

BROWN BAG SEMINAR

Thursday, November 21, 2013

(third Thursday of each month)

Noon - 1 p.m.

633 17th Street

Conference Room 12 A

(note different meeting place)

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 Court of Appeals decisions issued from
October 12, 2013 through November 15, 2013

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-779-040 & 4-844-545

IN THE MATTER OF THE CLAIM OF

JAMES TENNAPEL,

Claimant,

v.

FINAL ORDER

BOWIE RESOURCES, LLC, and
OXBOW MINING,

Employers,

and

NEW HAMPSHIRE INSURANCE and
PINNACOL ASSURANCE COMPANY,

Insurers,
Respondents.

The respondents, Oxbow Mining and Pinnacol Assurance (Oxbow), seek review of an order of Administrative Law Judge Mottram (ALJ) dated July 9, 2013, that denied and dismissed the claimant's petition to reopen his claim against Bowie Resources and New Hampshire Insurance Company (Bowie) and ordered Oxbow to pay for the claimant's medical care and temporary disability benefits after January 3, 2011. We affirm the ALJ's order.

This case previously was before us. In his initial order the ALJ found that the claimant sustained an admitted injury to his cervical spine on November 23, 2008, while employed by Bowie. The claimant was involved in an explosion that caused him to hit his head on the roof of a mine. The claimant was placed at maximum medical improvement (MMI) for this injury on April 28, 2009, and given a 10 percent whole person rating. Bowie filed a final admission of liability consistent with the MMI date and impairment rating. The claimant's treating physician recommended follow up care noting that the claimant could need surgical treatment at some time in the future.

The claimant quit working for Bowie and began working for a separate employer loading trucks. The claimant testified that this position required the claimant to lift up to 70 pounds. During this period of time, between being placed at MMI and beginning to work for Oxbow, the claimant did not receive treatment for his cervical spine condition.

On July 13, 2010, the claimant began working as a laborer for Oxbow, performing strenuous tasks such as lifting and carrying up to 100 pounds. On January 3, 2011, the claimant worked a particularly rough shift. On that day the claimant was sent into an area of the mine that was heavily heaved to the point that the ceiling of the mine was less than 5 feet. As he was working he struck his head at least twice on roof bolts and one time was knocked to the ground. The claimant testified that after his shift his neck was pulsating and he was taken by ambulance to the emergency room. The claimant underwent cervical surgery on January 19, 2011.

On July 21, 2011, Dr. Fall examined the claimant. In Dr. Fall's opinion the work injury on January 3, 2011, aggravated the claimant's pre-existing cervical spine condition and she would consider the Oxbow incident a new injury and she also opined that the claimant's need for surgery could be related to his original injury in November 2008. Dr. Fall also provided an opinion that apportioned liability between Bowie and Oxbow. In the ALJ's first order, he found Dr. Fall's opinions credible and persuasive on the issue of causation.

Based on these findings the ALJ determined that the claimant sustained a compensable new injury on January 3, 2011, and ordered Oxbow to pay temporary disability and medical benefits. The ALJ declined to apportion these benefits concluding, that the 2008 amendments to §8-42-104, C.R.S., precluded apportionment of temporary disability and medical benefits. The ALJ also denied the petition to reopen the November 23, 2008, injury based on change of condition. Oxbow appealed the ALJ's order and argued that the ALJ erred in failing to apportion temporary disability and medical benefits based on the contribution of the November 2008 injury. In an order dated April 9, 2012, we agreed with Oxbow's argument that the ALJ erred in failing to consider the evidence of apportionment between the industrial injuries pursuant to §8-42-104(6), C.R.S., and remanded the matter for the ALJ to consider evidence which might justify apportionment of temporary disability and medical benefits.

On remand the ALJ entered an order crediting Dr. Fall's opinion for apportioning 40 percent of the claimant's current condition to his injury with Oxbow and 60 percent of the claimant's current condition to his injury with Bowie. The ALJ then concluded that even though he denied the claimant's petition to reopen the Bowie claim in the original order and the claim remained closed, he could order Bowie to reimburse Oxbow 60 percent of the claimant's medical and temporary disability benefits pursuant to §8-42-104(6), C.R.S.

Bowie and the claimant appealed the ALJ's order on remand and argued that the ALJ erred in ordering Bowie to reimburse Oxbow for the apportioned temporary disability and medical benefits because the claim was closed. Bowie specifically

contended that the ALJ did not have authority or jurisdiction to order the reimbursement to Oxbow under §8-42-104(6), C.R.S., because the ALJ denied the claimant's petition to reopen against Bowie. The claimant petitioned to review the order separately on the grounds that apportionment of temporary and medical benefits was not permitted under §8-42-104(3), C.R.S., and that the ALJ's apportionment determination is unsupported by the evidence because he sustained a new compensable injury that is 100 percent attributable to Oxbow.

In an order dated April 5, 2013, we agreed with Bowie that the contribution or reimbursement from a prior employer contemplated by §8-42-104(6), C.R.S. is limited to only open claims. This conclusion was based on the fact that the plain language of §8-42-104(6), C.R.S., allows contribution or reimbursement “*as permitted by law*” and contrary to the ALJ’s order on remand, an order requiring reimbursement in a closed claim is not “*permitted by law.*” See *Burke v. Industrial Claim Appeals Office*, 905 P.2d 1 (Colo. App. 1994); *Brown and Root, Inc. v. Industrial Claim Appeals Office*, 833 P.2d 780 (Colo. App. 1991). We, therefore, remanded the matter again because the ALJ’s order failed to resolve the pertinent conflicting findings concerning causation for the issues of reopening and apportionment.

In the ALJ’s second order on remand he found that the claimant’s current condition was directly attributable to the intervening injury on January 3, 2011, with Oxbow. In reaching this conclusion the ALJ specifically credited the portion of Dr. Fall’s opinion which stated that the January 3, 2011, incident with Oxbow represented a new injury. The ALJ also rejected Dr. Fall’s opinion with regard to apportionment and determined that Oxbow was solely responsible for the medical and indemnity benefits that resulted from the January 3, 2011, new industrial injury. The ALJ further denied the claimant’s petition to reopen the Bowie claim concluding that the January 3, 2011, injury represents an intervening event that severs the causal connection of liability.

On appeal Oxbow initially contends for the first time that Bowie’s claim was not closed because an admission for maintenance medical benefits had been filed. Oxbow also makes arguments concerning the application of §8-42-104(6), C.R.S. and whether contribution or reimbursement can be ordered in a closed claim. To the extent that these issues were raised below, Oxbow’s arguments are premised on the ALJ’s findings of fact he made in the November 5, 2012, order which apportioned liability between Bowie and Oxbow. These issues are now irrelevant in view of the ALJ’s determination that the claimant’s current condition is solely related to the January 3, 2011, injury with Oxbow. In any event we are not persuaded to depart from the reasoning in our prior orders on the issue of apportionment or reopening.

Generally, the authority to reopen a claim under §8-43-303(1), C.R.S., is discretionary with the ALJ. Thus, we may not interfere with the order unless there is fraud or a clear abuse of discretion. *Renz v. Larimer County School District Poudre R-1*, 924 P.2d 1177 (Colo. App. 1996). An abuse is not shown unless the order is beyond the bounds of reason, as where it is unsupported by the law or contrary to the evidence. *See Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). Moreover, whether the claimant's condition is due to the natural progression of the pre-existing condition or a new industrial accident is one of fact for resolution by the ALJ. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999). Similarly, the extent to which various causative factors contributed to the claimant's disability or need for medical treatment is also a question of fact for the ALJ. *See Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999); *Ramirez v. Garfield's Off Broadway*, W.C. No. 4-689-414 (March 13, 2007). We are bound by the ALJ's resolution of factual issues if they are supported by substantial evidence and may not interfere with his assessment of the probative value of the evidence. *See Eisnach v. Industrial Commission*, 633 P.2d 502 (Colo. App. 1981).

Although Oxbow does not appear to contest that the ALJ's findings are unsupported by the evidence, the record, nonetheless, contains substantial evidence that the claimant's current condition is solely related to the January 3, 2011 injury with Oxbow. The opinions of Dr. Witwer, Dr. Fall and Dr. McLaughlin all support the ALJ's determination that the claimant sustained a new injury on January 3, 2011. The ALJ also found it significant that prior to the January 3, 2011 injury, the claimant did not require any medical treatment. To the extent that Dr. Fall's opinion on apportionment was inconsistent with this determination, the ALJ was free to rely on those portions he found persuasive and to reject other portions. *See Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968). Under these circumstances we cannot say the ALJ abused his discretion in denying the petition to reopen and apportioning benefits between Oxbow and Bowie.

Oxbow argues that the ALJ exceeded the scope of the remand in making new findings concerning causation. We disagree with this contention. Generally the tribunal which enters an order remanding a case is in the best position to determine the scope of the remand. *See Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986). The order of an appellate tribunal which remands for further proceedings consistent with its ruling is a general remand and the lower tribunal may make new findings and conclusions as long as there is no conflict with the appellate ruling. *Musgrave v. Industrial Claim Appeals Office*, 762 P.2d 686 (Colo. App. 1988).

Here, our order of remand directed the ALJ to resolve the conflicts in the evidence concerning causation and remanded for proceedings consistent with the views expressed

in remand. The remand was general in nature and authorized the ALJ to reexamine the record and to make new findings and conclusions to resolve the pertinent conflicts in the evidence on the issue of causation. *See Musgrave v. Industrial Claim of Appeals Office*, 762 P.2d 686 (Colo. App. 1988)(case remanded for further proceedings consistent with appellate court's opinion constitutes a general remand authorizing trial court to make new findings and conclusions.) We do not see anything to suggest that the ALJ acted inconsistently with our order of remand.

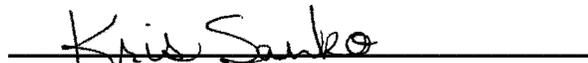
Because we have determined that the evidence supports the ALJ's determination that the claimant sustained a new injury on January 3, 2011, and the claimant's current need for medical treatment and disability is not related to the prior injury with Bowie, §8-42-104(6), C.R.S., is inapplicable to this claim. We have considered Oxbow's remaining arguments in this regard and see no basis to disturb the ALJ's order on review. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated July 9, 2013, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



Kris Sanko

CERTIFICATE OF MAILING

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

_____ 11/6/2013 _____ by _____ RP _____ .

JAMES TENNAPEL, 24504 TIMOTHY ROAD, CEDAREEDGE, CO, 81413 (Claimant)
BOWIE RESOURCES, LLC, Attn: LOU GRAKO, P O BOX 1488, PAONIA, CO, 81428-1488
(Employer)
NEW HAMPSHIRE INSURANCE COMPANY, 70 PINE STREET, NEW YORK, NY, 10270-
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WITHERS SEIDEMAN RICE & MUELLER P.C., Attn: DAVID B. MUELLER, ESQ., 101
SOUTH THIRD STREET, SUITE 265, GRAND JUNCTION, CO, 81502 (For Claimant)
TREECE ALFREY MUSAT, P.C., Attn: JAMES B. FAIRBANKS, ESQ./KAREN TREECE,
ESQ., 999 18TH STREET, SUITE 1600, DENVER, CO, 80202 (For Respondents Bowie
Resources, LLC and New Hampshire Insurance Company)
OXBOW MINING, INC., Attn: STEVE LEWIS, P O BOX 535, SOMERSET, CO, 81434
(Other Party - Employer)
PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ., 7501 E. LOWRY
BLVD., DENVER, CO, 80230 (Other Party 2 – For Respondents Oxbow Mining, Inc. and
Pinnacol Assurance)
RITSEMA & LYON, P.C., PAUL D. FELD, ESQ./ALANA S. MCKENNA, ESQ., 999 18TH
STREET, SUITE 3100, DENVER, CO 80202 (Rep for Oxbow Mining)
WELLS FARGO DISABILITY MANAGEMENT, 353 FALLS DRIVE, ABINGTON, VA
24210

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-832-507-06

IN THE MATTER OF THE CLAIM OF

DAVID VITWAR,

Claimant,

v.

ORDER OF REMAND

CITY OF COLORADO SPRINGS,

Employer,

and

SELF INSURED,

Insurer,
Respondent.

The respondent seeks review of an order of Administrative Law Judge Harr (ALJ) dated March 14, 2013, that ordered the claimant's melanoma compensable under the firefighter cancer presumption statute, §8-41-209, C.R.S. We set aside the ALJ's order and remand for a new order in light of the Colorado Court of Appeals' recent announcement in *Town of Castle Rock v. Industrial Claim Appeals Office*, 12CA2190 (July 3, 2013), 2013 COA 109, *cert. granted* 13SC560 (Oct. 15, 2013).

The parties stipulated that the claimant meets the threshold requirements of §8-41-209, C.R.S. The claimant has been a firefighter for more than 20 years, he suffered an onset of melanoma which is specifically covered under §8-41-209, C.R.S., and there is no evidence showing that the claimant had melanoma at the time he was hired by the respondent employer.

In October 2009, when the claimant was 44 years, he sought medical attention for a raised, pink lesion on his left anterior chest wall. The lesion arose in the setting of a dysplastic nevus, or atypical mole. A biopsy of the lesion revealed early-stage malignant melanoma. The claimant underwent radical resection of the lesion, with staging, and he had three other lesions removed, which had varying amounts of dysplasia.

Subsequently, in June 2010, the claimant underwent a magnetic resonance imaging scan of his brain, which revealed a large mass arising in the right temporal lobe. The claimant was diagnosed with a central nervous system lesion and suspected malignant melanoma. Ultimately, the claimant underwent a surgical procedure to resect

the tumor from his right temporal lobe, and the pathology report showed metastatic melanoma of the brain.

The claimant also had a left subcutaneous nodule excised from his left armpit on July 2, 2010, which also was positive for metastatic disease. On August 4, 2010, a nodule was excised from the thoracic area of the claimant's back, which revealed metastatic melanoma in the subcutaneous space. By August 21, 2012, the claimant's physicians reported him disease free with the exception of one nodule in his right hip area.

At the request of the respondent, the claimant underwent an independent medical examination with Dr. Kudchadkar, an expert in the area of oncology and dermatology. Dr. Kudchadkar opined that the claimant's host or risk factors, which include his Scottish ancestry, history of dysplastic nevi, history of sunburn, and maternal grandmother's history of melanoma, made him more susceptible to damage from solar ultraviolet radiation. Dr. Kudchadkar opined that it was unlikely that the claimant's firefighting activities caused his melanoma. Rather, Dr. Kudchadkar opined that from an epidemiologic perspective, the claimant's atypical moles likely contributed most to his risk of melanoma development.

At the request of the claimant, Dr. Mayer performed an independent medical examination. Dr. Mayer is an expert in the area of occupational and environmental medicine. Dr. Mayer opined that the relative risk factors between firefighting exposure and developing melanoma are unknown because there is no epidemiological study. Dr. Mayer explained that an epidemiologic assessment of relative risk does not equal the assessment of causation of a disease. Dr. Mayer explained that the relative risk of melanoma increases with age. It is more common for people to develop melanoma in their 70s than at age 44, when the claimant developed melanoma. The claimant's grandmother succumbed to melanoma in her 70s.

After hearing on the matter, the ALJ issued his order. Relying upon the Colorado Court of Appeals' decision in *City of Littleton v. Industrial Claim Appeals Office*, 10CA1494 (Nov. 1, 2012), 2012 COA 187, *cert. granted*, 12SC871 (Oct. 15, 2013), the ALJ held that the respondent failed to show it more probably true than not that the claimant's melanoma did not result from, arise out of, or arise in the course of an exposure during his work as a firefighter. Thus, the ALJ concluded that the respondent failed to overcome the statutory presumption that the claimant's melanoma is an occupational disease caused by a workplace exposure. The ALJ therefore held the claimant's melanoma compensable and ordered the respondent employer to pay for the reasonable and necessary medical care provided by the claimant's physicians and provided by the National Cancer Institute. The ALJ credited Dr. Mayer's medical

opinion over that of Dr. Kudchadkar. The ALJ found and concluded that the key weakness of Dr. Kudchadkar's medical opinion was that her epidemiologic findings apply to populations of living human beings from which a study's sample is drawn, rather than specifically to the claimant firefighter. The ALJ concluded that Dr. Kudchadkar's epidemiologic opinion was not highly probative on the issue of causation specific to the claimant's melanoma. The ALJ further concluded that Dr. Kudchadkar conceded that because the cause of melanoma is multifactorial, there is no way to say how much the activity of firefighting increases the risk of developing melanoma.

The respondent then petitioned for review and filed its brief in support. On review, the respondent argues that the ALJ incorrectly applied the burden of proof under §8-41-209, C.R.S. The respondent asserts that the preponderance of the evidence shows that the claimant's melanoma likely was caused by dysplastic nevi and other additive factors as opposed to his firefighting occupation.

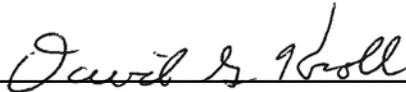
Shortly after the ALJ issued his order, the respondent filed its petition to review and brief in support, and the claimant filed his brief in opposition, the Colorado Court of Appeals issued its opinion in *Town of Castle Rock v. Industrial Claim Appeals Office*, 12CA2190 (July 3, 2013), 2013 COA 109, *cert. granted* 13SC560 (Oct. 15, 2013). In *Town of Castle Rock*, the Court addressed the firefighter cancer presumption enunciated in §8-41-209, C.R.S. Section 8-41-209, C.R.S. provides that an employer may overcome the presumption by establishing "by a preponderance of the medical evidence" that the cancer "did not occur on the job." Section 8-41-209(2)(b), C.R.S. The Court held that when applying the preponderance of the evidence standard, a fact finder must decide whether the existence of a contested fact is more probable than its nonexistence. According to the Court, if a party has the burden of proof by a preponderance of the evidence, and the evidence presented weighs evenly on both sides, then the finder of fact must resolve the question against the party having the burden of proof. *See Schocke v. State*, 719 P.2d 361 (Colo. App. 1986).

The Court further held that the firefighter cancer presumption can be overcome by establishing that the risk of cancer from other sources outweighs the risk created by firefighting. The Court held that an employer may overcome the statutory presumption of compensability created by §8-41-209(2)(b), C.R.S. with specific risk evidence demonstrating that a particular firefighter's cancer probably was caused by a source outside work. The Court further explained that requiring an employer to establish that a cancer specifically was caused by a source outside the workplace, creates a "nearly insurmountable barrier" over which most employers would not be able to climb, since the precise cause of most cancers cannot be determined.

Here, the ALJ discredited Dr. Kudchadkar's medical opinion on the basis that the studies she relied upon sampled a general population "rather than specifically to Claimant Firefighter." The Court in *Town of Castle Rock*, however, reasoned that evidence of increased risk of melanoma due to sun exposure and atypical moles, could be compared to the increased risk of melanoma from firefighting, to overcome the presumption. These factors for increased risks were developed "as compared to the general population." The ALJ then, must review the opinion evidence of both Dr. Kudchadkar and Dr. Mayer as being probative without regard to its origin in samples of the general population. Consequently, we necessarily remand the matter to the ALJ to consider the evidence in light of the requirements set forth in *Town of Castle Rock*. In reaching our result, we do not hold that the ALJ must find that the respondent has or has not overcome the presumption enunciated in §8-41-209, C.R.S. Rather, given the Court's recent announcement in *Town of Castle Rock*, we merely conclude that the ALJ must consider the requirements set forth in that case when considering the evidence presented by the parties.

IT IS THEREFORE ORDERED that the ALJ's order dated March 14, 2013, is set aside and remanded for consideration of the evidence in light of the Court's recent announcement in *Town of Castle Rock*.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

CERTIFICATE OF MAILING

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

_____ 10/22/2013 _____ by _____ RP _____ .

DAVID VITWAR, 17110 MOUNTAIN LAKE DRIVE, MONUMENT, CO, 80132 (Claimant)
CITY OF COLORADO SPRINGS, Attn: STEPHEN FOX, P O BOX 1575-630, COLORADO
SPRINGS, CO, 80901 (Employer)
LAW OFFICE OF O'TOOLE AND SBARBARO, P.C., Attn: NEIL D. O'TOOLE, ESQ., 226
WEST 12TH AVENUE, DENVER, CO, 80204-3625 (For Claimant)
RITSEMA & LYON, P.C., Attn: SUSAN K. REEVES, ESQ., 111 S. TEJON ST., #700,
COLORADO SPRINGS, CO, 80903 (For Respondents)
CITY OF COLORADO SPRINGS/UTILITIES, Attn: JANE MADSEN, P O BOX 1575-630,
COLORADO SPRINGS, CO, 80901-1575 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-817-985-03

IN THE MATTER OF THE CLAIM OF

JACK WAGONER,

Claimant,

v.

FINAL ORDER

CITY OF COLORADO SPRINGS,

Employer,

and

SELF INSURED,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Stuber (ALJ) dated May 21, 2013, that ordered the claimant to repay to the respondent an overpayment of \$4,657.88 and denied his request for permanent partial disability benefits. We affirm.

The claimant appeals the decision of the ALJ holding he did not prove by a preponderance of the evidence that he sustained a permanent impairment to his bilateral upper extremities. The claimant argues the ALJ committed error by denying him a second evaluation by a Division Independent Medical Examination (DIME) physician in regard to the permanent impairment rating. The claimant also contends the ALJ committed error in relying on the opinions of physicians finding he suffered no permanent impairment.

The claimant was injured on June 10, 2009. On that date he injured both his arms while using a power weed eater at work. The claimant saw Dr. Pise who referred him to Dr. Leppard for an EMG study. Based on that test, Dr. Leppard diagnosed bilateral neuropathy at the wrist and at the right elbow. After conservative treatment the claimant returned to work. He suffered an aggravation of this injury while using a jack hammer at work. In April, and August, 2010, Dr. Pise performed decompression surgery on both the right and left forearms. During post surgery physical therapy, the claimant complained of hypersensitivity to cold and heat on his left arm. The claimant was placed at maximum medical improvement (MMI) by Dr. Castrejon on October 13, 2010, without permanent impairment. The claimant returned to Dr. Castrejon and to Dr. Pise in April, 2011, complaining of hypersensitivity and pain in both arms.

Dr. Sandell completed a DIME review on April 6, 2011. He diagnosed carpal tunnel syndrome, bilateral pronator syndrome and sympathetically mediated pain. Dr. Sandell felt the claimant was at risk for developing CRPS. The doctor concluded the claimant was not at MMI and recommended pain management and nerve block injections. After a September 13, 2011, hearing the DIME finding of not at MMI was affirmed by an ALJ.

Dr. Castrejon recommended stellate ganglion blocks and found the claimant's response to be no more than fair. The doctor also prescribed QSART testing. The QSART exam was performed by Dr. Schakaraschwili. He observed it unlikely the claimant suffered from CRPS. Dr. Castrejon agreed and placed the claimant at MMI again on February 13, 2012. He recommended permanent restrictions which included no use of vibratory equipment or impact force activities. Dr. Sandell completed a repeat DIME report on April 6, 2012. Dr. Sandell agreed with the date of MMI on February 13, 2012. He determined the claimant did not have a diagnosis of CRPS and the doctor noted a lack of objective evidence of continued injury. He concluded there was no permanent impairment but allowed that stellate ganglion blocks may be necessary for the flare of symptoms in the future. The respondents filed a Final Admission of Liability on April 19, 2012, premised on Dr. Sandell's report. The Final Admission claimed an overpayment of \$4,657.88 represented by temporary benefits paid between the date of MMI and the date of the Final Admission.

Dr. Bisgard performed evaluations of the claimant in both 2011 and on June 19, 2012. The doctor noted the inconsistency of the claimant's subjective complaints and the absence of objective findings available to verify the claimant's symptoms. Both Dr. Bisgard and Dr. Castrejon viewed a video surveillance tape of the claimant dated June 29, 2012. Both physicians observed the claimant was performing activities in the video inconsistent with his complaints made in the examining room. These activities included work while the claimant was on the job for an excavating company showing him washing windows, using the right arm to pull himself under a truck and swinging his arms freely.

A hearing in the claim was conducted on September 11, 2012. The issues for determination were permanent partial benefits and the overpayment of temporary benefits. The parties did not dispute the date of MMI and the claimant's counsel set forth that the claimant was requesting a scheduled rating of the extremities. The claimant did not have a medical report providing an impairment rating. The ALJ agreed to the parties' request to have two doctors testify by deposition after the date of hearing.

The claimant arranged to be examined by Dr. Schwender on May 23, 2012. The doctor diagnosed sympathetically mediated pain. He suspected CRPS but acknowledged the QSART test was negative and other objective tests for CRPS had not been

completed. Dr. Schwender again examined the claimant on October 15, 2012. In his report of that date, Dr. Schwender deemed the claimant as eligible for an impairment rating based on the Cumulative Trauma Conditions chapter of the Division's Medical Treatment Guidelines. Using this methodology, Dr. Schwender deduced the claimant had suffered an 18% permanent impairment of each arm, which could be combined and converted to a 21% whole person rating.

Dr. Bisgard testified by deposition on March 7, 2013. The doctor criticized Dr. Schwender's application of the cumulative trauma guidelines pointing out he had did not make findings of objective criteria or signs. Dr. Schwender was noted to have relied primarily on subjective pain complaints. Dr. Schwender as well, did not investigate whether the claimant had interference with his activities of daily living. Dr. Bisgard read the guidelines as requiring a determination that the presence or absence of ADL activities affected symptoms. The doctor pointed to the activity of the claimant depicted in the surveillance video to illustrate he had scant restriction of ADLs.

Dr. Sandell submitted deposition testimony on May 3, 2013. He was not convinced Dr. Schwender's approach was valid. He did state when he performed his DIME evaluation he was primarily concerned with the diagnosis of CRPS. He acknowledged it might be possible to derive an impairment rating through cumulative trauma staging. However, Dr. Sandell stated he could not provide that type of impairment rating without performing another physical exam of the claimant.

The claimant moved the ALJ allow him a second impairment evaluation with Dr. Sandell as part of the DIME process. The ALJ denied the motion. It was reasoned a DIME opinion was not necessary to a determination of a scheduled impairment. The statutory reference to the DIME procedure allowed for a DIME review regarding MMI in all cases, but only for an impairment review when a whole person rating was at stake. Based on the statement of claimant's counsel at the September 11, 2012, hearing, the issue of a whole person rating was not before the ALJ.

The ALJ submitted an order on May 21, 2013. The ALJ placed considerably greater weight on the reports of Dr. Castrejon, Dr. Bisgard and Dr. Sandell, than on that of Dr. Schwender. The ALJ observed there did appear to be a paucity of objective evidence upon which to base a permanent impairment rating. The ALJ reasoned Dr. Schwender was required to obtain information pertinent to ADLs in order to correctly derive a rating from the Cumulative Trauma Staging Matrix. His failure to do so rendered his impairment rating inapposite. There was no other impairment rating in the record. The ALJ concluded the claimant had failed to establish an impairment rating by a preponderance of the evidence. The decision ruled the evidence required a conclusion that the upper extremities were the only part of the claimant's body affected by his work

injury. Accordingly, a whole person impairment was not justified. Any impairment was limited to a rating from the schedule of disabilities. The ALJ then found that even if the clear and convincing standard was applicable, the claimant had not crossed that threshold. The DIME had, in fact, decreed there was no permanent impairment. If the claimant could not overcome that determination by a preponderance of the evidence, then, by definition, he had not overcome it with clear and convincing evidence.

The ALJ, in addition, ordered the claimant to repay the respondents the \$4,657.88 in excess temporary benefits paid after the claimant was placed at MMI on February 13, 2012.

I.

The claimant argues the ALJ was in error when he denied the claimant's motion to allow a second DIME evaluation for the purpose of an impairment rating. At the outset of the September 11, 2012, hearing, the claimant's counsel had stipulated the claimant sought only an impairment rating for the extremities and based on the schedule of disabilities provided in § 8-42-107(2). (tr. pg. 4, 8, 9). Because they are mutually exclusive, this stipulation precluded a request for a whole person rating pursuant to § 8-42-107(8). At the September 11 hearing, the parties also stipulated they would submit, at most, the additional deposition testimony of Dr. Schwender and Dr. Bisgard. At the conclusion of Dr. Bisgard's deposition on March 7, 2013, the claimant asserted he needed to submit rebuttal testimony related to Dr. Bisgard's critique of Dr. Schwender's opinion the claimant had a measurable permanent impairment. Ironically, he contended this would best be provided by Dr. Sandell, the DIME physician. Dr. Sandell's DIME report was aligned with Dr. Bisgard's finding that there was indeed no permanent impairment. When Dr. Sandell responded to inquiries at his deposition that he was unable to agree with Dr. Schwender unless he was able to conduct another examination of the claimant, the claimant moved the ALJ to allow such an exam.

The ALJ denied the motion for a second DIME impairment exam. It was noted the matter only concerned a scheduled rating. As such, the statute did not attach any presumptive weight to the opinion of the DIME physician. The Court of Appeals made this determination in *Delaney v. Industrial Claim Appeals Office*, 30 P.3d 691, 693 (Colo. App. 2000):

Thus, the General Assembly expressly made some of the procedures provided for in § 8-42-107(8)-namely, those related to determination of MMI-available in cases of scheduled injuries as well as non-scheduled

injuries. However, it did not similarly make the procedures in § 8-42-107(8)(c)-the subsection on which claimant relies-available in cases of scheduled injuries. Thus, we decline to hold that the statute affords an absolute right to a DIME as a prerequisite to hearing in cases that clearly involve only scheduled injuries.

While the Division's Rules require an ALJ's permission to contact a DIME physician after the submission of his impairment report, W.C. Rule of Procedure 11-6(B), 7 Code Colo. Reg. 1101-3, the statute does not attribute any special regard for his opinion pertaining to impairment in the case of a scheduled rating. The ALJ then, did not abuse his discretion when he denied the request.

The ALJ has broad discretion in the conduct of evidentiary proceedings. *IMPC Transportation Co. v. Industrial Claim Appeals Office*, 753 P.2d 803 (Colo. App. 1988). We therefore review the ALJ's ruling in this instance under the abuse of discretion standard. *See Renaissance Salon v. Industrial Claim Appeals Office*, 994 P.2d 447 (Colo. App. 1999) (reviews of orders concerning the conduct of administrative hearings are subject to the abuse of discretion standard). An abuse of discretion does not occur unless the ALJ's order is beyond the bounds of reason, as where it is unsupported by the record or contrary to the law. *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867 (Colo. App. 2001); *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. App. 1993).

The claimant had been placed at MMI more than a year prior to the claimant's request. The hearing had been conducted eight months previously. The claimant was now requesting more than just a rebuttal medical opinion. He was seeking to reopen the entire DIME process. However, as noted, that process bore no extraordinary significance to the issue of a scheduled injury impairment rating. The ALJ cannot be seen as acting unreasonably in denying the claimant's motion.

II.

The claimant presents a list of reasons he contends the ALJ made mistakes in his findings of fact. We do not find these assertions compelling.

The claimant states the ALJ mistakenly required the claimant to achieve a burden of proof featuring clear and convincing evidence. The claimant instead, asserts the burden should be by a preponderance of the evidence. This complaint is difficult to comprehend. Nowhere in the ALJ's order does the ALJ maintain the burden of proof is

other than a preponderance of the evidence. In ¶ 34 of the findings of fact, the ALJ indulges in a hypothetical premised upon the claimant's claim in his post hearing pleading that he is entitled to a whole person impairment. Only in that case, the ALJ finds, would a clear and convincing standard apply. However, because the ALJ did not entertain a request for a whole person rating, he did not apply such a standard.

Here, the ALJ did not misapprehend the applicable burden of proof. He noted that by stipulation the claimant's injury was scheduled, which otherwise would turn on the factual question whether the claimant sustained functional impairment to a part of the body off the schedule. See *Warthen v. Industrial Claim Appeals Office*, 100 P.3d 581 (Colo. App. 2004); *Strauch v. Swedish Healthcare System*, 917 P.2d 366 (Colo. App. 1996). After he determined that the injury was scheduled, he weighed the evidence and assessed its probative value to determine the appropriate scheduled impairment rating. The ALJ properly recognized that the claimant had the burden of showing the extent of his impairment by a preponderance of the evidence.

The claimant declaims that his evidence succeeded in meeting the preponderance of evidence burden. He predicates that the ALJ was mistaken in attaching credibility to the opinions of doctors not in agreement with Dr. Schwender. The weight and credibility to be assigned expert medical opinion is a matter within the fact-finding authority of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). The ALJ may accept all, part, or none of the testimony of a medical expert. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968); see also *Dow Chemical Co. v. Industrial Claim Appeals Office*, 843 P.2d 122 (Colo. App. 1992) (ALJ may credit one medical opinion to the exclusion of a contrary medical opinion). To the extent there is substantial evidence in the record to support the ALJ's findings of fact, we may not question those findings. The ALJ's findings, based as they are upon the opinions of Dr. Bisgard, Dr. Castrejon and Dr. Sandell, are justified by substantial evidence in the record.

The claimant argues the ALJ misapplied the Division's Medical Treatment Guidelines chapter regarding Cumulative Trauma Conditions. He reasons the ALJ required evidence of objective support for symptoms reported by the claimant. This, he says, is not required by the CTC chapter. The claimant quotes a statement in Dr. Bisgard's testimony which asserts the CTC chapter requires subjective symptoms "must correlate with objective pathology." He then compares this to the language of the chapter where it specifies "it is *expected* that objective signs on physical examination will correlate with subjective symptoms." The claimant maintains 'must' is not the same as 'it is expected'. This is a distinction without significance.

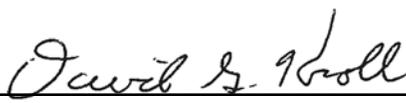
Although the Medical Treatment Guidelines are not part of the AMA Guides, they may be relevant to the impairment rating under consideration by the ALJ. A physician's application of those Guidelines when assessing an impairment rating, goes to the weight the ALJ gives to an impairment rating. *Ortiz v. Service Experts, Inc.*, W.C. No. 4-657-974 (January 22, 2009) (ALJ credited impairment rating of physician applying impairment rating tips).

It is contended by the claimant that the ALJ erred when he determined the claimant did not have functional impairment to a body part other than those on the schedule. Although a scheduled injury was stipulated, the ALJ also found the "alleged functional impairment is limited to pain in his forearms, distal to the arm at the shoulder." The claimant contends that "by negative implication" the ALJ believes a rating for overuse "requires a lesion proximal to the spine and beyond the shoulder." This 'negative implication' is not a reasonable conclusion to draw from the findings of the ALJ. In addition, it is difficult to imagine a lesion that is both close to the spine and at the same time further from the spine than the shoulder.

Finally, the claimant asserts Dr. Sandell's opinion the claimant had a 0% permanent impairment is not reliable because he did not apply the CTC chapter of the Medical Treatment Guidelines as did Dr. Schwender. The ALJ however, found Dr. Schwender actually misapplied the CTC chapter. We cannot say then, that Dr. Sandell is mistaken for the reason he did not agree with Dr. Schwender. That is a finding to be made by the ALJ. Application of the substantial evidence test requires that we defer to the ALJ's assessment of the probative value of the evidence and his resolution of conflicts in the record. *Metro Moving & Storage v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

IT IS THEREFORE ORDERED that the ALJ's order issued May 21, 2013, 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

_____ 10/21/2013 _____ by _____ RP _____ .

JACK WAGONER, 7781 BARN OWL DRIVE, FOUNTAIN, CO, 80817 (Claimant)
CITY OF COLORADO SPRINGS, Attn: STEPHEN FOX, P O BOX 1575 MAIL CODE 630,
COLORADO SPRINGS, CO, 80901-1575 (Employer)
STEVEN U. MULLENS, P.C., Attn: STEVEN U. MULLENS, ESQ., 105 EAST MORENO
AVENUE, COLORADO SPRINGS, CO, 80901 (For Claimant)
DWORKIN, CHAMBERS, WILLIAMS, YORK, BENSON & EVANS, PC, Attn: GREGORY
K. CHAMBERS, ESQ., 3900 EAST MEXICO AVE., SUITE 1300, DENVER, CO, 80210 (For
Respondents)

12CA2465 Colorado Springs School v. ICAO 10-03-2013

COLORADO COURT OF APPEALS

Court of Appeals No. 12CA2465
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-835-556

Colorado Springs School District #11,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado and Jeffrey Hobirk,
Respondents.

ORDER AFFIRMED

Division III
Opinion by JUDGE ROMÁN
J. Jones and Kapelke*, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(f)
Announced October 3, 2013

Clifton & Bovarnick, P.C., Richard A. Bovarnick, Denver, Colorado, for
Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Sears & Swanson, P.C., Jason T. Landress, Colorado Springs, Colorado, for
Respondent Jeffrey Hobirk

*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, self-insured employer, Colorado Springs School District No. 11, seeks review of a final order of the Industrial Claim Appeals Office (Panel), affirming the decision of the administrative law judge (ALJ) ordering employer to supply claimant, Jeffrey Hobirk, with a van capable of transporting a motorized wheelchair and with household services. We agree with the Panel that substantial evidence supports the ALJ's determination that the van is a reasonably necessary medical apparatus and that household services are a medical necessity in this case. We therefore affirm.

I. Background

Claimant sustained multiple vertebral and rib fractures as a result of an admitted, work-related accident in 2010 when he fell eight feet from a ladder. His authorized treating physician (ATP) placed him at maximum medical improvement (MMI) in December 2011, and opined that claimant is permanently and totally disabled by his injuries. Employer did not contest the ATP's MMI or permanent total disability (PTD) determinations.

After the accident, claimant was only able to ambulate short

distances with a walker. Because of the pain and difficulty claimant experienced ambulating with a walker, the ATP prescribed a motorized wheelchair for claimant's use. Employer provided claimant with the desired wheelchair.

The ATP also recommended two other services intended to aid claimant's functional capacity: (1) a wheelchair-accessible van capable of accommodating claimant's power wheelchair, which claimant could use to get to his medical appointments unassisted; and (2) a home health aide to assist with household chores and personal care. The ATP opined that the van was necessary because it would enable claimant to transport himself around the community without causing pain or a deterioration in his condition. Similarly, he opined that household assistance was necessitated by claimant's wife's illness, which prevented her from assisting claimant with household chores. The ATP's recommendations were echoed by a physical therapist who also opined that a wheelchair-accessible van and household assistance were reasonable necessities. The physical therapist further noted that although a manual wheelchair lift could be fitted to claimant's existing vehicle,

“there is no absolute way that he could lift a [fifty]-pound ramp to put his power wheelchair into it.”

However, relying on the opinions of its retained medical expert, employer declined to authorize these two expenses. Employer’s medical expert opined that claimant would benefit from ambulating with a walker and noted that inactivity and prolonged bed rest can cause deterioration of a patient’s condition and lead to deconditioning. Employer therefore applied for a hearing to resolve these issues.

After hearing testimony from claimant, the physical therapist, and employer’s medical expert, in addition to reviewing the ATP’s records, the ALJ found that both a wheelchair-accessible van and a household aide were medical necessities. The ALJ therefore ordered employer to pay for both a conversion van and a household aide for claimant. On review, the Panel affirmed, finding that substantial evidence supported the ALJ’s decision. This appeal followed.

II. Conversion Van to Accommodate Motorized Wheelchair

Employer first argues that a conversion van able to accommodate a motorized wheelchair does not, as a matter of law,

constitute a medical apparatus in this case. It argues that because the van will not provide therapeutic medical relief to claimant, it cannot be regarded as a medical apparatus. Employer therefore contends that the Panel erred in affirming the ALJ's decision awarding the van. We are not persuaded.

Under the Workers' Compensation Act (Act), an employer is required to provide an injured worker with "such medical, surgical, dental, nursing, and hospital treatment, medical, hospital, and surgical supplies, crutches, and apparatus as may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee from the effects of the injury." § 8-42-101(1)(a), C.R.S. 2013. The provisions of the Act thus require an employer to provide "any apparatus necessary for the treatment of the injury or which provides therapeutic relief from the effects of the injury." *Cheyenne Cnty. Nursing Home v. Indus. Claim Appeals Office*, 892 P.2d 443, 446 (Colo. App. 1995) (denying a quadriplegic's request for a stair glide to provide her with access to her basement in the event of dangerous weather conditions because the stair glide provided only

“peace of mind” but no therapeutic benefit to the claimant).

Whether a treatment, apparatus, or service “may reasonably be needed . . . to cure and relieve the employee from the effects of the injury” is a question of fact for determination by the ALJ. § 8-42-101(1)(a); *Hillen v. Tool King*, 851 P.2d 289, 290 (Colo. App. 1993); *Edward Kraemer & Sons, Inc. v. Downey*, 852 P.2d 1286, 1288 (Colo. App. 1992).

Employer argues that prior holdings by other divisions of this court, particularly in *Bogue v. SDI Corp., Inc.*, 931 P.2d 477 (Colo. App. 1996), and *Cheyenne County Nursing Home*, preclude the ALJ from finding that claimant’s minivan constituted a medical apparatus. In *Bogue*, a division of this court affirmed the Panel’s decision setting aside the order of an ALJ who had awarded the claimant a wheelchair-accessible van as a medical benefit. The division agreed with the Panel that the van requested in *Bogue* would not relieve the effects of the claimant’s injury, but was intended primarily “to facilitate travel unrelated to [the claimant’s] access to medical care.” *Bogue*, 931 P.2d at 479. Following the precedent set in *Cheyenne County Nursing Home*, the court rejected

as overly broad the claimant's contention that any device that would make the claimant "feel better" necessarily provides therapeutic relief. *Id.*

However, we agree with the Panel and the ALJ that the case before us is distinguishable from *Bogue* and *Cheyenne County Nursing Home*. Here, the ALJ found, with record support, that transferring in and out of his existing vehicle, a Chevy Trailblazer, and subsequently ambulating with a walker increased claimant's pain. The ATP observed that claimant reported less pain when he used the motorized wheelchair and that he appeared in substantially less discomfort and distress when he used it. Further, without a method to transport the wheelchair, which would enable claimant to get to his medical appointments and complete personal errands, the wheelchair's benefits could not be fully realized because claimant would be required to use his walker and his personal vehicle to get around the community or find a service capable of transporting him and his motorized wheelchair.

We are not persuaded that the contrary opinions of employer's retained medical expert merit a different outcome. First, the record

reflects that when originally asked about the need for a conversion van, employer's medical expert indicated such a van *was* necessary. Although she later retracted this statement – instead indicating that claimant would likely benefit from ambulating with a walker rather than using a power wheelchair – the ALJ rejected her retraction, finding it unpersuasive and contradicted by the credible and persuasive testimony and opinions of claimant, the ATP, and the physical therapist. We cannot disturb these credibility determinations “except in the extreme circumstance where the evidence credited is so overwhelmingly rebutted by hard, certain evidence that the ALJ would err as a matter of law in crediting it.” *Arenas v. Indus. Claim Appeals Office*, 8 P.3d 558, 561 (Colo. App. 2000).

Employer also suggests, as it did before the ALJ, that claimant could be transported to his medical appointments by a transportation service capable of accommodating his motorized wheelchair. It maintains that it should not be responsible for transporting claimant to any activity other than his medical appointments. But, claimant testified that transportation services

were impractical because: (1) services had to be scheduled well in advance; (2) even with advance planning, the services were not always available; and (3) the services dropped him off and picked him up at times that were not necessarily convenient or beneficial to him. Finding this testimony credible and persuasive, the ALJ rejected the suggested transportation services as an inadequate option for claimant. We perceive no basis upon which to set aside this credibility determination. *See id.*

Employer's remaining arguments – specifically, that claimant's relocation to Missoula, Montana, necessitates a re-evaluation of the availability of transportation services; that claimant's ATP equivocated concerning the medical necessity of a motorized wheelchair; or that evidence in the record warrants a decision in its favor – do not persuade us to reach a different conclusion. We cannot, as employer essentially asks us to do, reweigh the evidence to reach a result contrary to the ALJ's. *See Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995) (reviewing court must defer to the ALJ's credibility determinations and resolution of conflicts in the evidence and may not substitute its judgment for

that of the ALJ). On the contrary, where, as here, evidence in the record substantially supports the ALJ's factual determinations, we are bound by those findings and may not set them aside. See § 8-43-308, C.R.S. 2013; *Paint Connection Plus v. Indus. Claim Appeals Office*, 240 P.3d 429, 431 (Colo. App. 2010) (“When an ALJ’s findings of fact are supported by substantial evidence, we are bound by them.”).

Because we conclude that substantial evidence supports the ALJ’s finding that a conversion van capable of transporting claimant’s motorized wheelchair is a reasonably necessary medical apparatus in this case, we are bound by this factual determination. Consequently, we perceive no error in the Panel’s decision affirming the ALJ’s award of a motorized wheelchair-accessible conversion van to claimant.

III. Household Aide and Assistance

Employer next contends that the Panel erred in affirming the ALJ’s award of a household aide to claimant. It argues that claimant failed to establish that such services were a medical necessity, and that the ALJ therefore erred as a matter of law in

granting them. We disagree.

Household assistance may be considered a medical necessity under section 8-42-101(1)(a) if it is shown that the services are “incidental to obtaining such medical or nursing treatment.” *Country Squire Kennels v. Tarshis*, 899 P.2d 362, 363 (Colo. App. 1995). “The service must be reasonably needed to cure and relieve the effects of the injury and be related to a claimant’s physical needs.” *Bellone v. Indus. Claim Appeals Office*, 940 P.2d 1116, 1117 (Colo. App. 1997).

Whether services “are either medically necessary for the treatment of a claimant’s injuries or incidental to obtaining such treatment” is a question of fact to be determined by the ALJ. *Atencio v. Quality Care, Inc.*, 791 P.2d 7, 8 (Colo. App. 1990). “And, if the findings of fact entered by the ALJ are supported by substantial evidence, they are not to be altered by the Panel.” *Id.*

Claimant testified that he was unable to perform household tasks; that his wife was not able to assist with these tasks, either; and, that their home was unsanitary because of their inability to clean it. The ATP and the physical therapist agreed that claimant

required assistance with household chores and some personal care. This evidence supports the ALJ's determination that claimant's need for household help was a medical necessity.

While it is true that a prescription for services is not necessarily dispositive of medical necessity, such evidence may be considered in determining whether, under the totality of the circumstances, household assistance is incidental to obtaining medical treatment. *See Country Squire Kennels*, 899 P.2d at 363 (“[T]he mere fact that the housecleaning services are prescribed by a physician does not make them medically necessary.”); *Atencio*, 791 P.2d at 9 (holding that evidence was sufficient to support ALJ's finding that housekeeping services were necessary). Because this evidence, taken with the testimony of claimant, the ATP, and the physical therapist, substantially supports the ALJ's factual determination that household services are a medical necessity here, we may not set aside the finding. *See Atencio*, 791 P.2d at 9 (setting aside Panel order that had reversed ALJ's award of housekeeping services because the ALJ's decision was supported by substantial evidence in the record).

Employer's remaining arguments – that an evaluation of needed household services had not been completed at the time of the hearing, and that claimant's needs after his move to Montana were unknown – do not appear to have been raised before the ALJ and therefore are not preserved for review. *See City of Durango v. Dunagan*, 939 P.2d 496, 500 (Colo. App. 1997) (issue not raised before ALJ not preserved for appellate review). Notwithstanding the failure to preserve these issues, we are not persuaded by these arguments to set aside the Panel's decision in light of the substantial evidence in the record supporting the ALJ's findings of fact. *See Atencio*, 791 P.2d at 9.

We therefore conclude that the Panel did not err in affirming the ALJ's award of a household aide to claimant to assist him with household chores and some personal care.

The order is affirmed.

JUDGE J. JONES and JUDGE KAPELKE concur.

12CA1784 JEB Electric v. ICAO 10-10-2013

COLORADO COURT OF APPEALS

Court of Appeals No. 12CA1784
Industrial Claim Appeals Office of the State of Colorado
WC Nos. 4-683-537 & 4-822-611

JEB Electric, Inc., and Mid-Century Insurance Company,

Petitioners,

v.

Industrial Claim Appeals Office of the State of Colorado; and Carlos Ordonez,

Respondents.

ORDER SET ASIDE

Division VII
Opinion by CHIEF JUDGE LOEB
Terry and Navarro, JJ., concur

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

Announced October 10, 2013

Hunter & Associates, Joe M. Espinosa, Denver, Colorado, for Petitioners

No Appearance for Respondent Industrial Claim Appeals Office

Darrell S. Elliott, P.C., Robert F. James, Denver, Colorado, for Respondent
Carlos Ordonez

In this workers' compensation action, employer, JEB Electric, Inc., and its insurer, Mid-Century Insurance Company, seek review of a final order of the Industrial Claim Appeals Office (Panel). The Panel affirmed the order of an administrative law judge (ALJ) requiring employer to pay claimant, Carlos Ordonez, temporary total disability (TTD) benefits from the time claimant resigned from other employment until he reached maximum medical improvement (MMI). Employer contends that claimant's TTD benefits should have ceased under section 8-42-105(3), C.R.S. 2013, of the Workers' Compensation Act of Colorado (the Act), and should not have been reinstated because claimant failed to establish that his condition worsened. We conclude that the express language of section 8-42-105(3) prohibits claimant from receiving any further TTD benefits after he returned to work, and therefore set aside the Panel's decision and order.

I. Background

Claimant worked as a foreman electrician for JEB from February to March 2006. On March 17, 2006, he sustained an admitted, work-related injury when he tripped backwards over lumber at a construction site, severely injuring his left ankle.

Because claimant could not work, JEB began paying him TTD benefits in April 2006. He was initially placed at MMI by his authorized treating physician (ATP) in September 2007. In October 2007, JEB filed a final admission of liability (FAL) based on the ATP's MMI determination, and paid claimant a lump sum.

Claimant objected to the FAL, however, and requested a division-sponsored independent medical examination (DIME). The DIME physician examined claimant in February 2008 and concluded that claimant was not at MMI. Claimant, therefore, returned to his ATP for additional treatment.

In March 2008, JEB filed a new general admission of liability (GAL) and resumed TTD payments to claimant. Those TTD payments continued until February 2, 2009, when the same DIME physician determined claimant reached MMI.

In November 2007, however, after receiving the lump sum payment but before the DIME physician placed him at MMI, claimant was hired as a lead electrician by Barnes Electrical Contracting. He testified that he went to work for Barnes to support his family. However, claimant did not disclose to JEB, its

insurer, his ATP, the DIME physician, a rehabilitation specialist, or his psychologist that he had commenced employment with Barnes.

Claimant continued to experience significant ankle pain while working for Barnes. Claimant testified that the pain was so severe that, at times, he would hide in a crawl space to cry. In May 2008, he voluntarily left his employment with Barnes because of his continuing ankle pain.

Once it learned of claimant's employment with Barnes, JEB sought to recoup the TTD benefits it had paid to claimant after he began his employment with Barnes. Claimant conceded JEB was entitled to recover any TTD benefits it paid to him from November 2007 to May 2008, the period during which he worked for Barnes. However, the parties disagreed whether claimant was entitled to receive TTD after he left Barnes but before the DIME physician placed him at MMI — the period from May 2, 2008, to February 2, 2009.

After an evidentiary hearing, the ALJ found claimant's separation from Barnes "did not constitute a volitional act" because his separation "was due to [his] need to undergo additional medical treatment for the ankle injury." The ALJ also concluded that

Barnes provided “sheltered employment” to claimant.

Consequently, the ALJ found JEB was liable for TTD for the period May 2, 2008, through February 2, 2009.

Although the Panel agreed claimant was entitled to TTD payments for this period, it rejected the notion that claimant’s employment with Barnes was sheltered. Nevertheless, the Panel found the record supported the ALJ’s finding that claimant’s separation from Barnes was attributable to his injury and not a volitional resignation of employment and that his “wage loss . . . was due to his chronic and extreme ankle pain from his work injury.” Because substantial evidence supported the ALJ’s conclusion, the Panel found no error in the ALJ’s determination that claimant “was entitled to reinstatement of TTD benefits.” Consequently, it affirmed the ALJ’s order requiring JEB to pay claimant TTD benefits for the period after he left Barnes’ employ until he reached MMI. This appeal followed.

II. Reinstatement of Benefits

On appeal, JEB contends that the Panel erred by affirming the ALJ’s order to reinstate claimant’s TTD benefits. It argues that, because claimant’s condition was unchanged by his work at

Barnes, there were no grounds for reinstatement under the applicable statutory provisions. It maintains that the express language of section 8-42-105(3) prohibits reinstatement under the circumstances here and that the ALJ misapplied the statute by permitting reinstatement of claimant's TTD benefits despite his admitted return to work. We agree.

Section 8-42-105(1), C.R.S. 2013, provides, as pertinent here:

“Except where vocational rehabilitation is offered and accepted as provided in section 8-42-111(3) [which exception is not applicable here], temporary total disability payments shall cease upon the occurrence of any of the events enumerated in subsection (3) of this section.”

Section 8-42-105(3)(a)-(d)(I), C.R.S. 2013, provides, in pertinent part, that:

- (3) Temporary total disability benefits shall continue until the first occurrence of any one of the following:
 - (a) The employee reaches maximum medical improvement;
 - (b) The employee returns to regular or modified employment;
 - (c) The attending physician gives the employee a written release to return to regular employment; or
 - (d)(I) The attending physician gives the employee a written release to return to

modified employment, such employment is offered to the employee in writing, and the employee fails to begin such employment.

JEB argues that the condition in section 8-42-105(3)(b) was met when claimant went to work for Barnes in November 2007. Therefore, it reasons, claimant was not entitled to any TTD benefits after becoming re-employed unless he had shown that his condition had worsened. JEB contends that the Panel, therefore, erred by requiring it to pay TTD until the DIME found claimant to be at MMI in February 2009. It argues that because claimant demonstrated an actual ability to work at Barnes, section 8-42-105(3)(b) prohibits the reinstatement of his TTD absent a showing of a worsening condition.

Claimant does not dispute that his condition did not worsen. To the contrary, he testified that he suffered no new injury or aggravation while working for Barnes, but instead continued to experience the same base level of pain whether or not he worked.

We agree with employer and conclude that, on the record here, the plain and express language of the applicable statutes bars claimant's request for further TTD benefits. The language in

sections 8-42-105(1) and (3)(b) unambiguously and without exception provides that TTD benefits will discontinue when, as is the case here, an injured worker returns to work.

Further, several cases from divisions of this court have held that triggering one of the enumerated conditions in section 8-42-105, C.R.S. 2013, terminates an employee's entitlement to TTD. *See Laurel Manor Care Ctr. v. Indus. Claim Appeals Office*, 964 P.2d 589, 590 (Colo. App. 1998) ("The termination of TTD benefits under any one of the enumerated conditions is mandatory."); *City of Colo. Springs v. Indus. Claim Appeals Office*, 954 P.2d 637, 640 (Colo. App. 1997) (the claimant was not entitled to reinstatement of TTD where worsened condition did not lead to additional wage loss); *Burns v. Robinson Dairy, Inc.*, 911 P.2d 661, 662-63 (Colo. App. 1995) (TTD benefits were properly terminated where claimant returned to work even though the DIME found the claimant not to be at MMI).

Claimant urges us to disregard this precedential caselaw as well as the express language of the applicable statutes to uphold the ALJ's reinstatement order. But, we cannot do so.

When interpreting a statute, we must give effect to the General Assembly's intent in adopting the statute.

To do so, courts first look to the statutory language itself, giving words and phrases their commonly accepted and understood meaning. If the statutory language is unambiguous, there is no need to resort to interpretive rules of statutory construction. Therefore, if courts can give effect to the ordinary meaning of the words adopted by the General Assembly, the statute should be construed as written, because it may be presumed that the General Assembly meant what it clearly said.

Spracklin v. Indus. Claim Appeals Office, 66 P.3d 176, 177 (Colo. App. 2002). In addition, “when examining a statute’s plain language, we give effect to every word and render none superfluous because ‘[w]e do not presume that the legislature used language idly and with no intent that meaning should be given to its language.’” *Colo. Water Conservation Bd. v. Upper Gunnison River Water Conservancy Dist.*, 109 P.3d 585, 597 (Colo. 2005) (citation omitted; quoting *Carlson v. Ferris*, 85 P.3d 504, 509 (Colo. 2003)).

Although we may “give considerable weight to an agency’s interpretation of its own enabling statute,’ . . . we set aside actions or interpretations that are clearly erroneous, arbitrary, or otherwise not in accordance with the law.” *Davison v. Indus. Claim Appeals*

Office, 84 P.3d 1023, 1029 (Colo. 2004) (quoting *Colo. Dep't of Labor & Emp't v. Esser*, 30 P.3d 189, 194 (Colo. 2001)). Moreover, although generally “[w]hether an employee is at fault for causing a separation of employment is a factual issue for determination by the ALJ,” *Gilmore v. Indus. Claim Appeals Office*, 187 P.3d 1129, 1132 (Colo. App. 2008), where the ALJ has misapplied the law, the decision may be set aside. See *Paint Connection Plus v. Indus. Claim Appeals Office*, 240 P.3d 429, 431 (Colo. App. 2010) (“[A]n agency’s decision that misconstrues or misapplies the law is not binding.”).

Here, in our view, the Panel has read into the TTD statute an avenue for reinstating benefits that is neither anticipated nor articulated in the Act. We are not at liberty to read provisions into the statute, however, and conclude that in doing so the Panel has not interpreted the statute in accordance with its plain language. See *Kraus v. Artcraft Sign Co.*, 710 P.2d 480, 482 (Colo. 1985) (“We have uniformly held that a court should not read nonexistent provisions into the . . . Act.”).

Despite the plain statutory language, claimant urges us to look to policies underlying the Act, suggesting that the goals of the Act are best served by permitting an injured, temporarily disabled

employee who cannot work because of his injury and who has not yet reached MMI to resume receiving TTD benefits despite an intervening period of employment. At oral argument, claimant's counsel further argued that a bright line rule barring re-employed workers from continuing to receive TTD benefits would discourage injured workers from returning to their jobs. But, we cannot look to these underlying policies to trump express statutory language and clear legislative intent. *See, e.g., Lujan v. Life Care Ctrs. of Am.*, 222 P.3d 970, 977 (Colo. App. 2009) (“[A]lthough we acknowledge Colorado’s strong public policy in favor of arbitration, we are aware of no authority under which this policy has been applied to trump applicable statutory language or to create a right to arbitrate that does not exist in a statute.” (citation omitted)); *see also Concerned Parents of Pueblo, Inc. v. Gilmore*, 47 P.3d 311, 313 (Colo. 2002) (courts may not “substitute [their] own public policy determinations for those of the General Assembly”).

Nor are we persuaded to reach a different conclusion because of a perceived administrative trend in permitting reinstatement of benefits. Counsel for both parties seemed to acknowledge at oral argument that “reinstatement happens all the time.” And, indeed,

there are some published cases in Colorado that have permitted reinstatement of benefits on various grounds, but none fits the fact pattern presented here.

For example, in *Anderson v. Longmont Toyota, Inc.*, 102 P.3d 323, 327 (Colo. 2004), the supreme court held that the claimant was entitled to continuation of TTD benefits because the worker had suffered a worsening condition. Similarly, in *Grisbaum v. Industrial Claim Appeals Office*, 109 P.3d 1054, 1055-56 (Colo. App. 2005), because the claimant's condition worsened after his voluntary resignation and prevented him from working, his injury became the proximate cause of his wage loss, thereby entitling him to TTD benefits.

The case before us is factually distinguishable from *Anderson* and *Grisbaum*, however. Here, unlike in those cases, claimant did not suffer a worsening of his condition which renewed his inability to work. Rather, by claimant's own admission, he was able to work for Barnes, arguably with much success, despite experiencing the same pain level before, during, and after his employment with Barnes.

Similarly, in other cases, reinstatement was permitted because the ATP or referred physician issued at least one report indicating the claimant was unable to return to work. *See Imperial Headwear, Inc. v. Indus. Claim Appeals Office*, 15 P.3d 295, 296-97 (Colo. App. 2000) (where the physician issued conflicting reports regarding claimant's work release, the ALJ was authorized to determine whether claimant had been released to return to work); *Bestway Concrete v. Indus. Claim Appeals Office*, 984 P.2d 680 (Colo. App. 1999) (an ALJ is free to rely on the report of the claimant's surgeon that the claimant was not released to work, even though claimant's ATP had issued a medical work release). Here, however, claimant has not pointed us to any medical record opining that his condition had deteriorated or that he could not return to work after leaving Barnes.

In contrast, as noted above, in the absence of a worsened condition or demonstrated inability to work because of an industrial injury, other cases have concluded that TTD benefits were properly terminated. *See Gilmore*, 187 P.3d at 1132 (substantial evidence supported ALJ's conclusion that claimant was terminated for cause and that claimant's condition did not prevent him from working,

thereby rendering discontinuation of TTD proper); *City of Colo. Springs*, 954 P.2d at 640 (a subsequent injury does not entitle claimant to renewed TTD benefits post-MMI “unless the worsened condition causes an additional temporary loss of wages”).

Thus, claimant’s assertion, made without statutory or precedential authority, that “the statute itself makes it clear that only employees who are terminated for wrongdoing were meant to be barred from TTD benefits,” is simply not consistent with Colorado law. We perceive no statutory or precedential case authority barring TTD benefits only if the claimant committed wrongdoing. To the contrary, multiple cases have rejected a request to reinstate TTD benefits despite an absence of any allegation of wrongdoing by the claimant. *See City of Colo. Springs*, 954 P.2d at 640 (the claimant was not entitled to reinstatement of TTD benefits where a subsequent injury did not cause additional temporary wage loss); *Burns*, 911 P.2d at 662-63 (termination of TTD benefits was appropriate where the claimant’s physician released him to return to work).

While we are not unsympathetic to claimant’s situation, as an intermediary court, we are not at liberty to extend the statute in the

manner claimant seeks. *See Taxpayers for Pub. Educ. v. Douglas Cnty. Sch. Dist.*, 2013 COA 20, ¶ 105 (making decisions based on policy reasons, without regard for the law, is not part of the courts' constitutional function, and such arguments should be directed to the appropriate law-making bodies); *Davison v. Indus. Claim Appeals Office*, 72 P.3d 389, 391 (Colo. App. 2003) (“[W]e are bound to construe the statute as written.”), *rev'd*, 84 P.3d 1023 (Colo. 2004); *see also Concerned Parents of Pueblo, Inc.*, 47 P.3d at 313 (“[T]he court is not to substitute its own public policy determinations for those of the General Assembly.”).

Accordingly, we conclude that the express language of section 8-42-105(3)(b) does not permit reinstatement of TTD benefits under the circumstances here. We hold that the ALJ and the Panel misapplied the express statutory language of section 8-42-105(3)(b) by reinstating claimant's TTD benefits after his separation of employment from Barnes, and, therefore, we set aside the Panel's order affirming the ALJ's decision.

Having reached this conclusion, we need not address JEB's argument that the Panel erred by failing to set aside certain specific paragraphs of the ALJ's order.

III. Voluntariness of Resignation

Finally, JEB contends that claimant's resignation was voluntary and volitional. It argues that, because he resigned under the pretense that he may have lung cancer, the ALJ wrongly attributed claimant's separation from employment to his work injury. Having concluded that, under section 8-42-105(3)(b) claimant's work for Barnes barred him from receiving additional TTD, we need not address this contention.

The order is set aside.

JUDGE TERRY and JUDGE NAVARRO concur.

12CA1890 McCormick v. ICAO 10-10-2013

COLORADO COURT OF APPEALS

Court of Appeals No. 12CA1890
Industrial Claim Appeals Office of the State of Colorado
WC No. 459-46-83

May B. McCormick,

Petitioner and Cross-Respondent,

v.

Industrial Claim Appeals Office of the State of Colorado

Respondent,

and

Exempla Healthcare, Inc.,

Respondent and Cross-Petitioner.

ORDER AFFIRMED IN PART AND SET ASIDE IN PART

Division V

Opinion by JUDGE RICHMAN
Graham and Navarro, JJ., concur

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

Announced October 10, 2013

Chris Forsyth Law Office, L.L.C., Christopher Forsyth, Denver, Colorado, for
Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Thomas Pollart & Miller, LLC, Brad J. Miller, Greenwood Village, Colorado, for
Respondent and Cross-Petitioner Exempla Healthcare, Inc.

This is the fourth appeal in this heavily litigated workers' compensation case. In this current appeal, the parties have cross-appealed a final decision of the Industrial Claim Appeals Office (Panel). The parties raise the following issues:

(1) Claimant, May B. McCormick, challenges:

(a) the Panel's reduction of the attorney fees awarded to her by the administrative law judge (ALJ);

(b) the Panel's refusal to consider her appeal of the ALJ's denial of her request for penalties;

(c) the Panel's denial of her motion to disqualify the entire Panel; and

(d) the Panel's decision to permit the attorney who testified at the hearing on attorney fees to later represent the respondent, Exempla Healthcare, Inc., and its insurer, Sedgwick CMS (collectively employer), before the Panel and now before this court.

(2) Employer appeals:

(a) the Panel's reversal of an ALJ's initial decision denying claimant's entitlement to attorney fees for employer's alleged assertion of an unripe issue; and, in the alternative,

(b) the propriety of the attorney fees awarded to claimant.

We affirm the Panel's determination that claimant failed to preserve the penalty issue for appellate review, and conclude that the Panel committed no error when it denied both claimant's motion to disqualify the entire Panel and her motion to disqualify opposing counsel. However, we conclude that employer did not assert an unripe issue in its 2004 and 2005 applications for hearing, and therefore set aside the Panel's order awarding claimant attorney fees. The order is thus affirmed in part and set aside in part.

I. Factual and Procedural Background

This case presents a complex and lengthy procedural and factual background. The parties, at several points in their briefs, accuse each other of misrepresenting and mischaracterizing facts and procedural history. Rather than address each of these allegations of false assertions, we will recite the facts and history relevant to this appeal as we have reconstructed them from the record.

A. Commencement of Claim

Claimant sustained an admitted, compensable injury to her right wrist in August 2003. She was treated by an authorized treating physician (ATP), who placed her at maximum medical improvement (MMI) for the right wrist on September 4, 2003, with no permanent impairment. After re-injuring her hand in a non-work-related incident, she continued to treat with the ATP, who eventually placed at MMI a second time on July 14, 2004, with twelve percent impairment of the upper extremity.

B. First Appeal

Employer did not file a Final Admission of Liability (FAL) after receiving either of the ATP's MMI determinations. Instead, as permitted by Workers' Compensation Rule of Procedure 5-5(H)(2) (formerly Rule IV(N)(8)(b))¹, in August 2004 and again in February

¹ Rule 5-5(H)(2) provides:

(H) For those injuries required to be filed with the Division with dates of injury on or after July 1, 1991, and subject to § 8-42-107(2), C.R.S. scheduled injuries:

(2) Within 30 days after a determination of permanent impairment from an authorized Level II accredited physician is mailed or delivered, or a determination by the authorized treating physician providing primary care

2005, employer filed an application for hearing, endorsing as issues compensability, medical benefits, relatedness, and causation. See Dep't of Labor & Emp't Rule 5-5(H)(2), 7 Code Colo. Regs. 1101-3. The two applications for hearing were substantively identical. Employer did not dispute claimant had reached MMI by the time of its applications for hearing, and therefore did not endorse MMI as an issue in its pleadings seeking a hearing. After the first application for hearing was filed, but before the hearing occurred, the ATP clarified his position on MMI in a December 2004 letter to employer's counsel in which he stated that claimant's work-related symptoms resolved in September 2003. Later, in a June 2005 deposition, he confirmed his position, acknowledging that claimant reached MMI for the industrial injury in September 2003 and that all treatment rendered after that date was not related to the industrial injury.

that there is no impairment is mailed or delivered, the insurer shall either:

- (a) File an admission of liability consistent with the physician's opinion, or
- (b) Set the matter for hearing at the Office of Administrative Courts.

Because employer did not file an FAL, claimant did not obtain a division-sponsored independent medical examination (DIME) before employer filed its applications for hearing. Thus, when the matter proceeded to hearing in July 2005, no DIME had been conducted. The presiding ALJ, ALJ Friend, questioned whether the hearing could proceed without a DIME. But, during the course of the ensuing discussion, claimant expressly agreed that “she is at MMI,” a concession which helped convince ALJ Friend to proceed with the hearing. However, claimant later retracted this concession, stating that she “was confused” and did “not believe that she’s at MMI for her left hand.”

Nevertheless, the July 2005 hearing continued on the issue of medical benefits only. After the hearing, ALJ Friend ruled that claimant reached MMI in September 2003, and denied all benefits after that date.

On claimant’s petition for review, the Panel set aside the ALJ’s order, finding that the ALJ lacked jurisdiction to conduct a hearing touching on MMI because a DIME had not been completed prior to the hearing. A division of this court agreed with the Panel,

concluding that because “causation and MMI are often inextricably linked,” the hearing addressing employer’s causation challenge could not proceed without a DIME. Therefore, in the absence of a DIME, the ALJ lacked jurisdiction to proceed with the hearing. *Exempla Healthcare v. Indus. Claim Appeals Office*, (Colo. App. No. 06CA0329, Nov. 24, 2006) (not published pursuant to C.A.R. 35(f)).

C. Second Appeal

In December 2005, claimant sought penalties against employer under section 8-43-304, C.R.S. 2013, for procedural errors. An ALJ denied that request, and the Panel affirmed that decision. A division of this court remanded the matter back to the Panel, however, for further findings. *McCormick v. Indus. Claim Appeals Office*, (Colo. App. No. 07CA0849, May 1, 2008) (not published pursuant to C.A.R. 35(f)).

D. Third Appeal

On remand, the Panel defined the scope of “determination of permanent impairment” as used in Rule 5-5(H)(2) to exclude deposition testimony and correspondence, and thus ruled that because employer had not violated the rule, claimant was not

entitled to penalties. A division of this court agreed with the Panel that claimant was not entitled to penalties under Rule 5-5(H)(2), and affirmed the Panel's ruling. *McCormick v. Indus. Claim Appeals Office*, (Colo. App. No. 08CA2249, May 14, 2009) (not published pursuant to C.A.R. 35(f)).

E. Instant Appeal

In March 2007, claimant filed an application for hearing seeking attorney fees on the grounds that employer's August 2004 and February 2005 applications for hearing were unripe because no DIME had been obtained before the applications for hearing were filed. Specifically, claimant sought fees under section 8-43-211(2)(d), C.R.S. 2013, which prohibits any party from requesting a hearing or filing "a notice to set a hearing on issues which are not ripe for adjudication at the time such request or filing is made," and imposes attorney fees against any party who violates the statute. In addition, claimant also requested penalties pursuant to section 8-43-304, asserting that employer violated a court order or rule both by failing to file a FAL and by instead filing an untimely notice and proposal for a DIME in December 2006.

After a delay, the matter proceeded to hearing before ALJ Friend in April 2010. ALJ Friend ruled that employer's applications for hearing were unripe and that claimant was entitled to attorney fees, but he reserved ruling on the amount of fees to be awarded. He denied claimant's request for penalties, finding that employer was not prohibited from filing a notice and proposal for a DIME.

Because attorney fees were not determined by ALJ Friend, claimant filed an affidavit of attorney's fees, claiming entitlement to fees and costs totaling \$42,943.35. A hearing concerning the fee award was then held before ALJ Jones. At the hearing, employer moved for reconsideration of ALJ Friend's order finding it had violated section 8-43-211(2)(d) by filing an unripe application for hearing. ALJ Jones agreed that the endorsed issues were not unripe when employer filed its applications for hearing. She therefore granted the motion for reconsideration and denied claimant's request for attorney fees.

On claimant's petition to review, the Panel rejected ALJ Jones' ripeness determination, setting aside her order denying claimant attorney fees. Citing to the decision of a division of this court in

Exempla Healthcare, (Colo. App. No. 06CA0329), the Panel noted that because causation and MMI were “inextricably linked” in this case, the failure to obtain a DIME before the July 2005 hearing was a “legal impediment to adjudication . . . [of] ongoing medical benefits.” The Panel therefore set aside ALJ Jones’ order granting employer’s motion for reconsideration, and remanded “for determination of the amount of the attorney fees and costs to be imposed.”

The Panel declined to review claimant’s request for penalties, however, concluding claimant had not raised it in her prior petition for review and therefore had failed to preserve the issue for appeal.

On remand, ALJ Jones awarded claimant all the fees and costs she requested. The Panel affirmed most of the fee award, but set aside and remanded the portion attributable to claimant’s request for permanent total disability (PTD) benefits, concluding that PTD was unrelated to the unripe issues endorsed by employer. The Panel also reiterated its rejection of claimant’s appeal of the penalties issue. This appeal followed.

II. Award of Attorney Fees for Endorsing Unripe Issues

Both parties argue that the Panel committed errors in its imposition of attorney fees against employer. Claimant contends that the Panel improperly reduced her fee award by instructing the ALJ to deduct fees associated with her claim for PTD benefits. Employer argues that its 2004 and 2005 applications for hearing were ripe when filed and that the Panel erred in finding that it had violated the ripeness requirement of section 8-43-211(2)(d). In the alternative, employer contends that the fees imposed against it were excessive and not related to the allegedly unripe issue.

A. Applications for Hearing were Ripe

Employer's August 2004 and February 2005 applications for hearing endorsed compensability, medical benefits, relatedness, and causation. Neither application endorsed MMI because, employer asserts, at the time the applications for hearing were filed, the parties did not dispute claimant had reached MMI. The ALJ questioned whether the hearing could proceed, but agreed to go forward because claimant agreed she had reached MMI. As discussed above, though, shortly thereafter claimant recanted her agreement that she had reached MMI. Employer contends that it

was not until claimant's mid-hearing retraction that a DIME became necessary. It argues that the legal impediment rendering its application for hearing unripe – the failure to obtain a DIME before addressing MMI at hearing – did not arise until the hearing was already underway, well after it filed its applications for hearing. It conceded at oral argument that at claimant's recantation, the ALJ lost jurisdiction and the hearing should have ceased. But, until that point, it claims, MMI was not at issue, the hearing could have proceeded, and, consequently, its applications for hearing were ripe at the time of filing. We agree.

The Workers' Compensation Act mandates that parties endorse only issues ripe for adjudication in applications for hearing.

The statute provides:

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.

§ 8-43-211(2)(d). Under the express language of the statute, an issue must be ripe "at the time" the application for hearing is filed.

Inclusion of an unripe issue in an application will result in the

mandatory imposition of fees against the offending party.

An issue is ripe for hearing when it “is real, immediate, and fit for adjudication.” *Olivas-Soto v. Indus. Claim Appeals Office*, 143 P.3d 1178, 1180 (Colo. App. 2006). Conversely, an issue is not ripe and “adjudication should be withheld for uncertain or contingent future matters that suppose a speculative injury which may never occur.” *Id.* Whether an issue is ripe for review is a question of law that we review de novo. *See Timm v. Prudential Ins. Co. of Am.*, 259 P.3d 521, 528 (Colo. App. 2011) (“On appeal of a determination of ripeness, we review the trial court’s factual findings for clear error and its legal conclusions de novo.”).

Here, the Panel observed that it had previously determined that the ALJ lacked jurisdiction to proceed with the July 2005 hearing because there was “a constructive challenge to MMI in the absence of a DIME.” The Panel therefore disagreed with ALJ Jones’ determination that MMI did not become at issue until claimant’s mid-hearing declaration that, contrary to her earlier statement, she was not at MMI. Relying on the opinion of a division of this court in *Exempla Healthcare*, (Colo. App. No. 06CA0329), the Panel noted

that “causation and MMI were inextricably linked when reviewed in totality, and it was apparent that the substance of the dispute between the parties was the conflicting MMI findings.”

In our view, the Panel has read *Exempla Healthcare* too broadly. The issue in that case was whether the ALJ had jurisdiction to conduct the July 2005 hearing in light of the parties’ MMI dispute. Although employer now concedes that the hearing should have been discontinued when claimant verbalized her dispute with the ATP’s conclusion that she had reached MMI, at the hearing, it argued that the ALJ could proceed because causation, not MMI, was at issue.²

It is true that a dispute limited to causation does not require a pre-hearing DIME, but the posture of *Exempla Healthcare* at the hearing prevented the neat separation of causation from MMI in this case. See *Delaney v. Indus. Claim Appeals Office*, 30 P.3d 691, 693 (Colo. App. 2000) (DIME is not “a prerequisite to hearing in

² Causation “is a threshold requirement which an injured employee must establish by a preponderance of the evidence before any compensation is awarded. The question of causation is generally one of fact for determination by the ALJ.” *Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000). Therefore, a DIME physician’s opinion regarding threshold causation and

cases that clearly involve only scheduled injuries”); *Egan v. Indus. Claim Appeals Office*, 971 P.2d 664, 666 (Colo. App. 1998) (“[T]his interpretation of the statutory scheme, requiring causation questions to be challenged through a division IME, applies only to injuries resulting in whole person impairment. When there is a dispute concerning causation or relatedness in a case involving only a scheduled impairment, the ALJ will continue to have jurisdiction to resolve that dispute.”).

The *Exempla Healthcare* court noted that, at the hearing, claimant offered conflicting MMI positions, agreeing she was at MMI with respect to her right hand, but disagreeing “that her left hand had reached MMI.” *See Exempla Healthcare*, (Colo. App. No. 06CA0329). However, we do not read the opinion as deciding *when* MMI became at issue; rather it determined only that the ALJ lacked jurisdiction to proceed with the hearing and issue a ruling in the absence of a DIME given that MMI and causation were both at issue. Thus, the issue presented here – whether a DIME was needed when the applications for hearing were filed so as to make

compensability carries no presumptive weight. *See id.*

the application for hearing ripe – was not addressed by *Exempla Healthcare*.

Claimant nonetheless maintains that employer violated section 8-43-211(2)(d) when it filed its applications for hearing because the lack of a DIME was a legal impediment to resolving the MMI dispute. She argues that a “challenge to MMI cannot be done absent a DIME,” and that employer wrongfully filed its application for hearing without first obtaining a DIME in an attempt to deprive her of the opportunity to obtain a DIME. Citing to prior opinions of the Panel, she contends that once a claimant has been placed at MMI, no hearing can take place until a DIME has been completed. In support, she quotes the following from the Panel’s opinion: “we have stated ‘once an authorized treating physician places the claimant at MMI, an ALJ lacks jurisdiction to award additional medical benefits for the purposes of curing the industrial injury and assisting the claimant to reach MMI unless the claimant undergoes a DIME.’ *Eby v. Wal-Mart, Inc.*, [(W.C. No. 4-350-176, Feb. 14, 2001.)].” *McCormick v. Exempla Healthcare*, (W.C. No. 4-594-683, Jan. 27, 2006). When asked at oral argument for precedential case

law supporting this contention, claimant's counsel noted that "tons" of authority espouses this rule, yet he failed to provide any citations supporting this contention.

Claimant's reliance on the Panel's prior decision is misplaced, however. The passages quoted at length by claimant, when read in context, make clear that the Panel was addressing only those circumstances in which a claimant is seeking post-MMI medical benefits "for purposes of further curing her injury, *i.e.*, *reaching MMI*, or to obtain reinstatement of temporary total disability benefits." *Story v. Indus. Claim Appeals Office*, 910 P.2d 80, 82 (Colo. App. 1995) (emphasis added). The cases relied upon by the Panel, particularly *Eby* which cites to *Story*, make clear that the precedent upon which they rely applies in those instances in which the claimant seeks additional treatment to reach MMI. Unlike the specific circumstance discussed by the Panel in the excerpt quoted by claimant, claimant here was not, at the commencement of the hearing, claiming she had not yet reached MMI. To the contrary, and as we have previously noted, her contention that she was not yet at MMI was not made until the parties were well into arguing

their position before ALJ Friend. Thus, the quotations from the Panel offered by claimant do not support the proposition she advances.

Consistent with the principle articulated by the Panel and *Story*, a DIME is not required before a hearing where, as here, “the authorized treating physician issues conflicting opinions concerning MMI.” *Blue Mesa Forest v. Lopez*, 928 P.2d 831, 833 (Colo. App. 1996). If an ATP has issued conflicting opinions concerning the date on which a claimant reached MMI “it is for the ALJ to resolve the conflict, and the ALJ may do so without requiring the claimant to obtain an IME.” *Id.* Similarly here, at the time the application for hearing was filed, as well as at the commencement of the July 2005 hearing, the only unresolved issue concerning MMI was the conflicting MMI dates given by the ATP.

We are not persuaded by claimant’s plea that we disregard this precedential case. Although it is true that an argument not raised before an ALJ is not preserved for review, *see City of Durango v. Dunagan*, 939 P.2d 496, 500 (Colo. App. 1997), in our opinion, employer is not barred from arguing *Blue Mesa* before us. First,

employer argued *Blue Mesa* in its position statement to ALJ Jones after moving for reconsideration of ALJ Friend's order awarding claimant attorney fees. Thus, contrary to claimant's contention, the case was identified by employer to the ALJ before employer raised it here. Second, because jurisdiction, not ripeness, was at issue at the July 2005 hearing and the ensuing appeal, *Exempla Healthcare*, the conflicting MMI dates were not the focus of the discussion. And, third, at that July 2005 hearing, claimant's counsel pointed out to ALJ Friend that *Blue Mesa* permitted the hearing to continue because it held that an ALJ is authorized to make a factual determination "regarding the date of MMI" without first obtaining a DIME.

Nor are we persuaded by the distinctions claimant attempts to draw between *Blue Mesa* and this case. Like the case currently before us, the ATP in *Blue Mesa* issued one MMI date, and then later issued a different date. Because the conflicting opinions were issued by the same physician, the ALJ was free to resolve the conflict. *Blue Mesa*, 928 P.2d at 833; see also *Town of Ignacio v. Indus. Claim Appeals Office*, 70 P.3d 513, 516 (Colo. App. 2002)

(distinguishing *Blue Mesa* and requiring a DIME before hearing where multiple physicians have issued conflicting opinions about MMI).

Applying *Blue Mesa* to the facts before us, we conclude that because the only dispute concerning MMI *at the time* employer filed its applications for hearing was the conflicting MMI dates issued by the ATP, the lack of a DIME was not a legal impediment to proceeding to hearing at that time. A DIME was necessitated – and deprived the ALJ of the ability to hear the case – when claimant proclaimed she was not at MMI. Thus, employer did not assert an unripe issue in its application for hearing. MMI *became* nonadjudicable when claimant recanted her earlier agreement that she had reached MMI.

Therefore, we conclude that employer did not violate section 8-43-211(2)(d) when it filed its application for hearing. Rather, the Panel erred when it determined that employer asserted an unripe issue and set aside ALJ Jones' order reconsidering the award of attorney fees. Accordingly, the attorney fees awarded to claimant by ALJ Jones and affirmed by the Panel are set aside.

B. Validity of Attorney Fees

Having determined that employer did not assert an unripe issue in its 2004 and 2005 applications for hearing, we need not address the propriety of either the Panel's order reducing the fees and costs awarded to claimant or the extent of fees awarded.

III. Request for Penalties was not Preserved for Review

The Panel declined to consider claimant's assertion that ALJ Friend had improperly rejected her request for penalties, finding that she had failed to preserve the issue. She requested these penalties in her 2007 application for hearing for employer's "failure to comply with the Court of Appeals' November 24, 2006, Order by failing to file a [FAL] in this case." She also claimed entitlement to penalties on the ground that employer filed a notice and request for proposal for a DIME that was not compliant with the requirements of section 8-42-107.2(2)(a)(I)(B), C.R.S. 2013. ALJ Friend ruled that, contrary to claimant's contention that the notice and proposal for a DIME was untimely, "the time for the filing of the Notice and Proposal has not yet begun to run. As such, the filing of the Notice and Proposal was not filed too late." He therefore denied

claimant's request for penalties.

Because ALJ Friend's order neither awarded nor denied benefits – he deferred ruling on the amount of attorney fees to be awarded to claimant – his order did not become final and appealable until ALJ Jones ruled on claimant's entitlement to attorney fees. See *Flint Energy Servs., Inc. v. Indus. Claim Appeals Office*, 194 P.3d 448, 450 (Colo. App. 2008) (“Where an order neither awards nor denies benefits, it is merely interlocutory and is “not ripe for appellate review.”) (quoting *U.S. Fid. & Guar., Inc. v. Kourlis*, 868 P.2d 1158, 1163 (Colo. App. 1994)). Indeed, ALJ Friend decreed in his order that “No part of this order is subject to a Petition to Review until the issues of the amount of the attorney fees and against whom the fees should be assessed is determined.” ALJ Jones issued her order reconsidering the ripeness question and denying claimant attorney fees and costs on February 2, 2011, at which time ALJ Friend's order became final and appealable. Under section 8-43-301(2), C.R.S. 2013, claimant's petition to review was due within twenty days of ALJ Jones' February 2, 2011 order. See *Youngs v. Indus. Claim Appeals Office*, 2013 COA 54, ¶ 13 (“A party

that misses the twenty-day statutory time limit for filing a petition for review is jurisdictionally barred from obtaining further review of the order.”).

Although claimant *did* file a petition to review within that window, she only requested review of “the corrected order of the . . . ALJ Margot Jones mailed and served on February 2, 2011.” Claimant made no mention of ALJ Friend’s June 2010 order. But, “a party petitioning for review of an ALJ’s order must make the request in writing and ‘shall set forth in detail the particular errors and objections of the petitioner.” *Id.*, ¶ 15 (quoting § 8-43-301(2)). Consequently, claimant’s failure to identify ALJ Friend’s June 15, 2010 order in her otherwise timely petition to review deprived the Panel of jurisdiction to review the penalties issue.

We therefore perceive no error in the Panel’s refusal to review ALJ Friend’s denial of claimant’s request for penalties.

IV. Recusal of Panel

Claimant asserts that the entire Panel should have recused itself from hearing her case because “at the same time this case was before the [Panel], the [Panel] was directly adverse to [claimant’s]

counsel in the case of *Patrick Youngs v. ICAO.*” We presume, because it is not clear in her brief, that claimant’s assertion that the Panel “was directly adverse” to her counsel arises out of the Panel’s appearance and filing of briefs in the *Youngs* case. But, we disagree that this factor warranted recusal of the entire Panel.

The claimant relies upon *Venard v. Department of Corrections*, 72 P.3d 446 (Colo. App. 2003), for the proposition that an appearance of impropriety arises when an individual with adjudicative authority is simultaneously serving as adversary counsel to the plaintiff’s counsel in a different matter. In *Venard*, however, unlike here, the same individual served on the decision-making board and acted as the counsel for the state in another matter being handled by the plaintiff’s counsel. Claimant has neither shown which Panel members were involved in the *Youngs* decision, nor acknowledged that the Panel was represented by counsel from the State Attorney General’s Office. Thus, the Panel members involved in *Youngs* were not in the same adversarial posture as the board member/attorney described in *Venard*.

Moreover, the affidavit claimant’s counsel submitted in

support of her motion to disqualify the entire Panel is replete with innuendo and conjecture but largely devoid of factual support. In his attached affidavit, her counsel surmises that “it appears clear to me that the ICAO is retaliating against me for raising the issue of the constitutionality of the ICAO.” He provides no evidence to support this contention. Later, he states that “the fact that the ICAO paid an attorney to litigate against [him] in *Youngs* makes [him] wonder whether the ICAO has a stake in the fees and makes [him] more concerned about the financial relationship between Pinnacol, the firm that represents Pinnacol, and the ICAO.” This type of unsubstantiated conjecture is inappropriate in a motion to disqualify and cannot serve as the basis for recusal. *See Zoline v. Telluride Lodge Ass’n*, 732 P.2d 635, 639 (Colo. 1987) (“To be legally sufficient, the documents must ‘state facts from which it may reasonably be inferred that the judge has a bias or prejudice that will prevent him from dealing fairly with the defendant.’ Facts are required; conclusory statements, conjecture, and inuendo (sic) do not suffice.” (quoting *People v. Botham*, 629 P.2d 589, 595 (Colo. 1981))).

A denial of a motion to disqualify a judge will not be set aside absent abuse of discretion. *See Tripp v. Borchard*, 29 P.3d 345, 346 (Colo. App. 2001) (“A decision by a trial judge on a disqualification issue in a civil case will not be reversed absent an abuse of discretion.”). Because we perceive no abuse of discretion by the Panel here, we decline to set aside the Panel’s ruling on this issue.

V. Disqualification of Employer’s Counsel

Claimant next contends that the Panel erred by failing to disqualify employer’s appellate counsel, Brad J. Miller. Mr. Miller represented employer early in this litigation, serving as counsel during the July 2005 hearing before ALJ Friend. Substitute counsel, obtained at some time thereafter, served as counsel during the hearings and disputes regarding attorney fees and penalties. Mr. Miller was called upon to testify on employer’s behalf at the hearing on attorney fees before ALJ Jones in November 2010. Subsequently, Mr. Miller stepped back in to represent employer on the petition to review before the Panel and in this appeal. Claimant argues that Mr. Miller’s dual roles as both witness and counsel for employer were improper and that the Panel erred when it refused to

disqualify him or take “a position on the propriety of [employer’s] counsel representing the respondent on appeal.”

However, claimant offers no legal authority in support of her contention that Mr. Miller’s reappearance as counsel for employer was expressly improper or unethical. We note that, in her motion to disqualify Mr. Miller, she conceded that ethical opinions on the propriety of representation by appellate counsel who had previously testified have stated that “if the lawyer’s testimony is not material to the issues on appeal then the attorney can be appellate counsel.”

While we agree that it is highly unusual for an attorney who testified to later represent a party in the litigation, we note that: (1) Mr. Miller was not representing employer at the time he testified; and (2) the determination of ripeness, which was at issue in the November 2010 hearing, is a legal question independent of the evidence presented. *See Timm*, 259 P.3d at 528.

Consequently, we perceive no error in the Panel’s denial of the motion to disqualify Mr. Miller.

VI. Attorney Fees on Appeal

Lastly, in her Answer-Reply Brief claimant requests attorney

fees. But, a request for attorney fees on appeal must be raised “in the party’s principal brief in the appellate court.” C.A.R. 39.5.

Because she failed to raise her request for fees in her principal (opening) brief, claimant has waived her claim for fees. *See Amos v. Aspen Alps 123, LLC*, 298 P.3d 940, 957 (Colo. App. 2010)

(“Because C.A.R. 39.5 requires that appellate fee requests be made in principal briefs, we conclude that Amos waived her claim for appellate fees by raising this argument only in the reply brief.”), *rev’d on other grounds*, 2012 CO 46; *Tuscany, LLC v. W. States Excavating Pipe & Boring, LLC*, 128 P.3d 274, 280 (Colo. App. 2005) (“[B]ecause Western States requested attorney fees for its C.R.C.P. 60(b)(2) motion only in its reply brief on appeal, we need not address this issue.”).

Accordingly, the Panel’s order is affirmed in part and set aside in part.

JUDGE GRAHAM and JUDGE NAVARRO concur.