

BROWN BAG SEMINAR

Thursday, October 20, 2016
(Third Thursday of each month)
Noon – 1 p.m.

633 17th Street

2nd Floor Conference Room
(use elevator near Starbucks)

1 CLE (including .4 ethics)

Presented by
David Gallivan
Prehearing Administrative Law Judge
Colorado Division of Workers' Compensation

Sponsored by the Division of Workers' Compensation
Free

This outline covers ICAP and appellate decisions issued through October 12, 2016

Contents

Colorado Court of Appeals Decisions

Colorado Springs Transportation v. Shaikh	2
Roy v. Primesource Staffing	13

Industrial Claims Appeals Office Decisions

Adams v. Heart of the Rockies	24
Cross v. Genuine Parts Company	29
Dalton and Reid v. Pace Joint Interests-Denver	33
Evans v. JC Penny	45
Holder v. Staffmark	51
Huston v. Allcable	55
Ketiku v. Integrated Healthcare Staffing	63
Sparks v. Mattas Marine & RV	66

15CA2161 Colo Sprgs Trans v ICAO 10-06-2016

COLORADO COURT OF APPEALS

DATE FILED: October 6, 2016
CASE NUMBER: 2015CA2161

Court of Appeals No. 15CA2161
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-968-013

Colorado Springs Transportation, d/b/a Yellow Cab; and Old Republic
Insurance Company,

Petitioners,

v.

Industrial Claim Appeals Office of the State of Colorado and Rae Shaikh,

Respondents.

ORDER AFFIRMED

Division III
Opinion by JUDGE WEBB
Hawthorne and Navarro, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced October 6, 2016

Moseley, Busser & Appleton, P.C., Scott M. Busser, Denver, Colorado, for
Petitioners

No Appearance for Respondent Industrial Claim Appeals Office

The Viorst Law Offices, P.C., Anthony Viorst, Denver, Colorado, for Respondent
Rae Shaikh

¶ 1 In this workers' compensation action, employer, Colorado Springs Transportation, also known as Yellow Cab, and its insurer, Old Republic Insurance Company, (collectively employer) seek review of a final order of the Industrial Claim Appeals Office (Panel) affirming the decision of an administrative law judge (ALJ). The ALJ awarded claimant indemnity benefits at a rate calculated by employer, but declined to reduce the award by fifty percent for an alleged safety violation. We affirm the Panel's decision.

I. Background

¶ 2 In September 2014, claimant, Rae Shaikh, entered into a contract to drive a taxi for Yellow Cab in Colorado Springs. Under the terms of the contract, claimant would lease her vehicle from Yellow Cab. Several weeks later, claimant entered into a superseding contract with Yellow Cab, under which she agreed to purchase her taxi from Yellow Cab and become an owner-operator. Both agreements unambiguously stated that claimant was an independent contractor and not an employee of Yellow Cab. As an independent contractor, claimant controlled when to work, where to work, what calls to accept and which rides to provide, and, with the exception of applicable Public Utilities Commission regulations

pertaining to passengers, “for the most part,” made “all the rules regarding how” to transport people safely. In addition, claimant paid for fuel for the vehicle and for her own workers’ compensation insurance, the premium for which Yellow Cab deducted from her pay.

¶ 3 On November 23, 2014, claimant was involved in a motor vehicle accident while driving her cab. When she realized she was going to collide with another vehicle, claimant unfastened her seat belt because she feared being trapped in the vehicle. She sustained injuries to her cervical spine, right shoulder, and right knee.

¶ 4 Employer admitted liability for claimant’s injuries, and began paying claimant’s medical benefits and temporary total disability (TTD) benefits. However, employer reduced claimant’s TTD benefits by fifty percent because, it claimed, claimant violated a safety rule when she unfastened her seat belt before the collision. Claimant objected to the statutory penalty reducing her compensation benefits and requested a hearing on the issue.

¶ 5 The ALJ determined that claimant was not an employee of Yellow Cab, but was instead an independent contractor and thus self-employed. Because she was not Yellow Cab’s employee, she

was not subject to its safety rules. Rather, the ALJ found that claimant “did not have a safety policy requiring her to wear a seat belt during the operation of her business.” Further, the ALJ found that there was “insufficient credible evidence” demonstrating that claimant, who acted as her own employer, “adopted a safety rule requiring that she wear a safety belt while driving a cab,” and that, consequently, employer failed to establish that “claimant violated a safety rule adopted by the employer (i.e. the claimant).” The ALJ therefore denied employer’s request to reduce claimant’s compensation benefits by fifty percent. The Panel held that substantial evidence supported the ALJ’s factual determinations and therefore affirmed the ALJ’s order.

II. Analysis

¶ 6 On appeal, employer contends that the ALJ and the Panel misapplied the law in finding that claimant was not its employee and thus not subject to its safety rules. Specifically, it contends that the ALJ failed to make sufficient “findings and conclusions as to whether the agreements between [c]laimant and Yellow Cab satisfied” the requirements of section 40-11.5-102, C.R.S. 2016. It also contends that the ALJ similarly failed to make necessary

findings addressing “the source of [c]laimant’s workers’ compensation insurance and whether it was her policy or not.”

¶ 7 Essentially, employer implies that Yellow Cab’s contract with claimant may not have complied with the statutory requirements for a lease provision between a motor carrier and an independent contractor set out in section 40-11.5-102, and that the ALJ’s failure to make necessary, statutory findings about the contract necessitates a remand. It reasons that if the contract did not meet the statutory criteria, then claimant was Yellow Cab’s employee and subject to its safety rules. By taking off her seat belt, it argues, claimant violated Yellow Cab’s safety rule, thereby warranting the fifty percent penalty reduction in her disability payments under section 8-42-112(1)(b), C.R.S. 2016.

¶ 8 As claimant points out, however, Yellow Cab failed to preserve these arguments. We have reviewed the record, including the parties’ written statements and briefs to the Panel, , but have not found any indication that these arguments were raised in employer’s petition to review. Before the ALJ, employer argued that it correctly calculated claimant’s average weekly wage and had established the requisite elements to justify taking a fifty percent

penalty reduction against claimant's compensation. Employer repeated these arguments to the Panel. Absent from employer's brief in support of its petition to review is any contention that the ALJ should have made specific findings under section 40-11.5-102. And, it is clear that employer was aware of its obligation to raise challenges to the adequacy of the ALJ's findings before the Panel because employer argued below that the case should be remanded to the ALJ to make additional findings pertaining to the imposition and enforcement of its safety rules. Yet, employer made no parallel demand that the Panel remand to the ALJ for additional findings under section 40-11.5-102. Employer did not *mention* section 40-11.5-102 in its brief to the Panel. Likewise, employer's brief to the Panel did not address claimant's alleged need to prove the source or validity of her workers' compensation insurance policy or the policy's named insured.

¶ 9 Because these arguments are raised for the first time on appeal, they are not preserved for our review. *See Arenas v. Indus. Claim Appeals Office*, 8 P.3d 558, 561 (Colo. App. 2000) (arguments not raised before the Panel will not be addressed for the first time on appeal); *City of Durango v. Dunagan*, 939 P.2d 496, 500 (Colo.

App. 1997) (same); *see also Melat, Pressman & Higbie, L.L.P. v. Hannon Law Firm, L.L.C.*, 2012 CO 61, ¶ 18 (“It is axiomatic that issues not raised in or decided by a lower court will not be addressed for the first time on appeal.”). We therefore decline to address these arguments.

¶ 10 Employer also asserts that the Panel erred by making its own finding that the agreement between it and claimant “did contain all of the provisions embodied by section 40-11.5-102,” and should have remanded the case for further findings. But, employer does not develop this argument further, never articulating precisely what facts the Panel allegedly improperly found. Indeed, as we read the Panel’s order, the Panel took great pains to repeatedly note that it was the ALJ who found claimant was self-employed. Moreover, where the Panel discusses section 40-11.5-102, it recites only the statutory rule, and does not expound on the statutory criteria or evidence which may support those factors in this case. Because employer has not sufficiently developed this argument, we decline to address it. *See Mauldin v. Lowery*, 127 Colo. 234, 255 P.2d 976 (1953) (counsel has duty to identify specific errors and to set out basis for any challenge thereto); *Youngquist Bros. Oil & Gas, Inc. v.*

Indus. Claim Appeals Office, 2016 COA 31, ¶ 35; *Middlemist v. BDO Seidman, LLP*, 958 P.2d 486, 495 (Colo. App. 1997) (failing to identify specific errors and provide supporting legal authority results in affirmance); *accord Biel v. Alcott*, 876 P.2d 60 (Colo. App. 1993).

¶ 11 The remainder of employer’s arguments suggest that substantial evidence does not support the ALJ’s finding that claimant was an independent contractor rather than Yellow Cab’s employee, and therefore not subject to Yellow Cab’s safety rules. We disagree.

¶ 12 The Workers’ Compensation Act (Act) defines “employee” as “any individual who performs services for pay for another.” § 8-40-202(2)(a), C.R.S. 2016. However, the Act expressly excludes from the scope of “employee” “any person who is working as a driver under a lease agreement pursuant to section 40-11.5-102., C.R.S., with a common carrier or contract carrier.” § 8-40-301(5), C.R.S. 2016.

¶ 13 Here, both claimant and her Yellow Cab supervisor unequivocally testified that claimant worked as an independent contractor, not as an employee. The ALJ also found, and the record

supports, that claimant paid for her own workers' compensation insurance, in addition to other fees she paid to Yellow Cab.

Moreover, the contract between Yellow Cab and claimant in effect at the time of the accident unambiguously and in bold, capital letters identifies claimant as an independent contractor, not an employee.

Such a clear statement in a contract supports a prima facie showing of an independent contractor relationship between the parties. See § 40-11.5-102(4), C.R.S. 2016; *Frank C. Klein & Co. v. Colo. Comp. Ins. Auth.*, 859 P.2d 323, 327 (Colo. App. 1993) (agreements containing the provisions required by section 40-11.5-102(1)(a) "are presumed to be prima facie evidence of an independent contractor relationship between the parties").

¶ 14 Because the record amply supports the ALJ's finding that claimant was an independent contractor, we may not disturb the finding on review. See *Dana's Housekeeping v. Butterfield*, 807 P.2d 1218, 1220 (Colo. App. 1990) ("The determination of the operative facts as to whether a person is an employee or an independent contractor is generally within the province of the ALJ and the Panel" and therefore will not be disturbed if "there is substantial evidence to support their conclusions.").

¶ 15 An employee can be penalized under the Act if the employee's work-related injuries arose because the worker violated the employer's safety rules. See § 8-42-112(1)(b). Employer implies that the ALJ improperly concluded that Yellow Cab's safety rules, including a mandate to always wear a seat belt, did not apply to claimant and that employer failed to establish that claimant, as her own employer, had not set any safety rules concerning seat belt use. However, we have already concluded that claimant was not Yellow Cab's employee and therefore was not subject to Yellow Cab's safety rules. Moreover, the record is devoid of evidence showing that claimant imposed such a rule on herself, and employer has not pointed us to any such evidence in the record. Absent such a showing, we cannot say that the ALJ erred or abused his discretion in finding that employer failed to show that claimant violated a safety rule.

¶ 16 We therefore conclude that substantial evidence supports the ALJ's finding that claimant was an independent contractor, and that, because she was not Yellow Cab's employee, she was not subject to its safety rules. Accordingly, we find no error in the ALJ's order, or the Panel's decision affirming it, denying employer's

request to impose a fifty percent penalty on claimant's compensation.

¶ 17 The order is affirmed.

JUDGE HAWTHORNE and JUDGE NAVARRO concur.

16CA0186 Roy v ICAO 09-15-2016

COLORADO COURT OF APPEALS

DATE FILED: September 15, 2016
CASE NUMBER: 2016CA186

Court of Appeals No. 16CA0186
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-952-006-03

Hubbert H. Roy,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, Primesource Staffing
LLC, and Zurich American Insurance,

Respondents.

ORDER AFFIRMED

Division I
Opinion by JUDGE TAUBMAN
Dunn and Ashby, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced September 15, 2016

Hubbert H. Roy, Pro Se

No Appearance for Respondent Industrial Claim Appeals Office

Ruegsegger Simons Smith & Stern, LLC, Michele Stark Carey, Bryan D.
Neihart, for Respondents Primesource Staffing LLC and Zurich American
Insurance

¶ 1 In this workers' compensation action, claimant, Hubbert H. Roy, seeks review of a final order of the Industrial Claim Appeals Office (Panel) affirming the denial and dismissal of his claim for benefits. We affirm.

I. Background

¶ 2 Roy worked for Primesource Staffing, LLC, a temporary services agency. On May 24, 2014, he was assigned to sort and stack trays at a King Soopers facility. Roy alleged that, while he was bent over lifting some trays, a large number of trays on a nearby pallet fell, striking him in the head, neck, shoulder, back, and buttocks. None of Roy's coworkers witnessed the alleged event, nor did any of King Soopers' video surveillance cameras record it.

¶ 3 Roy immediately informed a supervisor that he had sustained an injury, and the supervisor told him to report the injury to Primesource. Roy then clocked out and drove to a hospital for treatment. The emergency room (ER) physician treated Roy for back pain and contusion, and prescribed percocet, an opioid painkiller.

¶ 4 Four days later, Roy informed Primesource of his alleged injury. He was referred to Dr. Ladvig, who assessed a lumbosacral

strain. Roy informed Dr. Ladvig that he had no prior history of spine injury, and based on that information, Dr. Ladvig opined that Roy's back strain was likely a work-related injury. Among other things, Dr. Ladvig prescribed additional opioid painkillers. Dr. Ladvig subsequently ordered an MRI, which revealed a "variety of degenerative changes" to the lumbar spine, particularly spondylosis and moderate foraminal stenosis at the L3-4 and L4-5 vertebrae. Dr. Ladvig referred Roy to Dr. Shih for physical therapy and acupuncture.

¶ 5 After examining Roy and the MRI ordered by Dr. Ladvig, Dr. Shih opined that "it [was] unlikely that the trays actually hitting [Roy's] back were the primary mechanism of injury," and that the mechanism of injury was more likely "potentially jerking when [Roy] was hit by the trays."

¶ 6 Medical records predating the alleged injury at King Soopers revealed that Roy had an extensive history of visits to the ER for low back pain and treatment:

- In 2002, Roy was seen at an ER for low back pain following a purported bus accident. X-rays showed mild degenerative

disk disease of the lumbar spine, particularly at the L3-4 and L4-5 vertebrae.

- In 2011, Roy went to an ER complaining of neck pain, back pain, and headaches following a car accident. X-rays revealed mild degenerative disease and facet arthrosis at the L3-4 and L4-5 vertebrae.
- In 2012, Roy reported to an ER physician that he was experiencing “new” low back pain after a twisting injury while catching himself from a fall.
- In 2013, Roy visited the ER on numerous occasions, once after a purported fall, once after lifting heavy boxes, and once after a purported bus accident. X-rays continued to show mild degenerative changes to the lumbar spine.
- In early 2014, Roy visited the ER on six occasions. One of these visits occurred roughly a month before the incident at King Soopers after Roy was involved in a car accident. Lumbar x-rays showed degeneration and arthritic facet joints.
- On May 31, 2014 — just a week after his alleged workplace injury — Roy visited a doctor at Kaiser Permanente,

complaining of lower back pain, the result of a purported car accident on May 28.

¶ 7 At some of Roy's ER visits and medical appointments, he denied suffering any previous injuries to his low back. He often sought or was prescribed opioid pain medications.

¶ 8 Roy was also treated by Dr. Koval following his report of the injury at King Soopers. Dr. Koval opined that "a lot of [Roy's] changes are degenerative and have likely taken place over a much longer period of time. While . . . [the] trays falling on him certainly may produce soreness, contusion[,] and maybe even muscle strain, I do not believe the degenerative changes in his spine resulted from the incident." Dr. Koval also noted that Roy was "evasive when we attempted to explore the issue of his past back pain and treatment."

¶ 9 Dr. Koval consulted with Dr. Raschbacher, who also examined Roy. Roy told Dr. Raschbacher that he had "prior lumbar problems," but had never had an MRI or CT scan prior to his alleged injury. After reviewing all of Roy's medical records, Dr. Raschbacher confronted Roy, who denied experiencing prior symptoms and stated that "he was healthy before his most recent injury claim." Dr. Raschbacher opined that there was not "a clear

basis for treating [Roy] for [the alleged] injury.” In particular, Dr. Raschbacher indicated that Roy’s back injury and pain were not likely caused by the alleged work-related incident because (1) Roy had an extensive history involving claims for back injuries; (2) Roy had “pre-existing, nonwork-related, degenerative changes at the spine”; and (3) there was no “clear[,] objective change” in Roy’s back as a result of the purported injury at King Soopers.

¶ 10 Based on this record, the ALJ found that Roy had not met his burden of proving that “he sustained an injury proximately caused by the performance of service arising out of and in the course of his employment.” The ALJ thus concluded that Roy was not entitled to any benefits, and denied and dismissed his claim. The Panel affirmed the ALJ’s findings and conclusions.

II. Discussion

¶ 11 As we read his brief, Roy contends that the ALJ erred in concluding that his alleged injury was not compensable because it did not arise out of and in the course of his employment. Specifically, he appears to challenge the ALJ’s finding that he failed to prove that he suffered a work-related injury. We reject Roy’s contention.

A. Governing Law

¶ 12 To be compensable under the Workers' Compensation Act, an injury incurred by an employee must arise out of and in the course of the employee's employment. § 8-41-301(1)(b), (c), C.R.S. 2015. A pre-existing condition "does not disqualify a claimant from receiving workers' compensation benefits." *Duncan v. Indus. Claim Appeals Office*, 107 P.3d 999, 1001 (Colo. App. 2004). A claimant may be compensated if a work-related injury "aggravates, accelerates, or combines with" a worker's pre-existing infirmity or disease "to produce the disability for which workers' compensation is sought." *H & H Warehouse v. Vicory*, 805 P.2d 1167, 1169 (Colo. App. 1990).

¶ 13 Nonetheless, a claimant must demonstrate that an injury actually "occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions." *Madden v. Mountain W. Fabricators*, 977 P.2d 861, 863 (Colo. 1999). That is, proof of work-related causation of an injury is a threshold requirement that a claimant must establish by a preponderance of the evidence before any compensation may be awarded. *Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000).

¶ 14 A determination of causation “is generally one of fact for determination by the ALJ.” *Id.* Likewise, whether a claimant has met his burden of establishing a compensable injury is a question of fact for determination by the ALJ. *See Vicory*, 805 P.2d at 1170. It is the sole province of the ALJ, as fact finder, to weigh and resolve conflicts in the evidence and we defer to such credibility determinations and resolutions of conflicting evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995). If substantial evidence supports the ALJ’s compensability determination, we are bound by it. § 8-43-308, C.R.S. 2015; *Leeway v. Indus. Claim Appeals Office*, 178 P.3d 1254, 1256 (Colo. App. 2007).

B. Substantial Evidence

¶ 15 As he did before the Panel, Roy essentially asks us to reweigh the evidence and conclude that he suffered a compensable injury while working at King Soopers on May 24, 2014. He asks us to credit his testimony and the medical opinions of Drs. Ladwig and Shih, who opined that his injury was work-related. However, we may not reweigh the evidence. *See Metro Moving & Storage*, 914 P.2d at 415. Nor may we interfere with the ALJ’s credibility

determinations unless the evidence is “overwhelmingly rebutted by hard, certain evidence” to the contrary. *Arenas v. Indus. Claim Appeals Office*, 8 P.3d 558, 561 (Colo. App. 2000); *see also Youngs v. Indus. Claim Appeals Office*, 2012 COA 85M, ¶ 46, 297 P.3d 964, 973.

¶ 16 In its written order, the ALJ found that Roy failed to prove that he suffered “any accidental event while he was at work on May 24, 2014.” Although Roy testified that he sustained a back injury when the trays allegedly fell on him, the ALJ found that this testimony was “not credible” because it was (1) uncorroborated by any eyewitness and (2) undermined by Roy’s drug-seeking behavior and obfuscation of his medical history. In particular, the ALJ found that Roy had sought medical treatment for his back at least eight times since 2002. On seven of these occasions, Roy reported that he had sustained accidental injuries to his back. And Roy repeatedly denied experiencing previous accidents or injuries when seeking medical treatment. The ALJ also found that Roy’s opioid drug seeking provided a substantial motive to falsely report the alleged injury. Specifically, the ALJ relied on medical reports, noting that Roy had received “frequent refills of opioid medication

[from] multiple providers” both before and after the alleged work-related injury. The record supports these findings.

¶ 17 The ALJ found the opinions of Drs. Ladwig and Shih unpersuasive because neither doctor knew Roy’s complete medical history before offering an opinion. In contrast, the ALJ credited Dr. Raschbacher’s opinion that, based on his review of Roy’s full medical records and his physical examination, Roy probably did not suffer the alleged injury.

¶ 18 The ALJ rested his findings on credibility determinations and Dr. Raschbacher’s medical opinion. Although Roy may disagree with these findings, the record evidence does not overwhelmingly rebut them. *See Youngs*, ¶ 46, 297 P.3d at 973. Indeed, after reviewing all of Roy’s medical records, Dr. Raschbacher opined that Roy’s back injury and pain were not caused by a work-related incident because, among other things, there was no “clear[,] objective change” in Roy’s back after the purported injury at King Soopers. Dr. Koval opined that, without Roy’s medical records, she could not determine causation, but the damage to Roy’s spine was degenerative in nature, had taken place over a long period, and was likely not related to his alleged work injury. The documentary

evidence presented at the hearing supports a finding that none of Roy's other doctors had access to Roy's complete medical records when they opined that he had suffered a work-related injury. Thus, we may not disturb the ALJ's finding that Dr. Raschbacher's opinion was more credible and persuasive than the other evidence.

III. Conclusion

¶ 19 Because substantial evidence supports the ALJ's findings, we affirm the Panel's order affirming the ALJ's denial and dismissal of Roy's claim for benefits.

JUDGE DUNN and JUDGE ASHBY concur.

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-947-730-01

IN THE MATTER OF THE CLAIM OF
KAREN ADAMS,

Claimant,

v.

FINAL ORDER

HEART OF THE ROCKIES REGIONAL
MEDICAL CENTER,

Employer,

and

CHA TRUST,

Insurer,
Respondents.

The *pro se* claimant seeks review of an order of Administrative Law Judge Lamphere (ALJ) dated May 10, 2016, that determined the claimant was required to pay the respondents an overpayment totaling \$16,326.77. We affirm.

The following facts appear to be undisputed. A hearing on the respondents' request for recovery of an overpayment was set to take place on April 12, 2016. On April 12, 2016, ALJ Walsh entered an order approving the parties' stipulation to vacate the hearing and instead, argue the matter of the overpayment by way of pleadings.

Thereafter, on April 22, 2016, the respondents filed a Motion to Recover Overpayment. In their Motion, the respondents stated that Dr. Wigington placed the claimant at maximum medical improvement (MMI) on January 26, 2015, and assessed the claimant with a 0% impairment rating by Dr. Scherr. The respondents filed a Final Admission of Liability (FAL) on May 4, 2015, consistent with the reports, and terminated temporary total disability (TTD) benefits as of January 25, 2016.

The claimant requested a Division-sponsored independent medical examination (DIME), which was performed by Dr. Castrejon on September 8, 2015. Dr. Castrejon agreed with the 0% impairment rating but determined that the claimant reached MMI on June 9, 2014, which was approximately 33 weeks earlier than the previously admitted MMI date.

On November 25, 2015, the respondents filed a FAL consistent with Dr. Castrejon's report. The respondents admitted to a June 9, 2014, date of MMI with a 0% impairment rating, and asserted an overpayment due to TTD benefits being paid beyond the date of MMI. The respondents contended that the amount of the overpayment totaled \$16,326.77.

In response to the respondents' Motion to Recover Overpayment, the claimant asserted that the facts as stated by the respondents in their Motion were correct. However, the claimant contended that the respondents were not entitled to the full amount they requested. The claimant contended that pursuant to W.C.R.P. 5-5(D)(1)(a), after Dr. Wigington placed the claimant at MMI on January 26, 2015, he had 20 days within which to send the claimant to a Level II accredited physician. The claimant argued that under W.C.R.P. 5-5(D)(1)(a), since Dr. Wigington did not do that, the respondents were required to send the claimant to a Level II accredited physician within 40 days. The claimant alleged, however, that the respondents failed to accomplish this, and it was not until 72 days after reaching MMI that the claimant saw a Level II accredited physician. Consequently, the claimant requested that the overpayment be reduced by 10 weeks and 2 days, which she claimed was the amount of time the respondents took to comply with W.C.R.P. 5-5(D)(1).

In Reply, the respondents alleged that W.C.R.P. 5-5(D)(1)(a) only required them to *refer* the claimant to a Level II accredited physician within 40 days after the determination of MMI. The respondents attached correspondence which they claim demonstrated that the required referral was made on March 3, 2015, or 37 days after MMI.

Thereafter, the ALJ entered his order granting the respondents' Motion to Recover Overpayment, ruling, without more, as follows:

IT IS HEREBY ORDERED that the claimant, Karen Adams, shall pay to the respondents the amount of \$16,326.77, which is the amount overpaid to the claimant by the respondents during the course of her worker's compensation claim.

IT IS FURTHER ORDERED that the claimant shall repay the amount within 20 days of the date of service of this order, or after all appeals have been exhausted.

The claimant has petitioned to review the ALJ's order and filed a brief in support. In her brief in support, the claimant recites the industrial incident, her injuries, and the physician reports. She requests that we "forgive repayment" of the \$16,326.77. Although neither party has addressed the jurisdictional issue posed by the requirement in §8-43-215, C.R.S. that full findings of fact be requested within ten days of a summary order, that section applies to an order issued following the "conclusion of a hearing" and not to a procedural order such as that in this case which is not connected to a hearing. Consequently, we conclude we have jurisdiction to review this matter. Section 8-43-201(1), C.R.S.; OAC Rule 16.

The respondents initially request that we not consider the claimant's petition to review or brief in support on the grounds that neither sets forth any errors made by the ALJ. The respondents' argument notwithstanding, we conclude that the claimant's petition and brief are sufficient to preserve her argument that the ALJ erred in awarding recovery of the overpayment totaling \$16,326.77. The Panel previously has held that a petition to review need not take any particular form. See *Tanner v. Synthes USA*, W.C. Nos. 4-714-037 & 4-717-509 (October 27, 2008); *Miller v. Source One*, W.C. No. 4-418-173 (Dec. 19, 2003); see also *Ward v. Azotea Contractors*, 748 P.2d 338, 340 at n. 3 (Colo. 1987).

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

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

Pursuant to §8-40-201(15.5), C.R.S., therefore, "three categories of possible overpayment are included in the statutory definition: one category is for overpayments created when a claimant receives money "that exceeds the amount that should have been paid"; the second category is for money received that a "claimant was not entitled to receive;" and the final category is for money received that "results in duplicate benefits because of offsets that reduce disability or death benefits" payable under articles 40 to 47 of title 8. §8-40-201(15.5)." *Simpson v. Industrial Claim Appeals Office*, 219 P.3d 354, 359 (Colo. App. 2009), *rev'd in part on other grounds, Benchmark/Elite, Inc. v. Simpson*, 232 P.3d 777 (Colo. 2010); see also *Moreno v. Sysco Corp.*, W.C. No. 4-917-763 (June 24, 2016); *Josue v. Anheuser-Busch Inc.*, W.C. No. 4-954-271 (June 17, 2016);

Grandestaff v. United Airlines, W.C. No. 4-717-644 (Dec. 12, 2013). The respondents bear the burden of proof to establish that the claimant received an overpayment of benefits. See *City and County of Denver v. Industrial Claim Appeals Office*, 58 P.3d 1162 (Colo. App. 2002).

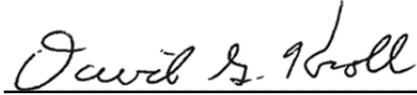
Here, in their Motion to Recover Overpayment, the respondents asserted that the DIME physician, Dr. Castrejon, assessed the claimant with a 0% impairment rating but determined that the claimant reached MMI on June 9, 2014, which was approximately 33 weeks earlier than the previously admitted MMI date assigned by the ATP, Dr. Wigington. Consequently, the respondents overpaid TTD benefits beyond the date of MMI in the amount of \$16,326.77. The claimant has not disputed any of these facts. See *Moreno v. Sysco Corp., Inc.*, *supra* (after DIME physician determined the claimant reached MMI approximately one year earlier, the ALJ ordered the claimant to repay at \$50 per week); see also *Marquez v. Americold Logistics*, W.C. No. 4-896-504 (Aug. 7, 2014)(since the claimant had not overcome the zero impairment rating of the DIME physician, the claimant received an overpayment of permanent benefits). Additionally, it is presumed that the ALJ was not persuaded by the claimant's argument that the respondents failed to comply with W.C.R.P. 5-5(D)(1)(a) and, therefore, the overpayment should be reduced. See *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000)(ALJ under no obligation to address every issue raised and we may consider findings which are necessarily implied by the ALJ's order); see also *Jefferson County Public Schools v. Drago*, 765 P.2d 636 (Colo. App. 1988) (ALJ is not required explicitly to reject unpersuasive arguments). Consequently, we affirm the ALJ's order allowing the respondents to recover an overpayment totaling \$16,326.77.

To the extent the claimant contends that she has "fallen four times due to the weakness in [her] left knee," we may not address this issue. Based on the ALJ's order, the only issue that presently is before us is the ALJ's order requiring the claimant to repay the \$16,326.77. The claimant's contention regarding her falling four times due to weakness in her knee is a matter better addressed by a petition to reopen. Section 8-43-303, C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated May 10, 2016, is affirmed.

KAREN ADAMS
W. C. No. 4-947-730
Page 5

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-961-489-02

IN THE MATTER OF THE CLAIM OF
MARSHA CROSS,

Claimant,

v.

FINAL ORDER

GENUINE PARTS COMPANY,

Employer,

and

TRAVELERS INDEMNITY INSURANCE
COMPANY,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Walsh (ALJ) dated May 25, 2016, that ordered the respondents liable for an ulnar decompression subcutaneous transposition surgery and a wrist carpal tunnel release surgery to the claimant's left arm. We affirm the decision of the ALJ.

The claimant injured her left arm on December 7, 2013. The claimant worked in the respondent employer's auto parts store as an assistant store manager. At the time of her injury the claimant was unloading a freight pallet of auto parts. When she took an item off the top and turned to set it on the ground she received a sharp pain in her left arm from the wrist to the elbow. After reporting the injury she initiated treatment with Dr. Dean at EmergiCare. She underwent physical therapy an X ray and an MRI of her arm. When the claimant's arm pain persisted, Dr. Dean referred the clamant to orthopedic physician Dr. Walden and for an EMG. Dr. Walden administered a steroid injection to the claimant's arm and referred her to Dr. Hart, an orthopedic surgeon. A February 20, 2014, EMG was read by Dr. Scheper to be normal.

The injection provided the claimant six weeks of relief until it wore off. Dr. Dean had recommended work restrictions of lifting no more than 20 pounds with the left arm and limited pushing and pulling. The claimant continued to perform her job within the parameters of these restrictions. On January 1, 2014, the employer's store was sold to a new owner. The claimant continued to work for the new owner in the same capacity. On

MARSHA CROSS

W. C. No. 4-961-489-02

Page 2

June 3, 2014, Dr. Dean wrote that the claimant was performing her regular work duties and placed the claimant at maximum medical improvement (MMI).

The claimant however, still complained of pain in her arm. Dr. Walden provided another injection which had little effect. The claimant saw Dr. Hart who recommended a second EMG. Dr. Hart noted on September 22, 2014, that the second EMG showed moderate nerve entrapment at the elbow and the wrist. The doctor suggested the claimant consider surgery in the form of an ulnar decompression subcutaneous transposition and a wrist carpal tunnel release.

The claimant was examined by Dr. Primack and by Dr. Hall. These doctors both agreed with the surgical recommendation of Dr. Hart. Dr. Mordick examined the claimant and determined the claimant's left arm condition was not related to her December, 2013, work injury. The claimant requested a Division selected Independent Medical Examination (DIME), which was performed by Dr. Tyler on January 22, 2015. Dr. Tyler noted the negative results of the claimant's first EMG of February, 2014, and compared it to the second EMG of September, 2014. Dr. Tyler found the claimant was at MMI on August 5, 2014. Because the doctor noted the second EMG showed mild nerve entrapment, he concluded that condition was not caused by the work injury. He assigned the claimant 0% permanent impairment. The respondents filed a Final Admission of Liability (FAL) admitting for no temporary benefits and no permanent impairment benefits.

The claimant filed an application for a hearing asking that the MMI determination of the DIME be set aside and that the surgery recommended by Dr. Hart be authorized. Following a hearing on February 16, 2016, the ALJ authored an order finding the MMI determination of the DIME doctor, Dr. Tyler, had been overcome. The ALJ found persuasive the opinions of Dr. Hart, Dr. Primack and Dr. Hall. The ALJ then ordered the respondents liable for the recommended decompression and release surgery.

The respondents' appeal arguing the claimant's need for surgery arose due to an aggravation of her condition while working for her new employer. The respondents assert the aggravation was in the nature of an occupational disease and that the decision in *Royal Globe Insurance Co. v. Collins*, 723 P.2d 731 (Colo. 1986), imposed liability for medical expenses on the employer 'on the risk' for insurance coverage as of the date the charge for medical services was incurred. The respondents contend the new owner of the

auto parts store employing the claimant is therefore liable for the cost of the surgery and not the respondents.¹

The difficulty with the respondents' argument is due to the absence of evidence to show the claimant's December, 2013, work injury was itself an occupational disease. An "occupational disease" is defined in § 8-40-201(14) C.R.S. to refer to an injury "seen to have followed as a natural incident of the work." However, an accidental injury is defined in § 8-40-201(1) as one stemming from "an unforeseen event occurring without the will or design of the person whose mere act causes it." In *Royal Globe* the claimant suffered from bicipital tendinitis in her right arm. This was found to be caused by "a work environment requiring certain kinds of and amounts of physical activity" and "during that time the requirements of her job established a work environment that would be sufficient to cause the disease in the event of continued work in such environment." *Royal Globe*, 723 P.2d at 733-34. In this matter, the claimant described lifting one item from a freight pallet through a single episode which caused her to twist and injure her arm. It was an "unforeseen event." "Continued work" was not involved. The record does not show the claimant's injury was an occupational disease.

The decision in *Royal Globe* considered a claim involving one occupational disease and the dispute between two successive insurance carriers as to their respective liability for continued medical benefits. The decision noted that the provision in § 8-41-304 (1), pertinent to an occupational disease, which requires the employer or carrier during the period of "last injurious exposure" to be solely liable for benefits, applies only to indemnity benefits and not to medical costs. The liability for medical costs was then assigned to the carrier "on the risk" at the time medical expenses are incurred. The Court divided the medical costs between the two carriers according to the period of their coverage. The date the costs were incurred governed each carrier's liability.

However, in *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001), the Court of Appeals considered a claim posing a combination of injuries similar to this matter. The claimant had sustained an earlier

¹ The claimant argues a second issue on appeal which includes the ALJ's determination the MMI decision of the DIME doctor was overcome. However, the Supreme Court in *Harman-Bergstedt, Inc. v. Loofbourrow*, 320 P.3d 327 (Colo. 2014), held that claims which do not feature liability for temporary or permanent indemnity benefits are not affected by the concept of MMI as that finding is only germane to the issue of indemnity benefits. "Whether or not an employer continues to furnish medical treatment ... the statutory consequences of a finding of 'maximum medical improvement' can apply only to injuries as to which disability indemnity is payable." 320 P.3d at 331. See *Thibault v. Ronnie's Automotive*, W.C. No. 4-970-099 (August 2, 2016). It is therefore unnecessary for the ALJ, or for us, to rule on whether or not the DIME physician was correct in regard to MMI since, at this juncture, MMI has no bearing on this claim.

MARSHA CROSS

W. C. No. 4-961-489-02

Page 4

accidental back injury. After beginning work for another employer, the claimant again injured her back through the process of an over use type of occupational disease. The decision in *University Park Care Center* determined the concept of assigning liability for medical benefits to the employer “on the risk” would not apply in a case where the prior injury had an accidental cause and the subsequent injury was an occupational disease. Instead, “the ordinary rules of causation and apportionment extend to medical benefits.” The standard then, required the ALJ to determine that the employment with the employer assigned liability for the medical benefits must have “caused, aggravated, or accelerated the claimant’s injury.” *See, Milan v. South Metro Fire and Rescue*, W.C. No. 4-783-192 (July 6, 2012). The issue then, is not as argued by the respondents. It is not adequate to establish a subsequent employer is ‘on the risk’ and so is therefore liable for medical costs. Instead, the ALJ is required to determine if there is an intervening cause which generates the need for the medical treatment.

Generally, the question of whether an injury is the result of an efficient intervening cause is a question of fact for determination by the ALJ. *Owens v. Industrial Claim Appeals Office*, 49 P.3d 1187 (Colo. App. 2002). Consequently, we must uphold the ALJ’s determination if supported by substantial evidence in the record. Causation is an issue of fact for determination by the ALJ. *University Park Care Center v. Industrial Claim Appeals Office, supra*.

In his findings of fact, the ALJ relied on the testimony of the claimant that she experienced pain continuously since the date of her injury in December, 2013. The claimant indicated her pain fluctuated based on the effects of the injections she received from Dr. Walden. She did not believe there was any variability due to activities she engaged in at work. She testified she had not done anything after December, 2013, that could have reinjured her arm or aggravated it. The ALJ noted the testimony of Dr. Primack that Dr. Tyler, and Dr. Mordick were mistaken in their comparison of the February, 2014, EMG test with that of the September, 2014, EMG. Dr. Primack reviewed the EMG from both dates and concluded the early test showed electrical velocity was moderately impaired and the claimant was reporting severe symptoms in her left arm. The later EMG also revealed slowing electrical velocity of the ulnar nerve. Dr. Primack advised that both EMGs demonstrated the claimant’s need for surgery. He did not find the claimant’s condition had worsened after the first EMG. Dr. Primack testified the claimant was never at MMI because she was continually a candidate for medical care that could reasonably be expected to improve her condition. Dr. Hall came to the same opinion as that of Dr. Primack. The ALJ found this medical evidence compelling and adjudged the need for surgery was due to the December 7, 2013, injury.

Accordingly, the ALJ found the claimant “did not suffer a new injury at work which is the cause for the recommended surgery.”

The ALJ has discretion to determine the weight to be accorded an expert medical opinion. *Rockwell Int'l v Turnbull*, 802 P.2d 1182, 1183 (Colo.App. 1990). The ALJ is the sole arbiter of conflicting medical evidence, and the ALJ's factual findings are binding on appeal if they are supported by substantial evidence or plausible inferences from the record. *Davison v. Indus. Claim Appeals Office*, 84 P.3d 1023, 1031 (Colo. 2004); *see also* § 8-43-301(8), C.R.S. ("If the findings of fact entered by the director or administrative law judge are supported by substantial evidence, they shall not be altered by the panel.")

"Substantial evidence" is evidence that is probative, credible, and competent, such that it warrants a reasonable belief in the existence of a particular fact without regard to contradictory testimony or inference. *City of Loveland Police Dep't v. Indus. Claim Appeals Office*, 141 P.3d 943, 950 (Colo. App. 2006); *see also Benuishis v. Indus. Claim Appeals Office*, 195 P.3d 1142, 1145 (Colo. App. 2008) ("Substantial evidence is that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence.")

We find the testimony and reports of Dr. Primack and of Dr. Hall, as well as the testimony of the claimant, represent substantial evidence to support the conclusion of the ALJ that the need for the proposed surgery was caused by the claimant’s work injury and not by an intervening injury occurring while working for a subsequent employer.

IT IS THEREFORE ORDERED that the ALJ’s order issued May 25, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Brandee DeFalco-Galvin

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. Nos. 4-977-664-01 &
4-977-800-01

IN THE MATTER OF THE CLAIM OF:

ARIEL DALTON and
RACHEL ARCHER-REID,

Claimants,

v.

FINAL ORDER

PACE JOINT INTERESTS-DENVER, LLC,
and CHIROPRACTIC HEALTHCARE
SOLUTIONS, LLC

Employers,

and

HANOVER INSURANCE COMPANY, and
TRAVELERS INDEMNITY COMPANY

Insurers,
Respondents.

The respondents, Chiropractic Healthcare Solutions LLC (Chiropractic Healthcare) and its insurer, Travelers Indemnity Company (Travelers), seek review of an order of Administrative Law Judge Cannici (ALJ) dated February 3, 2016, that determined the claimants suffered compensable injuries during the course and scope of their employment with Chiropractic Healthcare, and ordered Chiropractic Healthcare and Travelers liable for medical benefits and reimbursement for all out-of-pocket expenses for medical treatment as a result of the claimants' February 3, 2015, motor vehicle accident. We affirm.

This matter went to hearing on whether the claimants worked for the respondent Pace Joint Interests-Denver, LLC, or for Chiropractic Healthcare at the time of their February 3, 2015, motor vehicle accident. Prior to the commencement of the hearing, the parties agreed to consolidate the claimants' cases because there was an identity of facts, legal issues, and witnesses.

The following facts are undisputed: The claimants were injured in a motor vehicle accident on February 3, 2015. The claimants were in the course and scope of their

employment when they both were injured in the motor vehicle accident on February 3, 2015.¹ As a result of the accident, the claimant, Rachel Archer-Reid injured her neck, back, left knee, and shoulders. The claimant, Ariel Dalton, injured her head, neck, and back. The respondent insurer, Hanover Insurance Company, is the insurer for Pace Joint Interests-Denver, LLC. The respondent insurer, Travelers, is the insurer for Chiropractic Healthcare. Both insurance carriers have denied liability for the claimants' injuries and have chosen not to designate medical providers. Dr. Macaulay is designated as the primary authorized treating physician for the claimants.

After the hearing, the ALJ found that The Joint is a franchisor of numerous chiropractic clinics operating in multiple states, including Texas, Nevada, and Colorado. Phil and Erin Davis are franchisees of The Joint. The Colorado chiropractic clinics function under a separate limited liability company named Pace Joint Interests-Denver, LLC. Pace Joint Interests-Denver, LLC maintained six chiropractic clinics established as separate limited liability companies. These clinics are: Pace Joint Interests-Lakewood, LLC, Pace Joint Interests-Highlands Ranch, LLC, Pace Joint Interests-Southwest Plaza, LLC, Pace Joint Interests-Southglenn LLC, Pace Joint Interests-Tech Center, LLC, and Pace Joint Interests-Parker, LLC. Chiropractic Healthcare is identified as the "owner" of the six clinics under Pace Joint Interests-Denver, LLC.

Colorado requires a licensed chiropractor to have an ownership interest in the clinical aspects of the chiropractic business. Chiropractic Healthcare is an entity established by licensed Colorado chiropractor, Dr. Lloyd. Dr. Lloyd created the entity to satisfy the Colorado requirement that a chiropractic clinic must be owned by a licensed chiropractor.

¹ In their Brief in Opposition, the respondents, Pace Joint Interests-Denver, LLC and Hanover Insurance Company, assert that at the time the claimants sustained injuries in the motor vehicle accident they were commuting to work. These respondents, therefore, assert that the claimants' injuries are not compensable under the going to or coming from work exclusion. *See Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). Since the ALJ found, however, that all of the respondents stipulated that the claimants were in the course and scope of their employment when they both were injured in the motor vehicle accident on February 3, 2015, we decline to address this contention. Order at 2 ¶5; Tr. (Jan. 8, 2016) at 26. We further add that the respondents, Pace Joint Interests-Denver, LLC and Hanover Insurance Company, have not appealed the ALJ's order in this regard.

Fees generated for chiropractic services are deposited into an account under the business name of Chiropractic Healthcare. The fees are then placed in six separate accounts for each clinic under Pace Joint Interests-Denver, LLC. Chiropractic Healthcare then receives a flat monthly fee of \$400 per clinic for operating each facility. Each of the six clinics' operating accounts is used to pay for Chiropractic Healthcare's monthly fees and clinician salaries. After all clinical operating expenses are paid, any remaining funds are placed in Pace Joint Interests-Denver, LLC's account.

Chiropractic Healthcare and Pace Joint Interests-Lakewood, LLC executed a Management Agreement effective October 15, 2012. There are no written Management Agreements between Chiropractic Healthcare and any of the other five clinics under the Pace Joint Interests-Denver, LLC umbrella. Under this Management Agreement, Pace Joint Interests-Lakewood, LLC is identified as the "Company" and Chiropractic Healthcare is identified as the "P.C." Pursuant to this Management Agreement, the Company is obligated to provide furnishings, equipment, and management services to the P.C. for the P.C. to operate the chiropractic clinic. The Company then has the responsibility for the day-to-day administration and management of the operations of the P.C., excluding clinical matters. Further, under Article 3.3 of the Management Agreement, the Company is required to:

. . . employ or engage and make available to the clinic, on a non-exclusive basis, sufficient non-clinical personnel and administrative staff (collectively **Administrative Staff**). The hiring, firing, disciplining and determination of compensation and benefits of the administrative staff shall be within the sole discretion of the Company. . . . (emphasis in the original)

Article 18.4 of the Management Agreement specifies that it is complete and may not be changed orally but can only be amended by an agreement in writing executed by the parties.

While the Management Agreement specifies the duties and obligations of the parties, it is a contract only between Chiropractic Healthcare and Pace Joint Interests-Lakewood, LLC. Mr. Davenport, the manager of the clinical staff who is associated with Pace Joint Interests-Denver, LLC, explained that no written Management Agreements have been executed between Chiropractic Healthcare and any of the other Denver Metropolitan area chiropractic clinics operating under the Pace Joint Interests-Denver, LLC umbrella. Ms. Davis, who is part-owner of Pace Joint Interests-Denver, LLC, agreed and stated that this is the result of "simply a paperwork oversight." Nevertheless, Mr. Davenport maintained that the Management Agreement functions as the exact

agreement between Chiropractic Healthcare and the other five clinics operating under the Pace Joint Interests-Denver, LLC umbrella.

Kaitlin Ko worked for Pace Joint Interests-Denver, LLC to manage the six Denver Metropolitan area chiropractic clinics. Ms. Ko ceased working for Pace Joint Interests-Denver, LLC in September 2014. Dr. Lloyd, through Chiropractic Healthcare, assumed some of her duties in exchange for an increased flat monthly fee. In September 2014, Pace Joint Interests-Denver, LLC entered into a verbal agreement with Chiropractic Healthcare through Dr. Lloyd. Under this verbal agreement, Chiropractic Healthcare would assume marketing duties and Wellness Coordinator training duties as well as handle the clinical components of operating the six Pace Joint Interests-Denver, LLC clinics. In exchange, Pace Joint Interests-Denver, LLC would pay Chiropractic Healthcare an additional \$200 per month. Pace Joint Interests-Denver, LLC also increased the fees it paid to Chiropractic Healthcare from \$400 to \$500 each month for assuming the Wellness Coordinator training duties.

The claimants initially worked for Pace Joint Interests-Denver, LLC as Wellness Coordinators. The duties of Wellness Coordinators involve receptionist and front desk work at a specific clinic under the Pace Joint Interests-Denver, LLC umbrella. They are paid out of the general accounts maintained by each clinic. Wellness Coordinators are hired and paid by Pace Joint Interests-Denver, LLC.

In consultation with Mr. Davis, Dr. Lloyd decided to hire the claimants to perform the management duties and Wellness Coordinator training duties that Chiropractic Healthcare had assumed pursuant to the verbal agreement. As a result, the claimants reduced their hours as Wellness Coordinators for Pace Joint Interests-Denver, LLC so they could assume the additional responsibilities for Chiropractic Healthcare. Further, the claimants became marketers and managers for all six clinics under the Pace Joint Interests-Denver, LLC umbrella. They received a higher hourly wage for their additional duties than they had in their roles of Wellness Coordinators. While working as Wellness Coordinators at the individual clinics, the claimants were paid by Pace Joint Interests-Denver, LLC. However, while performing marketing and management duties, the claimants were paid by Chiropractic Healthcare.

On February 3, 2015, the claimants were involved in a motor vehicle accident at approximately 1:00 p.m. The claimants were coming from a promotional lunch meeting for employees of Eye Maxx. The claimants provided pizza and supplies for the

marketing event.² The promotional lunch meeting was designed to develop new patients for the six Pace Joint Interests-Denver, LLC clinics and promote “The Joint” brand generally. While conducting the promotional presentation at Eye Maxx, the claimants wore “The Joint” shirts and “The Joint” was printed on the marketing materials. The claimants were traveling to the Pace Joint Interests-Southwest Plaza, LLC to train another Wellness Coordinator. Chiropractic Healthcare paid the claimants for marketing and training the Wellness Coordinator as part of its management responsibilities. Neither claimant lost any time from work after the accident. However, the claimants require additional medical treatment as a result of the February 3, 2015, accident.

The ALJ ultimately determined that the claimants worked for Chiropractic Healthcare at the time of their February 3, 2015, motor vehicle accident. He found that at the time of the accident, the claimants were performing the marketing and management duties for Chiropractic Healthcare and not performing the duties of Wellness Coordinators for Pace Joint Interests-Denver, LLC. He also found that Chiropractic Healthcare paid the claimants for marketing and training the Wellness Coordinator at the Pace Joint Interests-Southwest Plaza, LLC clinic. The ALJ further found that the Management Agreement between Chiropractic Healthcare and Pace Joint Interests-Lakewood, LLC established a relationship between the two entities that was confirmed by the testimony of Dr. Lloyd, Ms. Davis, and Mr. Davenport. However, he determined that the Management Agreement was a contract only between Chiropractic Healthcare and Pace Joint Interests-Lakewood, LLC, and that there were no other written Management Agreements in place for the other five Denver metropolitan area chiropractic clinics. The ALJ essentially ruled that since there was no applicable written contract between Chiropractic Healthcare and Pace Joint Interests-Southwest Plaza, LLC, the parol evidence rule was inapplicable, and “extrinsic evidence” was admissible to determine the obligations of the parties in this matter. The ALJ therefore considered the verbal agreement between Chiropractic Healthcare and Pace Joint Interests-Denver, LLC, and found that Chiropractic Healthcare assumed marketing responsibilities and Wellness Coordinator training duties as well as handling the clinical components of operating the six Pace Joint Interests-Denver, LLC clinics. Accordingly, the ALJ ordered Chiropractic

² The respondents, Chiropractic Healthcare and Travelers, also argue that the ALJ erred in finding that Chiropractic Healthcare paid for the pizza and supplies at the Eye Maxx luncheon. To the extent the ALJ erred in making this finding, we are not persuaded to disturb the ALJ’s order on this ground. Tr. (Jan. 8, 2016) at 75. The basis of the ALJ’s order is apparent from his other findings of fact, his ultimate conclusions are supported by these other findings, and the ALJ is not held to a crystalline standard in articulating his findings of fact. *See Riddle v. Ampex Corp.*, 839 P.2d 489 (Colo. App. 1992).

Healthcare and its insurer, Travelers, responsible for all authorized, reasonable, necessary, and related medical treatment provided by Dr. Macaulay. He also ordered Chiropractic Healthcare and its insurer responsible for reimbursing the claimants for all out-of-pocket expenses for medical treatment.

I.

The respondents, Chiropractic Healthcare and Travelers, contend that the ALJ erred in failing to apply the parol evidence rule during the hearing. They contend the ALJ impermissibly admitted evidence that Chiropractic Healthcare would assume marketing duties and training of Wellness Coordinators, as well as handle the clinical components of operating the six Denver metropolitan chiropractic clinics. They contend that the Management Agreement that controlled the relationship between Pace Joint Interests-Lakewood, LLC and Chiropractic Healthcare controlled all of the other five clinics, was unambiguous and, therefore, no extrinsic evidence should have been admitted to vary its terms. We are not persuaded the ALJ committed reversible error.

The interpretation of a binding contract is generally a question of law for the court. However, it is for the factfinder to determine in the first instance whether the parties have entered into a contract. “More precisely, when the existence of a contract is at issue, and the evidence is conflicting or admits of more than one inference, the [factfinder] decides whether a contract in fact exists.” *I.M.A., Inc. v. Rocky Mountain Airways, Inc.*, 713 P.2d 882, 887 (Colo. 1986); *see also Yaekle v. Andrews*, 169 P.3d 196 (Colo. App. 2007). Appellate courts are bound by factual findings when substantial evidence exists in the record to support such findings. *I.M.A., Inc. v. Rocky Mountain Airways, Inc., supra*. Unless the findings are clearly erroneous, they will not be reversed on appeal. Section 8-43-301(8), C.R.S.

Further, as stated in *Glover v. Innis*, 252 P.3d 1204, 1208 (Colo. App. 2011), “[t]he parol evidence rule is a principle of contract law, rather than a rule of evidence. *See* Restatement (Second) of Contracts §213 cmt. a (1979). Where the rule applies, evidence of prior or contemporaneous agreements or negotiations may not be used to contradict a written instrument or to vary the terms of a written agreement. *See Id.* §215; *Neves v. Potter*, 769 P.2d 1047, 1054 (Colo. 1989)(generally, an unambiguous document must be interpreted based only on information contained within its “four corners”); *McGuire v. Luckenbach*, 131 Colo. 333, 338-39, 281 P.2d 997, 999-1000 (1955); *Reisig v. Resolution Trust Corp.*, 806 P.2d 397, 400 (Colo. App. 1991)(“If an instrument is clear in its terms, complete, and free from ambiguity, extrinsic evidence will not be permitted to modify it.”). . . .” To apply the rule, however, a court must make a preliminary determination that there is a written contract. *See generally Neves v. Potter, supra; Reisig v. Resolution*

Trust Corp., supra; Restatement (Second) of Contracts §213; *see also* Restatement (Second) of Contracts §218 (only a binding integrated agreement brings the parol evidence rule into operation).

We agree with the ALJ that the parol evidence rule is inapplicable here. The ALJ found, with record support, that there was no written agreement that applied to Chiropractic Healthcare and Pace Joint Interests-Southwest Plaza, LLC, the clinic where the claimants were traveling to in order to train the Wellness Coordinator working there. All witnesses who testified explained that there was no written Management Agreement between Chiropractic Healthcare and Pace Joint Interest-Southwest Plaza, LLC or between Chiropractic Healthcare and any of the other clinics, except for Pace Joint Interest-Lakewood, LLC. For instance, Mr. Davenport testified that there are no other written contracts that pertain to the other five clinics. Depo. of Dean Davenport at 27. Similarly, Dr. Lloyd testified that there was only one written contract, and that one was between Chiropractic Healthcare and Pace Joint Interests-Lakewood, LLC. He explained that there were no written contracts for the other five clinics. Tr. (Jan. 8, 2016) at 53-55. Further, Ms. Davis also testified that the only Management Agreement that existed was the one between Chiropractic Healthcare and Pace Joint Interests-Lakewood, LLC. She explained that through a paperwork oversight, the other five clinics did not have a Management Agreement. Depo. of Erin Davis at 16. Moreover, the Management Agreement introduced into evidence during the hearing provides that it is solely between Chiropractic Healthcare and Pace Joint Interests-Lakewood, LLC. There is no indication in the Management Agreement that it applies to any other chiropractic clinic, including the clinics where the claimants were marketing on behalf of prior to the accident, or driving to at the time of their accident. Ex. BBB.

We further note that throughout their Brief In Support, the respondents cite to disputed evidence in support of their argument that the Management Agreement controlled Chiropractic Healthcare and Pace Joint interests-Southwest Plaza, LLC. However, the mere existence of conflicting evidence and inferences provides no basis for relief on appeal, and we may not reweigh the evidence. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App.2004). Consequently, we disagree with the argument of Chiropractic Healthcare and Travelers that the ALJ erred in admitting evidence that Chiropractic Healthcare assumed marketing duties and training of Wellness Coordinators, as well as handling the clinical components of operating the six Denver metropolitan chiropractic clinics. The parol evidence rule is inapplicable here since there was no written agreement that applied to Chiropractic Healthcare and Pace Joint interests-Southwest Plaza, LLC. As explained above, when the existence of a contract is at issue, and the evidence is conflicting or admits of more than one inference, the ALJ as the factfinder decides whether a contract in fact exists. *See I.M.A., Inc. v. Rocky*

Mountain Airways, Inc., supra. Since the ALJ's determination in this regard is supported by substantial evidence in the record, we may not disturb his order on this ground. Section 8-43-301(8), C.R.S.

II.

The respondents, Chiropractic Healthcare and Travelers, argue that the ALJ erred in not finding that the claimants either were employed directly by Pace Joint Interests-Denver, LLC or were employed in a joint capacity for both Chiropractic Healthcare and Pace Joint Interests-Denver, LLC. They reason that Chiropractic Healthcare was in "no meaningful control of claimants as an employer, including actual payment of claimants." Brief In Support at 8. Thus, these respondents argue that either Pace Joint Interests-Denver, LLC is liable or both Chiropractic Healthcare and Pace Joint Interests-Denver, LLC are liable for the claimants' workers' compensation benefits. We perceive no reversible error in the ALJ's order.

Whether the claimants here were employees of either Chiropractic Healthcare or Pace Joint Interests-Denver, LLC, or both at the time they sustained injuries in the February 3, 2015, motor vehicle accident, is a factual question which must be resolved by the ALJ as the fact finder. *See Dana's Housekeeping v. Butterfield*, 807 P.2d 1218 (Colo. App. 1990). The ALJ's factual determinations are binding if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.

In Larson's Workers' Compensation Law §68.01, a distinction is made between "joint employment" versus "dual employment":

Joint employment occurs when a single employee, under contract with two employers, and under simultaneous control of both, simultaneously performs services for both employers, and when the service for each employer is the same as, or is closely related to, that for the other. In such a case, both employers are liable for workmen's compensation.

Dual employment occurs when a single employee, under contract with two employers, and under the separate control of each, performs services for the most part for each employer separately, and when the service for each employer is largely unrelated to that for the other. In such a case, the employers may be liable for workmen's compensation separately or jointly, depending on the severability of the employee's activity at the time of injury.

It does not appear, however, that the Colorado appellate courts or the Panel previously have adopted or applied Larson's distinct classifications of "joint employment" or "dual employment." Instead, it appears as though the phrases "joint employment" and "dual employment" are used interchangeably. See *Crump v. Builders Association of Pagosa Springs*, W.C. No. 4-767-757 (Feb. 14, 2011)(recognizing distinction between "joint employment" and "dual employment" but using the terms interchangeably only for purposes of that decision). In *Bigby v. Big 3 Supply Co.*, 937 P.2d 794 (Colo. App. 1996), for example, a former employee brought an action against an employer and the company for which the employer loaned the employee to work, alleging violation of Americans with Disabilities Act (ADA). The plaintiff asserted that the trial court erred in granting summary judgment against him on his ADA claim. The Court of Appeals agreed that the trial court erred in granting summary judgment and remanded for further proceedings on the ADA claim. In doing so, the Court explained that "[u]sing an analysis known as the 'joint employer doctrine,' some courts hold that when an entity exercises sufficient control over an individual's compensation, terms, and conditions of employment, it will be considered the individual's employer, even though the individual may be directly employed by another entity as well." *Id.* at 797. The Court further noted that other courts have analyzed the issue of who is an employer using a "single employer" theory. In such a circumstance, two separate entities are considered a single employer. In remanding the matter in *Bigby*, the Court noted that it need not decide whether to adopt the joint employer doctrine or the single employer theory because it would reach the same result using either analysis. *Id.* at 799. See *Industrial Commission v. Lopez*, 150 Colo. 87, 371 P.2d 269 (Colo. 1962)(the workers' compensation carrier was liable for injuries sustained by an employee of the joint enterprise even though the insured had paid no premium on the employee's employment; the court reasoned that the contractor and partner were engaged as principles in a joint enterprise which made them jointly responsible under the Act); see also *Micciche v. Billings*, 727 P.2d 367 (Colo. 1986)(Colorado Corporation Code imposed joint and several liability upon all persons who assume to act as corporation without authority and matter remanded to determine whether veil of corporation should be pierced to permit claimant to recover workmen's compensation from corporate officer); see also *City and County of Denver v. Dore*, 176 Colo. 367, 490 P.2d 694 (Colo. 1971)(where the claimant was a city police officer and a bank guard, Court remanded the matter for the development of facts concerning the issue of "dual employment"); *Raftshol v. Centura Health/St. Anthony Health Services D/B/A Granby Medical Center And/Or Teverbaugh K-Healthon Management Company*, W. C. Nos. 4-412-518, 4-417-006 (Feb. 28, 2000)(occupational disease developed as a result of the claimant's dual employment, and Panel affirmed the award of 20 percent of the claimant's temporary disability and medical benefits against one of the employers).

Here, the ALJ's order is consistent with the "dual employment" analysis as detailed in Larson's Workers' Compensation Law §68.01. As noted above, the ALJ held Chiropractic Healthcare solely liable on the basis that the claimants were performing services only for Chiropractic Healthcare at the time they sustained injuries in the motor vehicle accident. The record supports the ALJ's findings and determination in this regard. During the hearing, Ms. Dalton testified that on the date of the motor vehicle accident, she was employed by both Pace Joint Interests-Denver, LLC and Chiropractic Healthcare. She testified that her regular duties for Pace Joint Interest-Denver, LLC were working the front desk, checking patients in, and taking payments. She explained that her regular duties for Chiropractic Healthcare were training, hiring, interviewing, and marketing. Ms. Dalton explained that before the motor vehicle accident on February 3, 2015, she and Ms. Archer-Reid were marketing for the chiropractic clinic at Yosemite and Arapahoe, or for Pace Joint Interests-Tech Center, LLC. The claimants held a pizza luncheon for employees of Eye Maxx. Ms. Dalton explained that after the luncheon, she and Ms. Archer-Reid were planning on going to Pace Joint Interests-Southwest Plaza, LLC to train an employee there who worked as a Wellness Coordinator. Ms. Dalton testified that Dr. Lloyd and Mr. Davenport sent her to the event at Eye Maxx and to Pace Joint Interests-Southwest Plaza, LLC. After the accident occurred, Ms. Dalton reported the accident to Dr. Lloyd. She further testified that she emailed her timecard for that date to Dr. Lloyd. Tr. (Oct. 5, 2015) at 21-35, 54-55.

Similarly, Ms. Archer-Reid, testified that on the date of the motor vehicle accident, she was employed by both Chiropractic Healthcare and Pace Joint Interests-Denver, LLC. She explained that her duties for Pace Joint Interest-Denver, LLC were receptionist, front desk work, checking patients in, taking payments, scanning patient files. She said that for Chiropractic Healthcare her regular duties were interviewing, training, hiring, payroll, commissions, accounting, ongoing training, guerilla marketing, and HR work. Ms. Archer-Reid testified that when she performs front desk duties at each clinic, she would submit her timecard to Pace Joint Interest-Denver, LLC. When she is managing a clinic, however, she submits her hours to Dr. Lloyd. She testified that on the date of the motor vehicle accident, she was marketing at a pizza luncheon for Eye Maxx. She explained that Dr. Lloyd directed her to go to the Eye Maxx Lunch, and she was marketing for the clinic at the Arapahoe and Yosemite clinic location, or for Pace Joint Interests-Tech Center, LLC. After the luncheon was over, she and Ms. Dalton were headed to the Pace Joint Interest-Southwest Plaza, LLC clinic. Ms. Archer-Reid testified that she reported the accident to Dr. Lloyd, and since she and Ms. Dalton were performing management duties, they were under his supervision. She also testified that she submitted her hours to Dr. Lloyd on that date since she was "on his time period, time

pay.” Tr. (Oct. 5, 2015) at 58-66, 74. Thus, substantial evidence supports the ALJ’s determination that at the time of the February 3, 2015, motor vehicle accident, the claimants were performing the marketing and management duties for Chiropractic Healthcare and not performing the duties of Wellness Coordinators for Pace Joint Interests-Denver, LLC. As such, we may not disturb his order. Section 8-43-301(8), C.R.S.

We again note that throughout their Brief In Support, Chiropractic Healthcare and Travelers cite to conflicting evidence in support of their argument that Pace Joint Interest-Denver, LLC is solely liable or both Chiropractic Healthcare and Pace Joint Interests-Denver, LLC are liable. However, the mere existence of conflicting evidence and inferences provides no basis for relief on appeal, and we may not reweigh the evidence. *Wilson v. Industrial Claim Appeals Office, supra*.

Moreover, in their Brief In Support, Chiropractic Healthcare and Travelers argue that the ALJ erred in finding that “a new contract was entered into between claimants and [Chiropractic Healthcare] and that claimants became *loaned employees* to [Chiropractic Healthcare] from Pace Joint Interest [-Denver, LLC] as a result.” (emphasis added) Brief In Support at 13.

Section 8-41-303, C.R.S. provides as follows regarding the liability of a loaning employer for compensation:

Where an employer, who has accepted the provisions of articles 40 to 47 of this title and has complied therewith, loans the service of any of the employer's employees who have accepted the provisions of said articles to any third person, the employer shall be liable for any compensation thereafter for any injuries or death of said employee as provided in said articles, *unless it appears from the evidence in said case that said loaning constitutes a new contract of hire, express or implied, between the employee whose services were loaned and the person to whom the employee was loaned.* (emphasis added).

See Evans v. Webster, 832 P.2d 951 (Colo. App. 1991).

The respondents’ argument notwithstanding, the ALJ never expressly concluded that the claimants were “loaned employees,” and his analysis is inconsistent with a “loaning.” Rather, the ALJ instead concluded that the claimants were the direct employees of Chiropractic Health at the time of their February 3, 2015, motor vehicle

accident. A "loaned employee" and an "employee" under our Workers' Compensation Act are not the same. *See Continental Sales Corp. v. Stookesberry*, 170 Colo. 16 (Colo. 1969). Even assuming, however, that the "loaned employee" doctrine is applicable here, Chiropractic Health and Travelers nevertheless are liable under the Act because the ALJ clearly found that a new contract of hire was created between Chiropractic Healthcare and the claimants to perform the marketing and training duties. As explained above, under §8-41-303, C.R.S., a loaning employer is relieved of liability if there is substantial evidence to support an ALJ's finding that the loaning constituted a new contract of hire between the claimant and the company to whom the employee was loaned. *See Tuttle v. ANR Freight System, Inc.*, 797 P.2d 825 (Colo. App. 1990)(the existence of a contract of hire is a factual issue for resolution by the ALJ). We have reviewed the record and conclude that there is ample evidence to support the ALJ's finding of a new contract of hire between the claimants and Chiropractic Health. Section 8-43-301(8), C.R.S. Consequently, we are not persuaded to disturb the ALJ's order on this basis.

IT IS THEREFORE ORDERED that the ALJ's order dated February 3, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



Kris Sanko

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-904-748-04

IN THE MATTER OF THE CLAIM OF

ANN EVANS,

Claimant,

v.

FINAL ORDER

JC PENNY COMPANY,

Employer,

and

NATIONAL UNION INSURANCE,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Mottram (ALJ) dated April 15, 2016, that determined the claimant's condition worsened effective October 14, 2014, and ordered the respondents to pay temporary total disability benefits from October 14, 2014, through June 15, 2015, plus eight percent interest on all amounts of compensation not paid when due. We affirm the ALJ's order.

This matter went to hearing on the issue of whether the claimant was responsible for her termination and whether the claimant's condition worsened entitling her to additional temporary total disability benefits. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant sustained an admitted injury to her left foot on October 28, 2012. The claimant received treatment, including surgery, and was eventually placed at maximum medical improvement (MMI) by Dr. Price on April 8, 2014. Dr. Price gave the claimant a 12 percent impairment of her left lower extremity and two percent impairment for situational depression. The claimant was also released to return to work without restrictions on this date. The respondents filed a final admission of liability consistent with Dr. Price's report. The claimant timely objected and requested a Division Independent Medical Examination (DIME).

After the claimant was placed at MMI, the claimant stopped showing up for work and was terminated for job abandonment in April of 2014.

The claimant sought medical treatment with Dr. Wetstine on July 7, 2013, and reported that she had continued pain in her left ankle after her surgery, including a shooting, tingling, burning sensation along the inside of her left ankle. Dr. Wetstine recommended orthotics, custom bracing, physical therapy and a MRI. The MRI revealed that the claimant had scarring at the confluence of the tibialis posterior and flexor digitorum tendon, tenosynovitis of the flexor hallucis longus, osteochondral lesion of the lateral talar dome.

The claimant returned to Dr. Frazzetta on July 29, 2014. Dr. Frazzetta noted the recommendations of Dr. Wetstine and Dr. Parker and provided the claimant with a release taking the claimant completely off work. The claimant then returned to Dr. Price who noted the claimant's continued complaints and recommended acupuncture, use of a TENS unit and physical therapy. Dr. Price also refilled the claimant's prescriptions and referred the claimant to Dr. Good.

Dr. McLaughlin conducted the DIME on October 14, 2014. The DIME physician noted the claimant's continued complaints and diagnosed the claimant with posterior tibialis tendon insufficiency status post surgery and noted the claimant had possible nerve entrapment of the left foot due to scarring from the surgery. According to the DIME physician, the claimant was not at MMI and noted that the claimant appeared to have had a worsening of her condition after being placed at MMI.

The respondents referred the claimant to Dr. Raschbacher on January 28, 2015. Dr. Raschbacher concluded that the claimant was not at MMI and recommended additional consultation with a foot and ankle reconstructive specialist. The claimant was evaluated by such a specialist, Dr. Hahn, on March 16, 2015, who eventually performed surgery on June 16, 2015. The respondents filed an amended general admission of liability on July 16, 2015, admitting for temporary disability benefits beginning June 16, 2015.

Based on these facts the ALJ found that the claimant was responsible for her termination of employment due to abandonment. The ALJ further found that the claimant subsequently had a worsening of her condition and that the claimant established that she is entitled to an award of temporary total disability beginning October 14, 2014, through June 15, 2015.

On appeal the respondents contend that the ALJ erred in finding that the claimant's worsened condition caused a greater impairment on her work abilities than existed at the time of MMI. The respondents also contend that there is no medical basis

for Dr. Frazzetta taking the claimant off work and that the ALJ erroneously relied on *Anderson v. Longmont Toyota*, 102 P.3d 323 (Colo. 2004). We are not persuaded the ALJ committed reversible error and, therefore, affirm the order.

The ALJ's application of *Anderson v. Longmont Toyota, Inc., supra*, in this action was appropriate for purposes of determining whether the claimant's right to temporary total disability was reestablished. Under the termination statutes, §§8-42-103(1)(g), C.R.S., and 8-42-105(4), C.R.S., a claimant who is responsible for the termination of regular or modified employment is not entitled to temporary disability benefits absent a worsening of condition which reestablishes the causal connection between the injury and the wage loss. *See Anderson v. Longmont Toyota, supra; see also Grisbaum v. Industrial Claim Appeals Office*, 109 P.3d 1054 (Colo. App. 2005). A wage loss is "caused by a worsened condition" if the worsening results in physical limitations or restrictions which did not exist at the time of the termination, and these limitations or restrictions cause a limitation on the claimant's temporary earning capacity which did not exist when the claimant caused the termination. *Martinez v. Denver Health*, W.C. No. 4-527-415 (August 8, 2005). The burden of proof to establish a subsequent worsening of condition and consequent wage loss is on a claimant who has been found responsible for a termination. *Green v. Job Site, Inc.*, W. C. No. 4-587-025 (July 19, 2005).

The question of whether new restrictions resulting from a worsened condition have caused the claimant's wage loss following a termination from employment remains one of fact for determination by the ALJ. Proof of the causal connection between the injury and the wage loss may be by lay or medical evidence. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). Because the issue is factual in nature, we must uphold the ALJ's determination if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires us to consider the evidence in a light most favorable to the prevailing party, and to defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003).

The respondents' arguments notwithstanding, there is ample evidence in the record that the claimant sustained a worsening of condition after she was terminated that caused a restriction in her temporary earning capacity. The claimant was placed at MMI on April 8, 2014, with no restrictions. The medical records after this date indicate the claimant sought medical treatment for significant pain and that there was a decline in the claimant's condition. The medical reports further showed that the claimant attempted to work after she was placed at MMI but her injury prevented her from being able to stand.

The DIME physician's report also delineates the worsening of the claimant's condition with his review of the medical records that showed the claimant had decreased strength, range of motion and a "worsening of condition."

Although the respondents did not contest the DIME physician's determination that the claimant was not at MMI, the respondents point to *City of Colorado Springs v. Industrial Claim Appeals Office*, 954 P.2d 637 (Colo. App. 1997) for the proposition that to obtain additional temporary disability benefits once the claimant reaches MMI, the claimant must prove that she is no longer at MMI and must prove that the worsened condition caused a "greater impact" on the claimant's temporary work capacity than existed at the time of MMI. The respondents state that the claimant here is not entitled to temporary total disability just because she was taken off MMI, "as the off work note is not related to the workers' compensation injury."

It is true, as the respondents argue, that increased restrictions alone do not establish a worsened condition. *Apex Transp., Inc. v. Industrial Claim Appeals Office*, 321 P.3d 630 (Colo. App. 2014). However, contrary to the respondents' arguments, as noted above, the ALJ here did not rely solely on increased restrictions from Dr. Frazzetta when granting the claimant's request for temporary disability. Rather, the ALJ's order indicates that he conducted a thorough analysis of the evidence presented by both parties, implicitly credited the testimony of the claimant, and credited various opinions of the claimant's authorized treating physicians. Based on his review of the totality of the evidence, the ALJ was convinced that the claimant's work-related condition had worsened and that worsened condition resulted in increased work restrictions which did not exist at the time of MMI. *Lively v. Digital Equipment Corporation*, W.C. No. 4-330-619 (June 14, 2002)(in order to establish entitlement to additional temporary disability benefits, the claimant must show the worsened condition resulted in increased physical restrictions over those which existed on the original date of MMI, and that the increased restrictions caused a "greater impact" on the claimant's temporary "work capability" than existed at the time of MMI.)

The question of whether the claimant proved increased disability, as measured by a reduction in her capacity to earn wages, was a question of fact for determination by the ALJ. See *Lymburn v. Symbios Logic*, *supra*. And, as noted above, the ALJ's order is supported by substantial evidence. Section 8-43-301(8), C.R.S. Thus, under either *Longmont Toyota* or *City of Colorado Springs*, the claimant proved her entitlement to temporary disability benefits as found by the ALJ. In our view, the ALJ's order is supported by substantial evidence and by the correct application of the law, and we decline to disturb it.

IT IS THEREFORE ORDERED that the ALJ's order dated April 15, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



Kris Sanko

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-963-620-04

IN THE MATTER OF THE CLAIM OF

ERIC HOLDER,

Claimant,

v.

FINAL ORDER

STAFFMARK,

Employer,

and

CANNON COCHRAN MANAGEMENT
SERVICES, INC.,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Margot Jones (ALJ) dated June 21, 2016, that denied authorization for a spinal cord stimulator implant trial recommended by one of the claimant's physicians. We affirm the decision of the ALJ.

The claimant worked for the employer as a delivery driver. He injured his left leg and low back on October 1, 2014, when his leg fell through a gap between the delivery truck and a loading dock. A claim for benefits was admitted by the respondents. The claimant underwent treatment including emergency surgery, skin grafts, injections, physical therapy and pool therapy. Despite treatment, the claimant continued to complain of leg and back pain.

On January 19, 2016, Dr. Huser, one of the claimant's treating physicians, requested prior authorization for the surgical implantation of a spinal cord stimulator (SCS). The SCS device was aimed at reducing the extent of the claimant's back pain. It is surgically inserted into the back and delivers an electrical impulse to the nerves in the spine in an effort to stimulate the nerve. Dr. Huser's January 19 request indicated the first step in the process of SCS application involved a trial use of the stimulator system.

The respondents disputed the reasonableness of the SCS recommendation and submitted an application for a hearing on January 29, 2016, endorsing for hearing the

ERIC HOLDER

W. C. No. 4-963-620-04

Page 2

issue: “Respondents deny any recommendation made by Christopher Huser, M.D. ... for a spinal cord stimulator as not being reasonable, necessary and related to the work injury of October 1, 2014.”

A hearing in regard to the application was concluded on May 11, 2016. The claimant and Dr. Castro, the respondents’ medical expert, testified. The respondents submitted additional medical reports from Dr. Ladwig and Dr. Shih, treating doctors. The claimant presented reports from Dr. Huser. Following the hearing the ALJ authored Findings of Fact, Conclusions of Law and an Order on June 21. The ALJ determined the SCS procedure was not a reasonable medical treatment. Relying on the testimony and reports of Dr. Castro, Dr. Shih and Dr. Ladwig, the ALJ concluded SCS systems rarely provide long term pain relief, the implantation features surgery on an uninjured portion of the spine, it would not benefit the claimant due to the multi-level process affecting his spine, the SCS presents a significant risk of increasing the claimant’s pain, once implanted the SCS device would make useless MRI imaging, a CT scan would be necessary but is contraindicated by the claimant’s bleeding disorder history, and that a trial of an SCS device does not accurately predict the long term success of an SCS implantation. Accordingly, the ALJ resolved that “claimant’s request for a spinal cord stimulator trial is denied and dismissed.”

On appeal, the claimant contends that authorization of a permanent SCS was not an appropriate issue for the ALJ to decide. The claimant asserts Dr. Huser had only officially requested authorization for a trial of the SCS device. It is argued the claimant was not provided adequate notice the issue of a permanent SCS implantation was to be considered and that without a prior trial of the SCS device, the ALJ could no more than speculate as to the adequacy of its permanent application. We are not persuaded.

Both parties submitted as exhibits the January 19, 2016, fax from Dr. Huser with its attached report. The fax announced as its subject a “Prior Authorization Request for Coverage of Trial HF10™ Spinal Cord Stimulation via the Senza© System.” The text of Dr. Huser’s report states the reason for the trial is the doctor’s conclusion: “As a result of this patient’s condition and previous tried therapies, HF10 therapy is being recommended.” He then explains: “Before being eligible for the implant of HF10 therapy, all patients must first go through a trial phase with the spinal cord stimulation system before moving forward with the permanent implant.” Pursuant to the direction of W.C. Rule of Procedure 16-10(E), the respondents requested a hearing in regard to Dr. Huser’s preauthorization request. The respondents endorsed as an issue on that application for a hearing: “Respondents deny any recommendation made by Christopher Huser, M.D. ... for a spinal cord stimulator as not being reasonable, necessary and related

to the work injury of October 1, 2014.” A reasonable reading of these two documents advises that Dr. Huser is seeking to implement a spinal cord stimulator to treat the claimant, the first step involves a trial of the stimulator, and the respondents dispute the need for the trial for the reason that the entire treatment through an SCS is not reasonable or necessary.

We cannot state that an objection to all of the phases of a treatment is not a legitimate dispute to the necessity for the initial phase. Therefore, the claimant’s contention that the respondents’ dispute as to the reasonableness of the SCS procedure was not before the ALJ or that the claimant did not have notice of that dispute is to no avail.

The ALJ specifically noted in her finding of fact ¶ 16 that “a determination of whether a spinal cord stimulator trial is reasonably necessary necessitates an analysis of whether a permanent spinal cord stimulator is reasonably necessary.” The ALJ referenced statements and testimony of Dr. Castro asserting “In my experience, spinal cord stimulators are poor controllers of pain; and often if they do work, it is generally for a transient period of time” and that “I don’t think the trials help improve the long-term predictability of an outcome. Trials frequently have reasonably good results in the trial, and go on to implantation, and then their – the outcomes are not very good.” Findings of Fact ¶¶ 12 and 17. Dr. Castro testified for these reasons he ceased performing surgery to implant SCS devices seven years ago. He described how he now performs a considerable number of surgeries to remove malfunctioning SCS equipment. This expert medical evidence represents substantial evidence which supports the decision of the ALJ that the trial of the SCS is not reasonable and necessary. The ALJ’s conclusion cannot reasonably be characterized as speculation or conjecture.

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). We cannot say the ALJ here has made a decision not reasonably supported by the record. In addition, the ALJ’s plausible inferences may not be disturbed if drawn from substantial evidence in the record. We have no authority to substitute our judgment for that of the ALJ concerning the credibility of witnesses and we may not reweigh the evidence on appeal. *Id.*; *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993).

The ALJ's citation of the evidence in the record relied upon to support her conclusion can be characterized as substantial evidence which supports her findings. The existence of evidence which, if credited, might permit a contrary result affords no basis for relief on appeal. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002).

Accordingly, we find no compelling reason question to the decision of the ALJ.

IT IS THEREFORE ORDERED that the ALJ's order issued June 21, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-997-535-01

IN THE MATTER OF THE CLAIM OF
LYNETTE HUSTON,

Claimant,

v.

ALLCABLE, INC.,

Employer,

and

SENTRY INSURANCE CO.,

Insurer,
Respondents.

FINAL ORDER

The respondents seek review of an order of Administrative Law Judge Felter (ALJ) dated May 26, 2016, that ordered a change in the authorized treating physician pursuant to § 8-43-404(5) (a) (VI), C.R.S. We reverse and set aside the order of the ALJ regarding the change of physician.

The claimant asserted she sustained an injury to her shoulder, cervical and lumbar spine as a result of five hours she spent soldering wires to a metal fitting on June 18, 2015. The claimant reported her injuries to the employer and was referred to the Concentra Clinic for treatment. The claimant was provided several forms of treatment including a referral to a chiropractor. In July and August, 2015, the claimant treated through four sessions of chiropractic manipulation which she testified caused additional injury to her neck. On December 9, 2015, an attorney for the claimant sent a letter to the attorney for the respondents claiming the employer had failed to provide the claimant with a list of four doctors after notification of her injury from whom she could choose to treat. The letter asserted: “Therefore, Ms. Huston is allowed to select Dr. William Miller as her authorized treating physician.” The respondents did not reply to this letter.

The respondents contested the compensability of the injury. The claimant filed an application for a hearing checking on the application form the issues of compensability, average weekly wage, medical benefits reasonably necessary and authorized provider.

The claimant also specified a penalty claim involving the untimely denial of the claim. No other issues were mentioned. The claimant's Case Information Sheet referenced the same issues.

A hearing was convened by the ALJ on May 18, 2016. At the initiation of the hearing the issues were specified by another of the claimant's attorneys to include compensability and the authorization of Dr. Miller as referenced in the December 9, 2015, letter. The respondents objected to the letter's admission. At the conclusion of the testimony of the claimant and two witnesses from the employer, the ALJ found the claimant had been provided a list of four physicians in a timely manner. The ALJ then inquired of the respondents' counsel if he objected to the ALJ entertaining the issue of a change of authorized treating physician (ATP) to Dr. Miller. Counsel objected that issue had not been mentioned previous to the hearing and he opposed considering it at that juncture. He argued the December 9 letter was not a request by the claimant to change physicians. It was a declaration that she had the right to select another doctor. The objection notwithstanding, the ALJ ruled the December 9 letter admissible and determined to construe it as a request to be allowed to change physicians. At the conclusion of the hearing, the ALJ ruled the injury to be compensable and found that because the respondents had not responded to the December 9 letter within 20 days to deny the request, any objection was waived and Dr. Miller was designated as the new authorized treating physician.

On appeal, the respondents argue the ALJ's decision to authorize a new physician is an appealable order. The respondents contend their rights to procedural due process were abridged due to the absence of any notice for that issue. They also argue the December 9 letter was inadmissible hearsay and it cannot be characterized as a request by the claimant to change doctors.

We note the ALJ's order pertinent to the change of physician appears to possibly rest on two grounds. It was found that Dr. Miller had seen the claimant several times between November, 2015, and April, 2016. The ALJ made findings of fact that the December 9 letter should have been read by the respondents' attorneys as a request to change physicians. In his conclusions of law, the ALJ observed the claimant had more faith in Dr. Miller than in her Concentra doctors and therefore had shown good cause to justify a change of physicians. In the concluding order section the ALJ deemed Dr. Miller to be authorized for the reason that the respondents had failed to object to the December 9 letter within 20 days. The respondents were ordered to pay for all authorized and necessary medical care provided the claimant.

I.

The respondents argue the ALJ's order allowing a change of physician is subject to review on appeal for the reason that it also appears to retroactively order the respondents to pay for some specific medical treatments. The ALJ does include a ¶ 23 and 24 of the Findings of Fact which observes the claimant attended appointments with Dr. Miller on November 6, 2015, and on April 8, 2016. On April 8 it is noted Dr. Miller made treatment suggestions pertinent to another MRI, physical therapy and a psychological consult. A reasonable reading of the order does not indicate these treatment suggestions were actually approved and ordered by the ALJ. However, to the extent the ALJ analyzed the claimant's December 9, 2015, letter as a request to change doctors, which became effective 20 days later, a logical deduction would conclude that the respondents were being ordered to pay for the April 8, 2016, appointment with Dr. Miller. In that respect, the ALJ's order is a direction to the respondents to pay for a specific medical benefit.

In addition to this construction of the ALJ's order that it includes the payment of a specific medical benefit provided on April 8, we find the order subject to review due to recent developments in this area of workers' compensation benefits. The panel has many times construed § 8-43-301(2) as a prohibition to review on appeal an order by an ALJ authorizing a change of doctor. That section only allows an appeal to the Industrial Claim Appeals Office of an order which "requires any party to pay a penalty or benefits or denies a claimant any benefit or penalty." We have ruled that an order "requiring a change of physician merely determines that a particular provider is authorized to treat the claimant, but authorization is not itself a benefit." We further noted "such an order does not require the respondents to provide any particular treatment, and they remain free to challenge the reasonableness and necessity for any specific procedures or treatments which the new ATP may prescribe." *Browne v. Hewlett Packard*, W.C. No. 4-101-467-03 (April 24, 2015).

However, the panel has also determined that the ALJ's denial of a claimant's request for a change of physician is subject to appellate review.

Unlike an order that grants a request for change of physician without specific medical benefits, the panel has previously held that an order that denies a request for a change of physician to a specific doctor is equivalent to the denial of a specific benefit and, therefore, is final and

reviewable.” *Benton v. Lowe Enterprises*, W.C. No. 4-903-810-04 (September 14, 2015).

Our refusal to entertain review of the granting of a change of physician has been long standing. *Churchill v. Goodyear*, W.C. 4-203-686 (April 17, 1995); *Fernandez v. City and County of Denver*, W.C. No. 4-122-784 (Feb. 7, 1996); *Matthew v. UPS*, W.C. No. 4-325-652 (Dec. 15, 1997); *Dimit v. A and P Services*, W.C. No. 4-426-344 (Oct. 2, 2000); *Miller v. Garden Terrace*, W.C. No.4-164-248 (Sept. 26, 2003); *Sholund v. John Elway Dodge*, W.C. No. 4-522-173 (Oct. 22, 2004); *Braun v. Foley’s Department Store*, W.C. No. 4-603-819 (Feb. 28, 2005).

Nonetheless, the Court of Appeals has not found the review of an order granting a change of physician to be precluded by § 8-43-301(2), *See, Story v. Industrial Claim Appeals Office*, 910 P.2d 80 (Colo. App. 1995); *Lutz v. Industrial Claim Appeals Office*, 24 P. 3d 29 (Colo. App. 2000).

It initially appears arbitrary to reason that an ALJ’s approval of a request to change doctors is the granting of a benefit while the refusal of such a request is said to be something other than a denial of a benefit. However, the distinction is driven by the statutory language which allows an appeal of the ‘denial’ to a claimant of a ‘benefit’ *or* the requirement that a party (i.e. the respondent) ‘pay’ for a benefit. Therefore, the singular decision by an ALJ that the claimant is entitled to the benefit of a new doctor has been theorized to not require a respondent to pay anything. Accordingly, that decision will largely avoid appellate review.

Recent changes in the statute pertinent to the change of a physician convince us the General Assembly now includes the granting of that benefit to a claimant as something that entails a payment by the respondent. Accordingly, § 8-43-301(2) no longer bars an appeal.

In 2008, H.B. 07-1176 added to § 8-43-404(5)(a) the requirement that an employer provide an injured employee a choice of two doctors to treat for an injury (now four). In addition, the employee was given the option of switching from one physician to the other on the list for any reason within 90 days of the injury, § 8-43-404(5)(a)(III). Failure of the employer to comply also allowed an employee to accomplish a change of physician. The former “authorized treating physician” (ATP) is required to send to the new ATP a copy of the employee’s medical file, § 8-43-404(5)(a)(IV)(B). Once a change of physician was implemented, the new ATP was provided authority to determine the controlling work restrictions and return to work status of the employee, § 8-43-

404(5)(a)(IV)(D). The Director then promulgated W.C. Rule 8-6(B) and(C) to apply in the case of a change of the authorized treating physician. That rule specifies the respondents are to pay for the expense of the copying of the file and the injured employee is entitled to an appointment with the new ATP within 30 days. If the employee is unsuccessful in arranging for the appointment, the respondents are required to attempt to arrange the appointment. If the respondents are unsuccessful, they must provide the employee with another substitute doctor to be the ATP. As a result of these changes the respondents are obligated to pay, at a minimum, the fee for a doctor's appointment and the copying of the medical file.

Section 8-43-404(5)(a)(VI) pertains to a change of physician which may be obtained through the claimant's request to the respondents. The respondents may agree, may waive their rights by failing to respond within 20 days, or an ALJ may authorize the change. Effective July 1, 2016, and applicable to all pending claims, S.B. 16-217 added to § 8-43-404(5)(a)(VI), a subsection (B) and (D). Subsection (B) provides the claimant is entitled to an initial visit with the new ATP. Subsection (D) specifies that the new ATP is authorized to determine the controlling work restrictions and return to work status of the claimant. Accordingly, a change of physician pursuant to § 8-43-404(5)(a)(VI) also compels the respondents to pay for a minimum of one appointment with the new ATP which may include review of any pertinent work restrictions.

These amendments to the statute have added a requirement that respondents must make at least a minimum payment when a change of physician is ordered by an ALJ. This is the case whether the change is accomplished pursuant to either § 8-43-404(5)(a) (III) or (VI). The Medical Fee Schedule currently specifies the charge for copying a medical file as a minimum of \$18.53, § 18-6 (C), the charge for a physician's appointment is allowed for 10 to 60 minutes at a minimum, 18-6, Exhibit 7, and the respondents are liable for the claimant's mileage to attend the appointment, 18-6 (E).

While the respondents retain the ability to dispute the necessity and relatedness of proposed medical treatment, once an ALJ orders a change in the ATP, that right to dispute does not extend to the right of the claimant to be afforded an initial appointment with the new ATP. We can no longer conclude that an ALJ's order to authorize a change of physician does not represent an order to the respondents to 'pay' a benefit. Accordingly, the ALJ's order in this matter is subject to review pursuant to § 8-43-301(2).

II.

The respondents contend the ALJ was incorrect to the extent his order may be seen as justifying a change of physician when the respondents did not respond to the December 9, 2015, letter from one of the claimant's attorneys. They argue the letter could not reasonably read as a request by the claimant to the respondents to authorize a new doctor. Instead, the respondents argue the letter is akin to a notice to the respondents that the claimant was unilaterally changing her physician. We agree with the respondents' reading of the December 9 letter.

Section 8-43-404 (5)(a)(VI), as it read in December, 2015, allowed a claimant to "upon written request ...procure written permission to have a personal physician ... treat the employee. If permission is neither granted nor refused within 20 days, the employer or insurance carrier shall be deemed to have waived any objection to the employee's request." The ALJ construed the December 9 letter as such a request. He ruled that the failure of the respondents to submit a written objection to the letter within 20 days allowed the claimant a change of doctor.

The ALJ also used this analysis as authority to allow his order to change the ATP on a retroactive basis to December 29 of 2015. Otherwise, such an order would only be effective as of the date of the ALJ's oral ruling on May 19, 2016. *Consolidated Landscape v. Industrial Claim Appeals Office*, 883 P.2d 571 (Colo. App. 1994) (change of provider effective date of ALJ's oral order).

The December 9 letter stated initially that the "the employer shall provide the injured worker with a Designated Provider List in compliance with § 8-43-404(5)(a)(I)(A) ... ,employer failed to provide any Designated Provider List upon notice of the claim, ..." The letter then stated "Therefore, Ms. Huston is allowed to select Dr. William Miller as her authorized treating physician." We surmise this letter is not a "request for a change of physician" but rather, is a unilateral declaration of the claimant's intent to treat with Dr. Miller. As such, the 20 day period to respond to a "request " for a change of physician was never triggered. *Lutz v. Industrial Claim Appeals Office*, 24 P.3d 29 (Colo. App. 2000).

The *Lutz* case is dispositive. *Lutz* held that to comply with § 8-43-404(5)(a)(VI), C.R.S., a claimant must ask the insurance carrier to allow them to change physicians. The court explained that a unilateral declaration of intent to change physicians does not comply with the statute. In *Lutz* the court concluded that a letter that was sent by the claimant's counsel to the insurance adjuster was actually an announcement of the

claimant's unilateral change of physician and not a request for permission to change physician. The court, therefore, held that the letter did not constitute a request for a change of physician as required by §8-43-404(5)(a), C.R.S. Similarly, in this case, we disagree with the ALJ's finding that the letter sent by the claimant's counsel to the respondents' attorney on December 9 amounts to a request for permission to change physicians as required under § 8-43-404(5)(a)(VI), C.R.S. Thus, the 20 day period to respond was never triggered. *Tidwell v. Spencer Technologies*, W.C. No. 4-917-514-03 (March 2, 2015); *Petrich v. 180 Connect*, W.C. No. 4-766-673-02 (May 3, 2013); *Billea v. Pueblo County*, W.C. No. 4-507-284 (April 25, 2005). The December 9 letter provides no basis to justify a change of physician in this matter.

III.

The respondents argue the ALJ also committed error by justifying a change of physician upon the claimant's showing of good cause for a substitution of doctors. The respondents complain that the issue was not noticed as an item for hearing and they were prejudiced in their ability to defend against the claim. Section 8-43-404(5)(a)(VI) provides that "upon proper showing the employee may procure the division's permission at any time to have a physician of the employee's selection treat the employee, ..." The transcript of the May 18, 2016, hearing reveals that following the testimony of the employer witnesses, the ALJ inquired of the respondents' counsel if he would object to allowing the issue of a request for such a change of physician to be addressed. Tr. at 49. Counsel expressed his objection. The ALJ however, determined the December 9 letter from the claimant's attorney served to adequately provide notice of the claimant's request for a change of physician. In his conclusions of law the ALJ noted the claimant had more faith in Dr. Miller than she did in her other doctors. On that basis, the ALJ concluded the claimant had established good cause for his approval of a change of the ATP to Dr. Miller.

A review of the record does not indicate any prior notice that that the claimant was seeking a change of physician pursuant to § 8-43-404(5)(a)(VI). As noted above, the December 9 letter from the claimant's attorney asserted only that a change of physician was sought on the authority of § 8-43-404(5)(a)(I), on the basis that a list of treaters was not submitted to her at the time of the injury. The issue of "Authorized physician" was checked by the claimant but that notation would have applied to § 8-43-404(5)(a)(I), but not to (VI). The claimant nowhere stated she wished to pursue the issue of dissatisfaction with her physicians as justification for a change of doctors. The respondents assert this failure to provide notice of the issue prevented them from investigating that claim,

conducting discovery in that regard, interviewing the original physicians or even to cross examine the claimant at the hearing since the issue was first raised subsequent to her testimony. We agree with the respondent's argument.

Due process contemplates that the parties will be apprised of the evidence to be considered, and afforded a reasonable opportunity to present evidence and argument in support of their positions. Inherent in these requirements is the rule that parties will receive adequate notice of both the factual and legal bases of the claims and defenses to be adjudicated. *See Hendricks v. Industrial Claim Appeals Office*, 809 P.2d 1076, 1077 (Colo.App. 1990).

The ALJ's conclusion notwithstanding, we hold that neither the claimant's application for hearing , nor any other hearing document, sufficiently notified the respondents of the legal or factual basis of the claim for a change of physicians through application of § 8-43-404(5)(a)(VI).

IT IS THEREFORE ORDERED that insofar as the ALJ's order issued May 26, 2016, authorized a change of physician, it is set aside and reversed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-924-142-09

IN THE MATTER OF THE CLAIM OF
KIMBERLY KETIKU,

Claimant,

v.

REMAND ORDER

INTEGRATED HEALTHCARE
STAFFING, LLC,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Broniak (ALJ) dated May 16, 2016, that granted the respondents' motion to strike the claimant's application for hearing with prejudice. We set aside the ALJ's order and remand for further proceedings.

The matter originally went to hearing on the issues of compensability, medical and temporary disability benefits in front of ALJ Oliver. After hearing ALJ Oliver entered an order mailed to the parties on August 29, 2014, finding the claim not compensable and denying the claimant's request for workers' compensation benefits. The claimant failed to file a timely petition to review by September 18, 2014. The claimant filed a new application for hearing with the Office of Administrative Courts (OAC) on September 23, 2014. The ALJ found that even if the new application for hearing was construed as a petition to review, the claimant still failed to meet the 20-day deadline for filing an appeal.

The claimant eventually filed a petition to review on December 9, 2014. ALJ Oliver entered an order striking the petition to review as untimely. The claimant did not request reconsideration. The claimant filed other applications for hearing on November 24, 2014, and January 8, 2015. All of these applications for hearing were stricken. The

claimant also filed an appeal with the Colorado Court of Appeals which was dismissed on April 24, 2015, for lack of a final appealable order. ¹

The claimant filed another application for hearing on December 22, 2015, again endorsing the issues of compensability, medical benefits, average weekly wage, petition to reopen claim, disfigurement and penalties. The claimant alleged that her entire case was mishandled and stated in the application that “I was purposely given the wrong documents.”

ALJ’s Broniak’s order indicates that at the beginning of hearing the respondents moved to strike the claimant’s application for hearing citing jurisdiction, ripeness and claim preclusion. In an order dated December May 16, 2016, ALJ Broniak granted the respondents’ motion to strike the application for hearing. The ALJ found that the claimant’s claim for workers’ compensation benefits had been denied and dismissed by ALJ Oliver’s August 29, 2014, order and the order became final as of September 18, 2014, due to the claimant’s failure to timely appeal.

On appeal of ALJ Broniak’s order the claimant reasserts her arguments below and seeks to challenge ALJ Oliver’s original order due to the fact that her sons were not allowed to assist her at hearing despite a hearing impairment and the fact that she erred in calculating the date to appeal ALJ Oliver’s order because she did not know that weekends and holidays counted in the 20 days to file a petition to review. The claimant also alleges that she was given the wrong documentation to appeal ALJ Oliver’s order. Because ALJ Broniak’s order does not address the claimant’s issue of petition to reopen, we must remand the matter for further proceedings.

We note initially that it appears ALJ Broniak’s order in this case is actually an order for summary judgment rather than a procedural order simply striking the application for hearing. *See Barrera v. ABM Industries*, W.C. Nos. 4-849-952-01 & 4-865-048 (June 10, 2016). Office of Administrative Courts Rule of Procedure Rule 17, allows an ALJ to enter summary judgment where there are no disputed issues of material fact. Moreover, to the extent that it does not conflict with OAC Rule 17, C.R.C.P 56 also applies in workers' compensation proceedings. *Fera v. Industrial Claim Appeals Office*, 169 P.3d 231 (Colo. App. 2007); *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988)(the Colorado rules of civil procedure apply insofar as they are not inconsistent with the procedural or statutory provisions of the Act). Summary judgment

¹ Because of the court’s dismissal, the claimant has repeatedly stated that ALJ Oliver’s order is not final. However, ALJ Oliver’s order was a final order but because the order was not timely appealed to the Industrial Claim Appeals Office, the order was not final for purposes of review at the court of appeals.

is a drastic remedy and is not warranted unless the moving party demonstrates that it is entitled to judgment as a matter of law. *Van Alstyne v. Housing Authority of Pueblo*, 985 P.2d 97 (Colo. App. 1999). All doubts as to the existence of disputed facts must be resolved against the moving party, and the party against whom judgment is to be entered is entitled to all favorable inferences that may be drawn from the facts. *Kaiser Foundation Health Plan v. Sharp*, 741 P.2d 714 (Colo. App. 1987). We review the ALJ's legal conclusions de novo in the context of summary judgment. See *A.C. Excavating v. Yacht Club II Homeowners Association*, 114 P.3d 862 (Colo. 2005).

Although the ALJ's order does not specifically address the elements of claim preclusion, the ALJ summarily concludes that there are no ripe issues for hearing that require resolution because the claimant failed to timely appeal the August 28, 2014, order. It is undisputed that the claimant did not file a petition to review the order until December 9, 2014. Even assuming the claimant's subsequent application for hearing could be construed as a petition to review, this was not filed within the 20 day time frame.

Section 8-43-301(2), C.R.S., provides that an ALJ's order denying benefits is final unless appealed within 20 days of the date of the certificate of mailing of the ALJ's order. See *Burke v. Industrial Claim Appeals Office*, 905 P.2d 1 (Colo. App. 1994). Where the statute does not specify the method for calculation of elapsed time, the computation is governed by §2-4-108(1), C.R.S.; *Ralston Purina v. Lowry*, 821 P.2d 910 (Colo. App. 1991). Section 2-4-108(1) provides that in computing a period of days, the first day is excluded and the last day is included. Subsection 2-4-108(2) provides that if the last day of the period is on a Saturday, Sunday or holiday, the period is extended to the next day which is not a Saturday, Sunday or holiday. Moreover, a *pro se* litigant is presumed to have knowledge of the applicable statutes, and must be prepared to accept the consequences of her own mistakes if she elects not to retain counsel. *Manka v. Martin*, 200 Colo. 260, 614 P.2d 875 (Colo. 1980). The statutory time limits governing appellate review of workers' compensation decisions are jurisdictional. *Wal-Mart Stores, Inc. v. Indus. Claim Appeals Office*, 24 P.3d 1 (Colo. App. 2000). Thus, absent the filing of a timely petition to review, we lack jurisdiction to review an ALJ's order. See *Schneider Nat'l Carriers, Inc. v. Indus. Claim Appeals Office*, 969 P.2d 817 (Colo. App. 1998); *Buschmann v. Gallegos Masonry, Inc.*, 805 P.2d 1193 (Colo. App. 1991).

Here, we agree that the record compels the conclusion the claim was closed by the claimant's failure to timely appeal ALJ Oliver's order. Consequently we have no basis to disturb the ALJ's order insofar as it determines that the claimant's appeal was untimely and the claim is closed. Section 8-43-301(8), C.R.S.

The claimant, however, also listed the issue of petition to reopen in her application for hearing and alleges that she was given the “wrong documentation” resulting in her failure to timely file an appeal. The claimant also contends that ALJ Oliver erroneously denied her request that her sons be allowed to remain in the hearing room to assist her in understanding the testimony being presented because of her severe hearing loss. Section 8-43-303, C.R.S., authorizes an ALJ to reopen any award on the grounds of "an error, a mistake, or a change in condition." The reopening ground of "mistake" under these provisions includes any "mistake of law" as well as those of fact. *Ward v. Azotea Contractors*, 748 P.2d 338 (Colo.1987). A collateral attack on a prior decision may be supported by a request to reopen premised on a finding of mistake, including a legal mistake. *Renz v. Larimer County School District*, 924 P.2d 1177, 1180 (Colo. App. 1996); *See Cotter v. Busk Construction*, W.C. No. 4-796-185-02 (May 25, 2016) (a claim that testimony was “perjured” could constitute a basis to reopen a previously denied claim). The claimant’s statement in the application for hearing and on appeal that she was given the “wrong documentation,” in conjunction with the request for reopening, or that she was denied reasonable assistance to mitigate a hearing disability, could fairly be seen as stating the grounds for reopening due to a mistake. ALJ Broniak’s order does not address these issues. Because these issues may present disputed issues of fact, we cannot say the dismissal of this matter pursuant to a summary judgment is consistent with OAC Rule 17. We, therefore, must remand the matter for further proceedings on this issue.

IT IS THEREFORE ORDERED that the ALJ Broniak’s order dated May 16, 2016, is set aside and remanded for further proceedings.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



David G. Kroll

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-982-976-01

IN THE MATTER OF THE CLAIM OF
DONALD SPARKS,

Claimant,

v.

FINAL ORDER

MATTAS MARINE & RV,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Mottram (ALJ) dated April 13, 2016, that ordered temporary benefits paid until September 15, 2015, but also denied their request to terminate temporary benefits after that date. Pursuant to our understanding of the order, we affirm the order to the extent it directs payment of temporary partial benefits subsequent to September 15, 2015, but reverse the order insofar as it requires the payment of temporary total benefits after that date.

The claimant worked for the respondent employer as a detail supervisor and general laborer. The claimant's job duties included cleaning, repairing and refurbishing recreational boats. The claimant injured his low back at work on April 15, 2015. The respondents denied the claimant sustained an injury to his back through the course and scope of his injury. Following a hearing which occurred on September 24, December 7 and December 11, 2015, the ALJ found the claim compensable. A transcript of the hearing has not been provided for the purposes of appeal.

While the pleadings are not explicit, it appears the parties litigated the claimant's eligibility for temporary partial (TPD) and temporary total (TTD) disability benefits after the date of September 15, 2015, when the claimant was discharged by the employer. The pleadings indicate the parties agreed that if the claim was compensable the claimant would be entitled to TTD benefits from May 2 through May 12, 2015, and to TPD benefits from May 13 through September 15, 2015. Premised on the implication of the

parties' arguments and the ALJ's findings, the claimant contends he is entitled to TTD benefits following the September 15 job termination while the respondents assert he was responsible for his discharge and is therefore ineligible for any temporary benefits after that date. Although the ALJ's order is silent in regard to temporary benefits subsequent to September 15, we read this as an inadvertent oversight and rely on his conclusions of law which indicate he intended to order TTD benefits after that point.

The ALJ recorded in his findings of fact, ¶ 36 and 39, that on September 11, 2015, the claimant was at work and attempted to move a tractor parked in the bay door to the employer's shop.

36. ... Claimant testified he was not aware that a customer's boat was attached to the tractor. Claimant testified he moved the tractor and the boat struck the side pillar causing damage to the boat.

39. The ALJ finds that claimant was terminated from his employment due to his negligence in causing damage to a customer's boat. While claimant's actions in causing damage to the boat justify his termination, respondents have failed to establish that his actions were volitional.

In his conclusions of law the ALJ referenced §§ 8-42-103(1) (g) and 8-42-105(4) (a), C.R.S., which provide that "in cases where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributed to the on-the-job injury." The ALJ noted the determinations in *Colorado Springs Disposal v. Industrial Claim Appeals Office*, 58 P.3d 1061 (Colo. App. 2002) and *Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1995), that the additions of these two statutory sections introduced the concept of "fault" as used in unemployment insurance cases into the field of workers' compensation. The ALJ stated in his conclusions of law, §§ 10, 11 and 12:

10 ... In that context, "fault" requires that the claimant must have performed some volitional act or exercised a degree of control over the circumstances resulting in the termination. ...

11. In this case, claimant was terminated after he caused significant damage to a customer's boat on September 11, 2015. Claimant was terminated for this action as of September 15, 2015 according to the testimony of Greg

[Mattas], the owner, at hearing. While this action may have been grossly negligent, it has not been proven to be volitional.

12. As found, respondents have failed to establish by a preponderance of the evidence that claimant committed a volitional act that led to his termination of employment.

Based on these findings, the ALJ denied the respondents' request to terminate all temporary benefits after September 15. The respondents appeal and contend the finding by the ALJ that the claimant was negligent is sufficient to establish the claimant was at fault for his discharge and responsible for the termination. The claimant responds by asserting that in order to apply the termination statutes the ALJ must find the claimant acted such that he "willed, intended, premediated, or had any conscious deliberation to damage the customer's boat." We conclude the respondents have the more persuasive argument.

Initially, it would appear that the activity of entering a truck tractor, putting it into gear and driving forward, is a volitional act. However, the ALJ appears to focus on the circumstance that the claimant was "not aware" there was a trailer holding a boat attached to the tractor. The ALJ characterizes the claimant's failure to make himself aware of that detail as "negligent." The Colorado Jury Instructions for Civil Jury Trials, § 9.6, provides: "Negligence means a failure to do an act which a reasonably careful person would do, or the doing of an act which a reasonably careful person would not do, under the same or similar circumstances" Despite the ALJ's conclusion that a volitional act constitutes something more than negligence, the definition for 'fault,' as noted by the ALJ's case law reference, does not turn exclusively on the presence of a volitional act. Fault also encompasses exercising "a degree of control over the circumstances resulting in the termination." The ALJ found the claimant's actions to represent negligence. The claimant's failure to make himself aware of the presence of a trailer with a boat attached to the tractor would constitute not only negligence, but also a degree of control over the circumstances. There is no suggestion a trailer with a boat is difficult to see. For that reason the ALJ denominated the claimant's failure to make himself aware of the trailer an act of negligence. As such, a 'failure to act reasonably' is interchangeable with 'control over the circumstances.'

The Court of Appeals in *Richards v. Winter Park Recreational Assoc.*, 919 P.2d 933 (Colo. App. 1996), reviewed the discharge of a ski area employee who was fired when he forgot to perform a particular safety test on a ski lift prior to allowing it to be put into service. The claimant had informed his supervisor "he had been preoccupied and had forgotten to perform the test." The hearing officer had ruled the claimant not at fault

for his discharge because the hearing officer: “determined that claimant had not ‘willfully’ forgotten to perform the test and, therefore, concluded that he was not at fault for his separation.” The Court disagreed and set aside the hearing officer’s determination. The Court ruled “neither statutory nor case law has imposed a state of mind requirement that a claimant must act with ‘willful intent’ before a determination of fault may be made.” *Id.* at 934. The court resolved that the hearing officer’s findings do not “provide a basis to conclude that claimant’s failure to perform this test was somehow nonvolitional.”

We relied on the decision in *Richards* to decide *Elliott v. Hire Calling Co.*, W.C. No. 4-700-819 (November 16, 2007). In *Elliott*, the ALJ deemed the claimant to be negligent when he misread a question on his employment application regarding prior criminal history. His incorrect answer led to the claimant’s termination. The ALJ ruled the “negligent actions did not constitute volitional conduct” and the claimant was not therefore responsible for his termination. We set the order aside on the basis that “a finding of negligence is fully consistent with a corresponding finding that the claimant exercised control over the circumstances of his termination.” The same conclusion applies in this matter. The finding by the ALJ that the claimant’s activity, or lack of activity, was negligent, indicates the claimant failed to do an act which a reasonably careful person would do under the same or similar circumstances. That is all that is required to be at fault, or responsible, for the termination of employment.

In *Slack v. Farmers Insurance Exchange*, 5 P.3d 280 (Colo. 2000), the Supreme Court construed the General Assembly’s use of the terms “negligence or fault” in an application of the pro rata liability of defendants statute, § 13-21-111.5, C.R.S. The Court was asked to determine the effect the addition of the phrase “or fault” to the category of multiple defendants subject to the division and assessment of damages for injuries produced by their “negligence or fault.” The decision drew upon definitions drawn from both Black’s Law Dictionary and from Webster’s New Collegiate and Third New International Dictionary. Black’s was noted to define ‘negligence’ as “The failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation; any conduct that falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally, wantonly, or willfully disregardful of others’ rights.” Black’s was observed to define ‘fault’ as “an error or defect of judgment or of conduct; any deviation from prudence or duty resulting from inattention incapacity, perversity, bad faith, or mismanagement.” Both the majority opinion and the dissent agreed the definition of ‘fault’ included the definition of ‘negligence.’ The effect of adding ‘fault’ to the statute was to extend the scope of the relevant defendants because using only the word ‘negligence’ would not

have included those defendants committing intentional acts. The Court concluded that, indeed, adding ‘fault’ was intended by the legislature to cover not only negligent actors but also those acting with intent. The effect was to make the word ‘negligence’ superfluous. As applied in this matter, the finding in *Slack* indicates both the General Assembly and the Court considers ‘negligence’ to be included in the definition of ‘fault.’

Accordingly, the determination of the ALJ that the claimant’s termination was caused by his negligence is also a finding the claimant was at fault for that termination. Pursuant to § 8-42-105(4)(a) the claimant’s wage loss resulting from that termination is not attributable to the on-the-job injury.

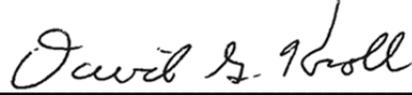
However, the application of § 8-42-105(4)(a) in this case does not serve to preclude the claimant from an award of TPD benefits after September 15. In the event the claimant had not damaged the customer’s boat and continued to work in his modified duty job, he still would have sustained the wage loss which the parties agreed made him eligible for TPD benefits prior to September 15. The wage loss “resulting” from the claimant’s termination does not include the preexisting wage loss represented by the difference between the claimant’s AWW and the wages he would have been paid had he not been terminated from the modified duty job.

In other words, the disputed portion of the wage loss would have “resulted” regardless of the termination and remained attributable to the industrial injury. Thus, even though the claimant was responsible for the termination of subsequent employment, he still could be entitled to temporary partial disability benefits to compensate that portion of his wage loss that continued to result from the injury. Accordingly, the claimant is entitled to an award of TPD benefits after September 15, 2015. *Tarman v. U.S. Transport*, W.C. No. 4-981-955-01 (June 2, 2016); *Clevenger v. El Paso Glass Co., Inc.* W.C. No. 4-712-079 (April 29, 2008).

IT IS THEREFORE ORDERED that the ALJ’s order issued April 13, 2016, is corrected to deny the claimant temporary total disability benefits subsequent to September 15, 2015, and instead, directs the payment of temporary partial disability benefits after that date.

DONALD SPARKS
W. C. No. 4-982-976-01
Page 6

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko