1061 (Colo. 1994).

¶ 50 When a document is ambiguous, a fact finder may consider the statements or conduct of the parties before any dispute arose between them, the language of the document, the negotiations, if any, surrounding its creation, and any reasonable expectations the parties may have had. *See Fire Ins. Exch. v. Rael*, 895 P.2d 1139, 1142-44 (Colo. App. 1995); *see also* Restatement (Second) of Contracts § 220 (1981) (“An agreement is interpreted in accordance with a relevant usage if each party knew or had reason to know of the usage and neither party knew or had reason to know that the meaning attached by the other was inconsistent with the usage.”); *id.* at § 219 (“Usage is habitual or customary practice.”).

#### *D. Application of These Principles*

¶ 51 I conclude that the certificate is ambiguous and that the kind and nature of the promises and disclaimers contained in the certificate present factual issues that the ALJ should first decide.

¶ 52 The certificate, which is dated October 20, 2010, identifies Alliance as the certificate holder and promises that a workers' compensation policy was in force as of that date, insuring MDR, with effective dates of July 9, 2010, to July 1, 2011. Concerning cancellation, the certificate promises that, "Should any of the above described policies be cancelled before the expiration date thereof, notice will be delivered in accordance with the policy provisions." This language is immediately adjacent to the designation of Alliance as the certificate holder.

¶ 53 But what does that promise mean? It does not specify that notice will be given to the certificate holder. One possible interpretation, adopted by the majority, is that the language of this provision and its physical location on the certificate required Pinnacol or Bradley to give notice to Alliance of any cancellation of the policy. And there are inferences that may be gleaned from the record to support this view.

¶ 54 For example, Pinnacol's underwriter testified at the hearing that the purpose of a certificate of insurance is to ensure that insurance coverage is in effect. She stated that both Pinnacol and Bradley, its agent, typically supply certificates of insurance upon request of the insured.

¶ 55 The underwriter testified that Bradley issued three different certificates to Alliance concerning workers' compensation coverage for MDR: one dated October 20, 2010 (showing coverage from July 9, 2010, to July 1, 2011); one dated March 11, 2011 (showing the same coverage dates); and one dated June 9, 2011 (stating that there was coverage from July 9, 2010, to March 11, 2011). From this, a fact finder could infer that Bradley sent a certificate to Alliance every time some type of coverage event occurred, but did not advise Alliance of the pending cancellation, thus breaching a promise made to Alliance.

¶ 56 Further, the underwriter testified that when an insured requests Pinnacol, itself, to issue a certificate, and it does so, Pinnacol affirmatively undertakes to notify a certificate holder when a cancellation of the insurance policy is upcoming. She explained that a certificate holder can receive either ten or thirty days' notice

when the policy is pending cancellation. But no explanation was given for why Bradley, Pinnacol's acknowledged agent, did not provide such notice here, even though the underwriter acknowledged that Bradley had the authority to issue certificates on Pinnacol's behalf.

¶ 57 At the same time, however, the certificate does not affirmatively promise that notice will go to Alliance in the event of cancellation. Instead, it states that notice "will be given in accordance with the policy provisions." There is no dispute here that MDR's workers' compensation policy provides only for notice to be given to the named insured, not to any certificate holder. Accordingly, a fact finder could infer that a certificate holder has no rights.

¶ 58 This inference is buttressed by the certificate's disclaimer. It cautions:

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policies below. This certificate of insurance does not constitute a contract between the issuing

insurer(s), authorized representative, or producer and the certificate holder.

¶ 59 Relying on these disclaimers, Pinnacol’s counsel asserted during oral argument before us that the document certifies the existence of workers’ compensation coverage only for the brief instance or transitory moment in time when the certificate itself is generated and sent to the holder; hence, he argued that the holder cannot rely on the certificate or the existence of coverage. But that assertion could fly in the face of the General Assembly’s stated purpose in providing for the use of certificates of insurance.

¶ 60 Pertinent portions of section 8-41-404, C.R.S. 2014, provide:

(1)(a) . . . [E]very person performing construction work on a construction site shall be covered by workers’ compensation insurance, and a person who contracts for the performance of construction work on a construction site shall either provide . . . workers’ compensation coverage for, or require proof of workers’ compensation coverage from, every person with whom he or she has a direct contract . . .

. . . .

(5) As used in this section:

. . . .

(c) “Proof of workers’ compensation coverage” includes a certificate or other written confirmation, issued by the insurer or authorized agent of the insurer, of the existence of workers’ compensation coverage in force during the period of the performance of construction work on the construction site.

¶ 61 Hence, a person who contracts for the performance of construction work must have workers’ compensation insurance or obtain a certificate that demonstrates the existence of coverage “during the period of the performance of construction work.”

Accordingly, when Alliance obtained the certificate from Bradley, it can be inferred that it was attempting to comply with the statutory requirement to secure proof of workers’ compensation coverage for MDR that was supposed to be in force while claimant was working on the Hoffs’ roof.

¶ 62 Thus, in light of the statutory language and absent more, the existence of the certificate here could lead to the conclusion that, on March 10, 2011, MDR had coverage in force. Indeed, the third certificate issued by Bradley to Alliance states that coverage existed to March 11, 2011, one day *after* the claimant was injured.

¶ 63 The majority reads the certificate to have a definite meaning and term, requiring Pinnacol or Bradley to give notice of

cancellation to Alliance. But, I am not convinced that it is appropriate for this court to reach that conclusion instead of allowing the ALJ, as fact finder, to make that determination, especially because there are conflicting inferences under the circumstances described. *See Rael*, 895 P.2d at 1142-44 (when a document is ambiguous, a fact finder may consider the statements or conduct of the parties before any dispute arose between them, the language of the document, the negotiations, if any, surrounding its creation, and any reasonable expectations the parties may have had); *see also Dorman*, 914 P.2d at 912 (when there is ambiguity in a written document, the fact finder must determine its meaning in the same manner as other questions of fact).

¶ 64 The majority concludes that, even if the notice provision is ambiguous, it must be construed against Pinnacol and Bradley and in favor of the insured. But MDR is the insured in this instance, not Hoff; hence, I do not view the legal principle as applicable in this instance. Furthermore, the certificate itself expressly states that it “does not constitute a contract between the issuing insurer(s), authorized representative, or producer and the certificate

holder,” and there is no indication that consideration was given by Alliance in return for any promise the certificate makes.

¶ 65 In addition, section 8-41-404(5)(c), does not contain any definition of a certificate of insurance, nor does it mandate that notice by the insurer must be given to a certificate holder. Instead, it simply states that a person who contracts for the performance of construction work on a construction site (here, Hoff and Alliance) shall require proof of workers’ compensation insurance, which proof may consist of a certificate or other written confirmation issued by the insurer or authorized agent of the insurer, of the existence of workers’ compensation coverage in force during the period of the performance of the work. I cannot construe this statute to require something it clearly does not. *See Colo. Dep’t of Revenue v. Hibbs*, 122 P.3d 999, 1004 (Colo. 2005) (courts do not add words to a statute or subtract words from it); *Town of Telluride v. Lot Thirty-Four Venture, L.L.C.*, 3 P.3d 30, 35 (Colo. 2000) (courts will not read into a statute an exception or proviso that the plain language does not suggest). And for similar reasons, I cannot agree with the majority that the disclaimers are void as a matter of law as against

public policy. The statute does not impose a duty to give notice of cancellation, or otherwise mandate that outcome.

¶ 66 Hence, given the conflicting inferences that can be drawn from the evidence, and the complicating factor of the language in section 8-41-404(5)(c), I perceive that the promise is ambiguous under these circumstances. In light of the ambiguity of the certificate, I conclude that factual determinations must be made concerning the first prong of Hoff's promissory estoppel claim. Accordingly, I would remand the entire promissory estoppel issue to the ALJ.

¶ 67 I therefore concur in part and respectfully dissent in part.

JUDGE BERGER concurring in part and dissenting in part.

¶ 68 In my view, Pinnacol is estopped, as a matter of law, from denying coverage for the injured claimant's benefits. The facts that are material to this determination are undisputed. Applying the law to these undisputed facts leads inexorably to this conclusion. Thus, while I agree completely with the majority's determination that Hoff has standing, and that, as a matter of law, Pinnacol had a legal duty to give notice of cancellation to Alliance, I disagree that a remand is necessary.

#### *I. Promissory Estoppel*

¶ 69 Hoff has pleaded a claim of promissory estoppel. The elements of promissory estoppel are: (1) a promise which the promisor should reasonably expect to induce action or forbearance of a definite and substantial character on the part of the promisee or a third person; (2) action or forbearance induced by that promise; and (3) the existence of circumstances such that injustice can be avoided only by enforcement of the promise. *Nelson v. Elway*, 908 P.2d 102, 110 (Colo. 1995); *Galie v. RAM Assocs. Mgmt. Servs., Inc.*, 757 P.2d 176, 178 (Colo. App. 1988). I believe that we can, and should, determine, as a matter of law, that the Panel was incorrect in

concluding that these elements are not met here.

*A. The Promise*

¶ 70 The majority has properly held that the cancellation provision of the certificate required Pinnacol or its agent to give notice of policy cancellation to Alliance. This is the promise that establishes, as a matter of law, the first element of a claim for promissory estoppel. And, the majority has corrected the Panel's erroneous view that the promise must have been made directly to Hoff; as the majority explains, the law is otherwise.

*B. Action or Forbearance Induced by the Promise*

¶ 71 The record establishes without contradiction that Alliance affirmatively sought evidence that MDR had workers' compensation insurance and, in fact, obtained the certificate. Based on the uncontradicted evidence that Alliance ceased working with MDR immediately after belatedly learning of the policy cancellation, the only reasonable inference that can be drawn is that Alliance would have taken steps protecting it, and hence Hoff, from liability if Pinnacol had met its legal obligation to provide notice of cancellation to Alliance.

¶ 72 Alliance was required by law either to obtain its own workers'

compensation insurance or obtain proof (such as a certificate of insurance) that another party in the chain of the construction work had such insurance. *See* § 8-41-404(1)(a), (5)(c), C.R.S. 2014. People are presumed to obey the law absent evidence to the contrary. No contrary evidence exists in this record; moreover, given that Alliance initially obtained the certificate in order to comply with its obligations under section 8-41-404(1)(a), it is reasonable to infer that Alliance would have taken additional actions to remain in compliance had it learned that MDR no longer possessed the legally required coverage. Any contrary finding by the ALJ would be without record support and clearly erroneous.

¶ 73 Additionally, the undisputed facts permit no factual determination other than that Hoff relied on Alliance's statement that it had liability coverage — an assurance which was based on Alliance's belief that MDR was adequately insured, which, in turn, was based on the certificate from Pinnacol. Consequently, Hoff took no further steps to protect herself from the type of liability at issue here, thus demonstrating a forbearance indirectly induced by the certificate's promise that MDR had workers' compensation

insurance.<sup>1</sup> Accordingly, Hoff has established, as a matter of law, the second element of a promissory estoppel claim.

¶ 74 I therefore disagree with the majority that it is not appropriate for us to make this determination. “If facts are undisputed and reasonable minds could draw but one inference from them, [the determination of an ultimate fact] is a question of law for [an appellate] court.” *Schrieber v. Brown & Root, Inc.*, 888 P.2d 274, 277 (Colo. App. 1993). This principle is fully applicable to workers’ compensation cases. *See id.*; *see also Dorsch v. Indus. Comm’n*, 185 Colo. 219, 221-22, 523 P.2d 458, 459 (1974); *Indus. Comm’n v. Havens*, 136 Colo. 111, 117, 314 P.2d 698, 701 (1957).

---

<sup>1</sup> An analogous situation arises in the context of the law of fraudulent misrepresentation. The maker of a fraudulent misrepresentation may be subject to liability to a third person who acts in justifiable reliance upon the misrepresentation if the maker has reason to expect that its terms will be repeated or its substance communicated to the third person and that it will influence his or her conduct in the transaction or type of transaction involved. Restatement (Second) Torts § 533 (1977). In such a context, the relevant inquiry is not whether the third person’s actions would have been different if the misrepresentation had not been made, but whether they *might* have been different. *See Morrison v. Goodspeed*, 100 Colo. 470, 479, 68 P.2d 458, 463 (1937). Similarly, here, the certificate was the basis for Alliance’s representation to Hoff that Alliance had coverage, and Hoff’s actions might have been different had the certificate never been issued to Alliance, and consequently Alliance had not made such an assurance to Hoff.

*C. Injustice Can Be Avoided Only by Enforcement of the Promise*

¶ 75 The third element of a claim for promissory estoppel is also met as a matter of law. In the absence of a viable claim for promissory estoppel, the result in this case is stark and fundamentally unjust: Hoff is indebted to the injured worker for an amount in excess of \$300,000 and Pinnacol, which issued the insurance policy and promised to notify Alliance of any cancellation of the policy, has no liability at all. This is an injustice which can be avoided only by sustaining Hoff's claim of promissory estoppel.<sup>2</sup>

*II. Conclusion*

¶ 76 I therefore agree with the majority that we must set aside the Panel's order insofar as it determined that Pinnacol was not liable

---

<sup>2</sup> Section 8-41-404(1)(a) provides that "a person who contracts for the performance of construction work on a construction site shall either provide . . . workers' compensation coverage for, or require proof of workers' compensation coverage from, every person with whom he or she has a direct contract to perform construction work on the construction site." A violation of this section is punishable by an administrative fine of not more than \$250 per day. §§ 8-41-404(3), 8-43-409(1)(b), C.R.S. 2014. However, the fact that Hoff may be liable for noncompliance with this requirement is not relevant to my determination that Pinnacol is estopped from denying benefits for claimant's injuries. In fact, that Hoff may be subject to a minimal administrative fine supports my conclusion that the General Assembly did not intend to impose on Hoff the immense amount of liability she is subject to under the Panel's order.

for medical and disability benefits to claimant, and that Hoff was liable for those benefits. However, I disagree that a remand is necessary to redetermine liability. Rather, this court should hold, as a matter of law, that Pinnacol is estopped from denying benefits to claimant. Because Pinnacol is estopped from denying benefits to claimant, there was a complying workers' compensation policy in effect, and Hoff, therefore, is not liable, also as a matter of law, for the claimant's benefits. See § 8-41-402(2), C.R.S. 2014 (immunizing owner from liability to a contractor or its employees if a complying workers' compensation insurance policy is in effect); *Wagner v. Coors Energy Co.*, 685 P.2d 1380, 1382 (Colo. App. 1984); see also *Krol v. CF & I Steel*, 2013 COA 32, ¶ 13.

¶ 77 I therefore concur in part and respectfully dissent in part.

14CA0297 Milroy v ICAO 11-06-2014

COLORADO COURT OF APPEALS

DATE FILED: November 6, 2014  
CASE NUMBER: 2014CA297

---

Court of Appeals No. 14CA0297  
Industrial Claim Appeals Office of the State of Colorado  
W.C. No. 4-884-077-02

---

Craig Milroy,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado and City of Colorado  
Springs,

Respondents.

---

ORDER AFFIRMED

Division II  
Opinion by JUDGE GABRIEL  
Casebolt and Román, JJ., concur

**NOT PUBLISHED PURSUANT TO C.A.R. 35(f)**  
Announced November 6, 2014

---

Steven U. Mullens, P.C., Pattie J. Ragland, Colorado Springs, Colorado, for  
Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Dworkin, Chambers, Williams, York, Benson & Evans, P.C., Gregory K.  
Chambers, Denver, Colorado, for Respondent City of Colorado Springs

In this workers' compensation action, claimant, Craig Milroy, seeks review of a final order of the Industrial Claim Appeals Office (Panel). The Panel affirmed the decision of an administrative law judge (ALJ) denying and dismissing claimant's claim. We conclude that (1) the record is sufficient to allow us to perform a meaningful appellate review, and thus, a new evidentiary hearing is unwarranted; and (2) substantial evidence in the record supports the ALJ's findings. Accordingly, we affirm.

### I. Background

Claimant has worked as a firefighter for the City of Colorado Springs (employer) since 1997. While on duty on March 30, 2012, he felt a twinge in his hip and down his legs. The next day, he again felt a twinge while sitting at his desk. He described the sensation as discomfort in his left hip and back and down his leg. This discomfort increased throughout the day, and over the next four days, claimant saw a chiropractor a total of six times and a deep muscle massage therapist once. By the end of the week, claimant felt significant relief.

A few days later, on April 11, 2012, claimant was awakened by

a fire alarm. He slid down the pole and “bunked out” (i.e., put on his fire gear). While doing so, he noted discomfort in his left leg, and this discomfort increased as he worked at the fire call. By the time claimant returned to the firehouse, he was in substantial pain and was unable to get comfortable standing, sitting, or lying down. After his colleagues administered intravenous fluids and gave him medication, he was transported to the emergency room, where he received additional medications to relieve his symptoms and pain. An MRI was taken the same day and revealed a herniated disc at L4-5.

Claimant sought workers’ compensation benefits, and employer contested that claim. On June 25, 2013, the ALJ conducted a videoconference hearing at which claimant and his expert, Dr. Jorge Klajnbart testified. Six days later, however, the ALJ emailed counsel for the parties to advise them that the hearing likely was not recorded due to an error on the ALJ’s part.

Thereafter, employer submitted the post-hearing evidentiary deposition of its expert, Dr. Elizabeth Bisgard, and both sides submitted position statements. In addition, claimant filed a

stipulated motion requesting that the ALJ's notes of the videoconference hearing be transcribed and submitted to the parties for inclusion in the record, "in order to preserve Claimant's case-in-chief." The ALJ granted this motion on July 30, 2013, and the order states that it was served on claimant's counsel on July 31, 2013. The ALJ's detailed notes were then made part of the record, although the record does not reflect precisely when this occurred.

On August 12, 2013, the ALJ issued his Findings of Fact, Conclusions of Law, and Order. As pertinent here, the ALJ found that claimant had failed to establish that he had sustained an injury arising out of and within the course of his employment. The ALJ thus concluded that claimant's claim was not compensable and denied and dismissed that claim.

The Panel subsequently affirmed the ALJ's decision, and claimant now appeals.

## II. Adequacy of the Record

Due to an error by the ALJ, the videoconference hearing was not recorded, and thus, no transcript of that hearing exists. (The transcript of Dr. Bisgard's post-hearing evidentiary deposition,

however, is in the record.) Claimant asserts that (1) the ALJ's failure to record the hearing was in violation of applicable statutory law, (2) claimant was deprived of the opportunity to attempt to reconstruct the transcript, and (3) any such reconstruction is now impossible because the ALJ has retired. Claimant thus contends that a new evidentiary hearing is required. We are not persuaded.

All testimony and argument at a workers' compensation hearing "shall either be taken verbatim by a hearing reporter or shall be electronically recorded by the division." § 8-43-213(1), C.R.S. 2014. The absence of a transcript, or a portion thereof, in a civil proceeding, however, does not necessarily bar appellate consideration or warrant a new hearing. *See, e.g., Goodwill Indus. v. Indus. Claim Appeals Office*, 862 P.2d 1042, 1046 (Colo. App. 1993) ("Even if there are some omissions in the transcript, if the relevant portions of the transcript are sufficient to allow review of the dispositive issues on appeal, the record is not insufficient to permit review.")

To obtain a new trial as relief for an inadequate record, an appellant must do three things:

“[A]n appellant seeking a new trial because of a missing or incomplete transcript must 1) make a specific allegation of error; 2) show that the defect in the record materially affects the ability of the appeals court to review the alleged error; and 3) show that a [C.A.R.] 10(c) proceeding has failed or would fail to produce an adequate substitute for the evidence. We believe these factors would be presented only in rare circumstances.”

*Knoll v. Allstate Fire & Cas. Ins.*, 216 P.3d 615, 617-18 (Colo. App. 2009) (quoting *Bergerco, U.S.A. v. Shipping Corp. of India*, 896 F.2d 1210, 1217 (9th Cir. 1990)).

Claimant has not met this burden here. Although he argues that he has been irreparably prejudiced because his entire case-in-chief is missing from the record, he makes no specific allegation of error, and he fails to acknowledge the import of the ALJ’s detailed hearing notes, which were made part of the record at claimant’s request and specifically to preserve claimant’s case-in-chief.

Nor has claimant shown how the missing transcript materially affects our ability to review any alleged errors, particularly given that the record includes (1) the ALJ’s detailed hearing notes; (2) all of the parties’ exhibits, including claimant’s personally-prepared chronology of events and voluminous medical records and reports;

(3) the transcript of Dr. Bisgard's post-hearing deposition; and  
(4) both parties' post-hearing position statements, which summarized the evidence in detail. In this regard, we note that claimant points to no errors or omissions in the ALJ's detailed hearing notes. Moreover, the ALJ's Findings of Fact substantially track the factual statement contained in claimant's position statement, belying any showing of prejudice.

And claimant has not shown that a C.A.R. 10(c) proceeding to complete the record has failed or would fail to produce an adequate substitute for the missing transcript. Claimant never made any effort to settle the record pursuant to C.A.R. 10(c). Moreover, although claimant repeatedly asserts that reconstruction of the record is impossible because the ALJ has retired, it is unclear to us why this is necessarily so. This is particularly true here, where the ALJ's detailed notes are in the record and would have guided the parties and any newly-appointed ALJ in settling the record, had any disputes about the evidence arisen.

For these reasons, we conclude that claimant has failed to show that this case comprises one of those "rare circumstances" in

which a missing transcript requires an entirely new evidentiary hearing. *See Knoll*, 216 P.3d at 617-18.

We are not persuaded otherwise by claimant's assertion that he was denied an opportunity to reconstruct the record because the appeals specialist for the workers' compensation division decreed the record complete just one day after claimant received the ALJ's notes. The record contains no evidence as to when claimant received the ALJ's notes. In any event, claimant did not make this argument before the Panel. Accordingly, we will not consider it. *See Arenas v. Indus. Claim Appeals Office*, 8 P.3d 558, 561 (Colo. App. 2000) (declining to address an argument that the claimant did not raise before the Panel).

Because the ALJ's error in not recording the videoconference hearing has not materially impaired our ability to conduct a meaningful appellate review, we conclude that a new evidentiary hearing is unwarranted.

### III. Substantial Evidence

Claimant next contends that the ALJ abused his discretion by denying and dismissing claimant's claim. Specifically, claimant argues that substantial evidence in the record shows that he sustained an accidental injury arising out of and in the course and scope of his employment. He further asserts that the ALJ applied the wrong legal standard when he characterized claimant's injury as an occupational disease, rather than as an injury resulting from an acute event occurring within the course and scope of claimant's employment. We are not persuaded.

#### A. Standard of Review

Before any compensation is awarded, a claimant must prove causation of an injury by a preponderance of the evidence.

*Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000). Whether a claimant has met his or her burden of establishing that an injury is compensable is a question of fact for the ALJ's determination. See *H&H Warehouse v. Vicory*, 805 P.2d 1167, 1170 (Colo. App. 1990) ("The ALJ has great discretion in determining the facts and deciding ultimate medical issues."). If

substantial evidence supports the ALJ's findings of fact, we are bound by and may not alter them. See § 8-43-308, C.R.S. 2014; *Leeway v. Indus. Claim Appeals Office*, 178 P.3d 1254, 1256 (Colo. App. 2007). This is true even when the evidence was conflicting and would have supported a contrary result. See *Pacesetter Corp. v. Collett*, 33 P.3d 1230, 1234 (Colo. App. 2001). We must defer to the ALJ's credibility determinations and resolution of conflicts in the evidence, and we may not substitute our judgment for that of the ALJ. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995).

#### B. Discussion

Here, claimant's expert, Dr. Klajnbart, testified at the videoconference hearing that claimant's herniated disc resulted from an acute event that occurred when he was responding to a call on April 11, 2012, and not from any outside work that he may have performed. Specifically, Dr. Klajnbart testified that claimant's disk herniation was caused by sliding down the pole and putting his bunkers on.

In contrast, employer's expert, Dr. Bisgard, testified that her

review of claimant's records and her conversation with claimant revealed no specific isolated event that brought on his symptoms. Rather, he was merely sitting in a chair when the symptoms developed, and sitting in a chair would not be considered a risk factor for the development of a herniated disk.

Having thus found no acute event that caused claimant's disk issue, Dr. Bisgard proceeded to evaluate whether claimant's general work activities resulted in a compensable occupational disease to his low back. Although Dr. Bisgard noted the high force and intensity of firefighting, she observed that this intensity was for short and infrequent durations, giving the body significant "down time" for recovery. She thus concluded that claimant did not meet the threshold for duration and frequency necessary to allow her to conclude that claimant had suffered a compensable occupational disease. As a result, Dr. Bisgard opined that claimant's back pain was most likely the result of "an insidious onset of a herniated disk regardless of his occupation" and that his condition was "just something that evolved over a period of time."

The ALJ found that Dr. Bisgard's opinions were "credible and

more persuasive” than those of Dr. Klajnbart and rejected Dr. Klajnbart’s testimony that claimant’s injury was the result of an acute event occurring in the course of his employment. These findings are supported by substantial evidence in the record. For example, evidence in the record shows that:

- Claimant noted a twinge on March 30, 2012 and then again on March 31, 2012.
- In the chronology that he prepared, claimant never mentioned any acute injury from sliding down the pole.
- When Dr. Bisgard specifically asked claimant if he was injured coming down that pole, he denied that he was and said that sliding down the pole was “nothing that made him say ‘ouch.’”
- Dr. Bisgard testified that Dr. Klajnbart’s April 2012 clinical note made no mention of any acute onset of pain that occurred when claimant slid down the pole. To the contrary, the note specifically said, “No acute event.”
- Claimant saw Dr. Greg Sabin at Sabin Chiropractic and told Dr. Sabin that his pain came “out of [the] blue” with no lifting or acute aggravation.

- Claimant saw a massage therapist on April 4 and April 6, 2012, and the therapist's clinical notes do not document claimant's having had any kind of acute injury that caused the onset of his low back pain.
- When claimant went to the emergency room on April 11, 2012, he reported that (1) he had been having left hip and back pain for approximately one week; (2) he had been doing better; and (3) that morning, when getting off the fire truck on a call, his back "kind of seized up."
- On April 11, 2012, claimant saw Dr. Miguel Castrejon. Claimant reported to Dr. Castrejon that he initially noticed discomfort to his low back on the morning of March 31, 2012, as he was sitting at his desk. He further stated that on April 11, 2012, as he was getting out of bed in response to an alarm, he noticed an increase in low back pain. Dr. Castrejon noted in his report that claimant could not recall any particular activity resulting in either low back or left leg pain.
- On or about April 16, 2012, claimant saw Dr. Susan Dern, and he was unable to isolate a specific injury that caused the

onset of his low back and left leg pain. Rather, he noted that he was awakened to answer a fire call and felt back, hip, and leg discomfort.

- On April 24, 2012, claimant told Dr. Joseph Illig that his symptoms gradually began toward the end of March 2012. Dr. Illig noted that claimant did not have “a specific clear precipitating event which led to these symptoms.”
- Although Dr. Klajnbart testified at the hearing that claimant had an acute injury from sliding down the pole and putting his bunkers on, Dr. Klajnbart’s clinical notes and an undated report in the record proffer no such opinion. Nor did he ever opine that claimant’s work activities rose to the level of a compensable occupational disease.

As noted above, we must defer to the ALJ’s credibility determinations and resolution of conflicts in the evidence, and we may not substitute our judgment for that of the ALJ. *Metro Moving & Storage Co.*, 914 P.2d at 415; *see also Rockwell Int’l v. Turnbull*, 802 P.2d 1182, 1183 (Colo. App. 1990) (noting that the weight to be accorded expert testimony is a matter exclusively

within the discretion of the ALJ as fact-finder). Because substantial evidence supports the ALJ's findings here, we are bound by and may not alter those findings. See § 8-43-308; *Leeway*, 178 P.3d at 1256.

We are not persuaded otherwise by claimant's assertion that the ALJ never considered claimant's position regarding his alleged acute injury but rather focused exclusively on the issue of occupational disease, thus applying the wrong compensability test. For the reasons discussed above, the ALJ properly rejected Dr. Klajnbart's testimony regarding claimant's alleged acute injury and considered the possibility of compensable occupational disease only after having done so.

Accordingly, we conclude that the Panel did not err in affirming the ALJ's decision.

#### IV. Conclusion

For these reasons, the order is affirmed.

JUDGE CASEBOLT and JUDGE ROMÁN concur.