COLORADO
Department of
Labor and Employment

Division of Workers' Compensation
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October Case Law Update

Presented by Judge John Sandberg and Judge John Steninger

This update covers ICAO and COA decisions issued between September 18, 2017 to October 13, 2017

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ADVANCE SHEET HEADNOTE
October 2, 2017

2017 CO 94

No. 17SA62, Catholic Health v. Swensson—Expert Testimony—Discovery Sanctions.

In this case, the supreme court considers whether an amendment to Colorado Rule of Civil Procedure 26(a)(2)(B) providing that expert testimony "shall be limited to matters disclosed in detail in the [expert] report," mandates the exclusion of expert testimony as a sanction when the underlying report fails to meet the requirements of Rule 26. The court concludes this amendment did not create mandatory exclusion of expert testimony and that instead, the harm and proportionality analysis under Colorado Rule of Civil Procedure 37(c) remains the proper framework for determining sanctions for discovery violations. Accordingly, the court makes its rule to show cause absolute and remands for further proceedings.

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

2017 CO 94

Supreme Court Case No. 17SA62
Original Proceeding Pursuant to C.A.R. 21
Broomfield County District Court Case No. 16CV30055
Honorable Edward Charles Moss, Judge

In Re:

Plaintiff:

Catholic Health Initiatives Colorado d/b/a Centura Health – St. Anthony North Hospital,

v.

Defendant:

Earl Swensson Associates, Inc.

Rule Made Absolute
en banc
October 2, 2017

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JUSTICE BOATRIGHT delivered the Opinion of the Court.

¶1 In 2015, this court amended Colorado Rule of Civil Procedure 26(a)(2)(B) to provide that expert testimony "shall be limited to matters disclosed in detail in the [expert] report." In this case, the trial court concluded that this amendment mandates the exclusion of expert testimony as a sanction when the underlying report fails to meet the requirements of Rule 26. We conclude that the amendment created no such rule of automatic exclusion. Instead, we hold that the harm and proportionality analysis under Colorado Rule of Civil Procedure 37(c) remains the proper framework for determining sanctions for discovery violations. Because the trial court here did not apply Rule 37(c), we make our rule to show cause absolute and remand for further proceedings.

I. Facts and Procedural History

¶2 In March 2016, Catholic Health filed suit against architectural firm Earl Swensson Associates ("ESA") after ESA designed Catholic Health's new hospital, Saint Anthony North Health Campus ("Saint Anthony"). Catholic Health alleged that ESA breached its contract and was professionally negligent by failing to design Saint Anthony such that it could have a separately licensed and certified Ambulatory Surgery Center ("ASC").

¶3 In December 2016, Catholic Health filed its first expert disclosures, endorsing Bruce LePage and two others. Catholic Health described LePage as an expert with extensive experience in all aspects of preconstruction services such as cost modeling, systems studies, constructability, cost studies, subcontractor solicitation, detailed planning, client relations, and communications in hospital and other large construction projects. Catholic Health endorsed LePage to testify about the cost of adding an ASC to

Saint Anthony. LePage's expert report estimated that it would cost $11 million to "repair" the hospital. ESA then filed its own expert report, which opined that LePage's estimates were insufficiently detailed and, as such, unreasonable and unverifiable.

¶4 On March 6, 2017—the deadline to file pre-trial motions and thirty-five days before the trial was to begin—ESA filed a motion to strike Catholic Health's designation of LePage as an expert, arguing that his report failed to meet the requirements of Rule 26(a)(2)(B)(I). Specifically, ESA argued that LePage's report "fail[ed] to identify the information, facts, or assumptions on which he based his opinions, or the documents or other information that he considered." At a hearing on the motion, ESA argued that the lack of detail in LePage's report prevented ESA from being able to effectively cross-examine him. ESA further argued that striking LePage as an expert was the proper remedy because Rule 26(a)(2)(B)(I) limits expert testimony to opinions that comply with the Rule, and LePage offered no opinions in compliance.

¶5 In response, Catholic Health argued that the basis for LePage's opinion was his experience, which did not need to be included in the expert report or supplemented by a specific breakdown of cost estimates. Catholic Health also argued that, if LePage's report was insufficient, Rule 37(c) governed sanctions for these types of discovery violations. Specifically, Catholic Health contended that striking LePage, its only damages expert, would essentially end the case, and that such a drastic sanction was inappropriate under Rule 37(c)(1), as Catholic Health had not blatantly disregarded the rules, engaged in subterfuge, or made an untimely disclosure.

¶6 The trial court agreed with ESA and found that LePage's report included "bare numbers with little explanation" and lacked sufficient detail as to the basis for his opinions, meaning it did not comply with the requirements of Rule 26(a)(2)(B)(I). When determining the remedy, the trial court noted that it approached the issue with "trepidation" because Rule 26 had been recently amended. The court explained that the amendment to Rule 26 added a provision saying that expert testimony shall be limited to what is disclosed in detail in the expert's report. As such, the court decided to exclude LePage's expert report from evidence and to preclude LePage from testifying. The trial court explained that it believed Rule 26(a)(2)(B)(I) to be controlling on the question and that it did not consider Rule 37(c)(1) in its analysis.

¶7 Catholic Health then requested a continuance to amend and supplement LePage's expert report. After the trial court denied that request, Catholic Health filed a petition under C.A.R. 21, and we issued a rule to show cause. We chose to exercise our original jurisdiction under C.A.R. 21 because the improper exclusion of an expert witness would significantly prejudice Catholic Health by preventing any evidence of damages.

II. Standard of Review

¶8 We review a trial court's imposition of sanctions for discovery violations for an abuse of discretion. St. Jude's Co. v. Roaring Fork Club, L.L.C., 2015 CO 51, ¶ 39, 351 P.3d 442, 454. A trial court abuses its discretion when its ruling is manifestly arbitrary, unreasonable, or unfair, or based on a misapprehension of the law. See id.; Battle

North, LLC v. Sensible Housing Co., 2015 COA 83, ¶ 17, 370 P.3d 238, 245. We interpret rules of procedure de novo. Garrigan v. Bowen, 243 P.3d 231, 235 (Colo. 2010).

III. Applicable Law and Analysis

¶9 To explain the relationship between Rule 26(a)(2)(B)(I) and Rule 37(c)(1) after the 2015 amendments to each of those rules, we first examine their text and then look to applicable jurisprudence and the comments that accompany the rules. Against this backdrop, we conclude that Rule 37(c)(1) remains the controlling authority for determining sanctions for Rule 26 discovery violations, and that the trial court erred by not conducting the harm and proportionality analysis required by Rule 37(c)(1).

¶10 Rule 26(a)(2)(B)(I) defines the disclosure requirements for expert testimony. It requires that experts provide, among other things, a written report including all opinions that the expert intends to express at trial and all data or information upon which the expert based his or her opinion. Before 2015, this subsection concluded: "In addition, if a report is issued by the expert it shall be provided." C.R.C.P. 26(a)(2)(B)(I) (2014) (repealed 2015). In 2015, we amended the rule by deleting that phrase and replacing it with the following: "The witness's direct testimony shall be limited to matters disclosed in detail in the report."[1] C.R.C.P. 26(a)(2)(B)(I). In other words, the rule now requires an expert to prepare and disclose a report.

¶11 Rule 37(c)(1) works in conjunction with Rule 26 to authorize the trial court to sanction a party for failing to comply with discovery requirements, including those

[1] The other 2015 amendments to Rule 26(a)(2)(B)(I) slightly altered the Rule's exact requirements for an expert report; those changes are not relevant to the question we address today.

found in Rule 26(a). This rule was also amended in 2015. Before the 2015 amendments, Rule 37(c)(1) provided that a party who failed to disclose information required by Rule 26(a) without substantial justification may not present that undisclosed evidence "unless such failure is harmless." C.R.C.P. 37(c)(1) (2014) (repealed 2015). It also provided that "[i]n addition to or in lieu of this sanction, the court, on motion after affording an opportunity to be heard, may impose other appropriate sanctions." Id. Now, Rule 37(c)(1) provides that if a party lacks substantial justification for failing to disclose the information required by Rule 26(a), that party may not present the undisclosed evidence at trial unless the non-disclosure "has not caused and will not cause significant harm" to the opposing party, "or such preclusion is disproportionate" to any harm caused. C.R.C.P. 37(c)(1). For clarity, the rule was amended as follows:

> (c) Failure to Disclose; False or Misleading Disclosure; Refusal to Admit. (1) A party that without substantial justification fails to disclose information required by C.R.C.P. ~~Rules~~ 26(a) or 26(e) shall not~~, unless such failure is harmless,~~ be permitted to present any evidence not so disclosed at trial or on a motion made pursuant to C.R.C.P. 56, unless such failure has not caused and will not cause significant harm, or such preclusion is disproportionate to that harm. ~~In addition to or in lieu of this sanction, the court, on motion after affording an opportunity to be heard, may impose other appropriate sanctions, which, in addition to requiring payment of reasonable expenses including attorney fees caused by the failure, may include any of the actions authorized pursuant to subsections (b)(2)(A), (b)(2)(B), and (b)(2)(C) of this Rule.~~ The court, after holding a hearing if requested, may impose any other sanction proportionate to the harm, including any of the sanctions authorized in subsections (b)(2)(A), (b)(2)(B) and (b)(2)(C) of this Rule, and the payment of reasonable expenses including attorney fees caused by the failure.

Id. Both before and after being amended, Rule 37(c)(1)'s framework is flexible, not absolute, and the trial court has the discretion to fashion an appropriate sanction proportionate to any harm caused. See id.

¶12 Prior to the 2015 amendments, we clarified that Rule 37(c)(1) authorizes preclusion of undisclosed evidence under Rule 26(a) unless that sanction is not appropriate. Trattler v. Citron, 182 P.3d 674, 680 (Colo. 2008). When preclusion is inappropriate, the trial court should consider alternative sanctions. Id. In other words, when a party failed to disclose evidence as required by Rule 26(a), Rule 37(c)(1) was not an automatic rule of exclusion; rather, a trial court was required to examine the harm caused by the non-disclosure and to weigh the proportionality of any sanction it imposed. See id. at 680–82.

¶13 The 2015 amendment of Rule 26(a)(2)(B)(I) did not change this fundamental relationship between Rule 26(a) and Rule 37(c). By its plain text, Rule 37(c)(1) remains the enforcement mechanism for imposing sanctions for a "fail[ure] to disclose information required by [Rule] 26(a)." C.R.C.P. 37(c)(1). While, as the trial court noted, Rule 26(a)(2)(B)(I) does say that an expert's direct testimony "shall be limited," Rule 37(c)(1) still requires the trial court to assess the harm and determine the appropriate proportional sanction. Nothing in the text of amended Rule 26(a) altered this established scheme to create a rule of automatic exclusion.

¶14 In fact, a comment to Rule 26 addresses the amendment and emphasizes that "[r]easonableness and the overarching goal of a fair resolution of disputes are the touchstones." C.R.C.P. 26 cmt. 21. An automatic rule of exclusion is inconsistent with

that stated goal. Further, a comment accompanying the 2015 amendment of Rule 37 states: "Rule 37(c) is amended to reduce the likelihood of preclusion of previously undisclosed evidence . . . ." C.R.C.P. 37 cmt. 4. Again, interpreting the language in Rule 26(a)(2)(B)(I) to automatically exclude evidence because of non-disclosure would conflict with the stated goal of the amendment to Rule 37.

¶15 Accordingly, we hold that the harm and proportionality analysis under Colorado Rule of Civil Procedure 37(c)(1) remains the proper framework for determining sanctions for discovery violations. See, e.g., Todd v. Bear Valley Vill. Apartments, 980 P.2d 973, 978 (Colo. 1999) (laying out factors for the court to consider in its Rule 37(c)(1) analysis). As such, the trial court misapprehended the law and abused its discretion in excluding LePage as an expert without conducting the Rule 37(c)(1) harm and proportionality analysis.

IV. Conclusion

¶16 We conclude that Rule 37(c)(1)'s harm and proportionality analysis remains the analytical framework for the imposition of sanctions for discovery violations and that the trial court erred in not applying that analysis. We thus make our rule to show cause absolute and remand the case for the trial court to apply Rule 37(c)(1).

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-997-403-03

IN THE MATTER OF THE CLAIM OF:

EDWARD FLAKE,

Claimant,

v.

FINAL ORDER

JE DUNN CONSTRUCTION CO.,

Employer,

and

LIBERTY MUTUAL INS.,

Insurer,
Respondents.

The pro se claimant seeks review of an order of Administrative Law Judge Lamphere (ALJ) dated May 2, 2017, that ordered the respondents liable for the costs of emergency room care and two days of temporary total disability benefits. The order also denied the claimant's request for penalties, authorization of his personal physician, additional medical treatment for his right knee and additional disability benefits. We affirm the decision of the ALJ.

The claimant worked for the employer as a carpenter. On September 22, 2015, the claimant was assigned to frame an indoor area to contain a pad for a boiler. The claimant indicated the boiler room in which he was working featured a temperature of approximately 130°. After working several hours in that room, and then on the building's roof, he returned home. That night the claimant experienced profound and painful muscle cramping. The claimant was transported by ambulance to an emergency room where he was treated with intravenous fluids. The claimant was diagnosed with symptoms of dehydration.

The claimant sent a text message to his employer on September 23 stating he would not be at work that day. The claimant proceeded to see his personal physician, Dr. Voutsalath. Dr. Voutsalath recommended the claimant not return to work for a week. The claimant then, did not return to work until September 28. The claimant indicated that he self-limited his work duties after September 28. The claimant returned to see Dr.

Voutsalath on October 12. She suggested light duty work restrictions. The claimant presented a copy of these restrictions to the employer on October 12. He complained to his employer that his restrictions were related to his work injury of September 22. The claimant was provided a list of doctors from which he could choose a treating physician. The claimant selected the Centura Centers for Occupational Medicine (CCOM) clinic. The claimant was laid off due to the work restrictions on October 13.

Physician's Assistant (PA) Byrne saw the claimant at the CCOM clinic on October 13. PA Byrne found the claimant had recovered from his condition of dehydration. The claimant complained of cramping in his legs, thigh and right knee pain. PA Byrne obtained an X ray of the claimant's right knee. The PA concluded there was no evidence of any acute bony injury to the knee and the claimant was placed at maximum medical improvement (MMI) for his September 22 injury. The WC 164 form stating the claimant was at MMI without permanent impairment was signed by PA Byrne and by Dr. Olson, M.D.

The employer filed with the Division of Workers' Compensation a first report of injury for dehydration on October 14. The respondent insurance carrier submitted a Notice of Contest to the Division on November 2.

The claimant retained counsel who contacted PA Byrne and Dr. Olson concerning their medical determinations. Both responded, respectively in June 2016, and January 2017, that the claimant's continuing complaints of right knee injury were not caused by the September 22 episode of dehydration. They both reiterated the X ray, the injury description and the physical examination did not justify a recommendation for any further treatment. They noted the claimant was indeed at MMI on October 13, 2015. The respondent insurance carrier arranged an examination and report on the claimant's complaints from Dr. Bernton on January 30, 2017. Dr. Bernton concluded the claimant suffered an episode of heat exposure on September 22, 2015, featuring dehydration and rhabdomyolysis (muscle damage due to heat exhaustion), and mild impairment of renal function. These conditions were surmised to have been successfully treated in the emergency room and returned to baseline status without impairment or the need for further treatment. Dr. Bernton observed the claimant suffered from a preexisting degenerative disease of his right knee. An MRI of the knee in May 2015, revealed a degenerative tear of the medial meniscus. The claimant underwent arthroscopy on the knee in July 2015, performed by Dr. Redfern. The claimant followed up with Dr. Redfern in January 2016. A repeat MRI at that time showed a progression of degenerative changes, cartilage loss and an arthritic condition. A second arthroscopy was performed

in March 2016. In July 2016, Dr. Redfern documented continued complaints of right knee pain by the claimant.

On February 14, 2017, the respondents filed a Final Admission of Liability noting an MMI date of October 13, 2015, admitting for $316 in medical benefits, no temporary disability benefits and no permanent impairment benefits. The claimant requested a Division sponsored Independent Medical Examination (DIME), which was pending at the time of the ALJ's order.

The claimant completed an application for a hearing on January 11, 2017. The claimant endorsed as issues compensability, medical benefits, the average weekly wage, and temporary total disability benefits from October 14, 2015, and ongoing. The claimant also sought several penalties complaining the employer violated W.C. Rule of Procedure 5-2(A), 7 Code Colo. Reg. 1103-3, by not reporting an injury to the 'Division' within 10 days, it violated W.C. Rule 8-2(A)(1) by not providing the claimant with a list of designated treating physicians after he reported his injury, that the claimant was not placed at MMI by a designated physician instead of a PA, and that the insurance carrier was not allowed to arrange a medical examination by Dr. Bernton pursuant to § 8-42-107(8)(b)(II) C.R.S.

A hearing was convened on March 23, 2017. The claimant proceeded without benefits of legal counsel. The claimant testified, as did Dr. Bernton. The claimant has not provided a transcript of the hearing in support of his appeal.

The ALJ found the claimant did not prove he provided sufficient notice to his supervisor on September 28, 2015, when he returned to work that he had missed work and needed medical treatment due to his work related episode of dehydration on September 22. The ALJ ruled the claimant only advised the employer of a work related condition on October 12. Therefore, the employer timely provided the claimant a referral list of authorized doctors from which to choose. The ALJ ruled the claimant's treatment with Dr. Voutsalath was not authorized. The ALJ held that the claimant chose from this list the CCOM clinic. The ALJ therefore surmised that PA Byrne and Dr. Olsen were authorized medical treaters. The ALJ also found the filing of the First Report of Injury by the employer satisfied whatever obligations were imposed on the employer by W.C. Rule of Procedure 5-2. The ALJ held that the claimant was placed at MMI by PA Byrne on October 13, 2015. The ALJ determined that Dr. Olson approved of this determination when he counter signed the MMI report originally prepared by PA Byrne. All penalty claims were denied. The respondents were found to have accepted liability for a dehydration injury occurring on September 22, but not for a right knee injury.

Accordingly, the ALJ found the medical treatment the claimant required in the emergency room following the September 22 episode was the liability of the respondents. The ALJ also reasoned that the claimant proved his absence from work from September 23 through September 27 was made necessary by the effects of this admitted work injury. The ALJ ruled the first three days were not compensable due to the waiting period set forth in § 8-42-103(1)(a and (b), but that the claimant was entitled to temporary total disability benefits for the work he missed on September 26 and 27. The ALJ found the claimant's average weekly wage to be $800.

The ALJ adjudged Dr. Olson to be an authorized treating physician who had determined the claimant was at MMI on October 12, 2015. The ALJ also observed that a DIME request was pending, but had not been completed. Accordingly, the ALJ ruled he was currently without jurisdiction to determine MMI, the cause of the claimant's right knee symptoms, the relation of his knee surgery subsequent to October 13, 2015, or the compensability of additional medical treatment. Similarly, the ALJ concluded he was without jurisdiction to decide the claimant's eligibility for temporary disability benefits subsequent to October 13 or whether his average weekly wage should be increased after that date to include the cost of continuing his personal health insurance coverage.

The claimant pursues several allegations of error on appeal. It is argued the employer did not timely designate a medical provider. The claimant asserts he is entitled to temporary disability benefits beginning on October 14, 2015, and continuing. He contends the average weekly wage was incorrectly calculated and the cost of continuing medical insurance must be included. The claimant contends penalties are appropriate for several reasons. The claimant argues the employer did not timely report his injury, the respondents illegally filed a Final Admission based on the MMI finding of a physician's assistant, and the respondents should be penalized for their tardy referral to a designated physician.

I.

The claimant points to W.C. Rule 8-2 (1) as authority for his contention the employer did not timely provide him a list of designated treating physicians from which he could choose a treating doctor. The Rule states the employer is to provide a list of four physicians or corporate providers within seven business days "following the date the employer has notice of the injury." *See also*, § 8-43-404(5)(a)(I)(A) (the list is to be provided "in the first instance"). The claimant asserts several pieces of evidence prove he notified the employer of his work injury prior to October 12 when the employer gave him a provider list. The claimant states the employer's First Report of Injury specifies

the date of notification as September 23 and a document he attaches to his brief on appeal makes an identical statement. However, the First Report states the employer was notified only that the claimant had a heat injury on September 22, but does not indicate the employer was advised the injury was work related. The document attached to the claimant's brief was not submitted into evidence and we therefore may not consider it. In any event, the document is a computer summary of the First Report of Injury which would not prove anything more than would the First Report itself. The ALJ considered the claimant's testimony at the hearing and concluded the claimant most likely made a report to his supervisor of muscle pain or right knee pain without explaining the pain was related to an event at work. The ALJ found the claimant did not reveal this work connection to the employer until October 12 when he demanded to see a designated doctor. The claimant contends these findings are not supported by the evidence. Where the appealing party fails to procure a transcript of the hearing, we must presume the pertinent findings of fact are supported by substantial evidence. *Nova v Industrial Clam Appeals Office*, 754 P.2d 800 (Colo. App. 1988). The ALJ's factual determinations must be upheld if supported by substantial evidence and plausible inferences drawn from the record. Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *City of Colorado Springs v. Givan*, 897 P.2d 753 (Colo. 1995). Accordingly, we have little basis to rule the ALJ was in error in finding the claimant did not report his symptoms as work related until October 12. Since the employer provided the list of doctors required by W.C. Rule 8-2 on October 12, we agree with the ALJ that the employer was not in violation of the Rule and the medical providers at CCOM, including PA Byrne and Dr. Olson, were authorized to treat the claimant.

For the same reason, the claimant's assertion that his personal physician, Dr. Voutsalath, became authorized because the choice of physician had passed to the claimant is rejected.

II.

The claimant argues his average weekly wage (AWW) was improperly calculated. He contends that although his wage record states that for the week ending October 13, he was paid $800, that week featured 32 hours of work and he was hired to work a 40-hour week. He maintains his AWW should be $1,000. He also complains that the ALJ did not add the cost of continuing his health insurance coverage to the AWW following the claimant's October 13 lay off. The ALJ noted the claimant's statement that he most often earned $1,000 per week. However, the ALJ also remarked on the absence of corroborating evidence to support his statement. The ALJ instead, found more

authoritative the pay stub provided by the claimant that verified he was paid $800 in the week ending on October 13. The ALJ's factual determinations must be upheld if supported by substantial evidence and plausible inferences drawn from the record. The record contains substantial evidence to support this finding and we may not set it aside.

Section 8-40-201(19)(b) provides that 'wages' shall not include the employee's cost of continuing the employer's group health insurance plan if the employer continues to pay the cost of health insurance coverage. Because the employer continued to make that payment at least until October 13, it could not be included in the claimant's AWW before that date. The temporary benefits awarded were for dates prior to October 13 and were therefore calculated on an AWW that did not include the cost of continuing health insurance. The ALJ determined he was without jurisdiction to address temporary disability benefits, including the rate of those benefits, after a declaration of MMI by an authorized treating doctor. That occurred on October 13. *Chapman v. American Medical Response*, W.C. No. 4-600-029 (September 15, 2006); *Ayala v. Conagra Beef Co.*, W.C. No. 4-579-880 (July 22, 2004). Therefore, the ALJ was not in a position to add the cost of continuing health insurance to the AWW. We do not find error in this reasoning of the ALJ.

The ALJ also concluded that the finding of MMI by an authorized treating doctor is binding until revised by a DIME review. Consequently, the ALJ reasoned any issue that turns on the presumptive review of a DIME physician is not presently subject to adjudication by an ALJ. This was deemed to include the issues of MMI, a causal link between the claimant's knee symptoms and the conditions of work, and the reasonableness of disputed medical treatment such as the claimant's 2016, knee surgery. Pursuant to our decisions in *McCormick v. Exempla Healthcare*, W.C. No. 4-594-683 (January 27, 2006), *Chapman*, *supra* and *Ayala*, *supra*, we affirm this holding of the ALJ.

III.

The claimant maintains the employer and the ALJ were mistaken in finding the claimant was at MMI based upon the MMI determination of PA Byrne or of Dr. Olson. The claimant contends he was not seen by Dr. Olson on October 13, 2015, only by PA Byrne. The claimant also argues that it was PA Byrne that determined the claimant was at MMI on October 13, and not Dr. Olson. The claimant asserts that § 8-42-107(8)(b)(I) requires an 'authorized treating physician' to make the decision regarding MMI. He states that because PA Byrne is not a physician, his finding of MMI is not valid and the ALJ may not rely on it.

In *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002), the Court indicated a doctor is an authorized treating physician if the claimant was referred to the doctor to see the claimant for purposes of treatment and not "simply for purposes of providing a disability rating." The term "treatment" was said to cover all the steps taken to effect a cure of the injury. This included "examination and diagnosis as well as application of remedies." The record indicates the respondents offered the CCOM clinic to the claimant as a medical provider. The referral was not for the sole purpose of litigation. The ALJ's conclusion that claimant's referral to CCOM on October 13 was for the purpose of diagnosis and examination is supported by substantial evidence.

In *Bassett v. Echo Canyon Rafting*, W.C. No. 4-260-804 (April 3, 1997) and in *Terry v. Captain D's Seafood Restaurant*, W.C. No. 4-226-464 December 9, 1997), we held that medical determinations made by physician assistants while under the direction and control of an authorized physician may be adopted by the physician and relied upon as a decision of the physician himself. The Director authored an Interpretive Bulletin dated January 16, 2003, addressing the role of PAs concerning legally significant medical determinations, including a finding of MMI. The Director noted state statute, § 12-36-106(5) C.R.S., allows PAs to work under a physician's direction. The Director resolved that as long the physician remains responsible for the supervision of the PA, "it appears that a physician's assistant may impose medical restrictions … and may offer an opinion as to the claimant's medical condition." The Director did require the physician "to countersign any Physician's Report of Workers' Compensation Injury (Form WC 164), opinions regarding return to work or any other reports relating to benefits issued by a physician's assistant." Accordingly, in *MacDougall v. Bridgestone Retail Tire Operations LLC*, W.C. No. 4-908-701-07 (April 12, 2016), we held that a WC 164 form completed by a PA and finding MMI would be accepted as a finding of MMI by an authorized treating physician. Although the physician was out of the office on the date the form was completed, the physician later adopted the MMI opinion by countersigning the PA's report.

In this matter, Dr. Olson also countersigned the WC 164 form completed by PA Byrne finding the claimant was at MMI. (Exhibit L). Dr. Olson also wrote a January 23, 2017, letter specifically stating he agreed with the October 13, 2015, determination of MMI by PA Byrne. The ALJ's factual determinations must be upheld if supported by substantial evidence and plausible inferences drawn from the record. The October 13, 2015, WC 164 form finding MMI and signed by both PA Byrne and by Dr. Olson is substantial evidence to support the finding of the ALJ that the claimant was placed at MMI on that date by an authorized treating physician.

IV.

The claimant contends the respondents should be penalized for filing a Final Admission of Liability (FAL) that is not supported by the medical reports attached in violation of the rules (W. C. Rule of Procedure 5-5). Because the FAL could not legitimately be filed on the date it was mailed, based as it was on a finding of MMI, the FAL is of no effect regardless of the medical reports attached.

The FAL was filed on February 14, 2017. The FAL was premature. The Supreme Court indicated in *Harman-Bergstedt, Inc. v. Loofbourrow*, 320 P.3d 327 (Colo. 2014), that a "finding of 'maximum medical improvement' can apply only to injuries as to which disability indemnity is payable." In a case that "did not result in excess of three day's lost work time, no … admission of final liability was possible." On February 14, the respondents had not awarded the claimant any TTD benefits, nor had any ALJ made such an award. Accordingly, on that date "no admission of final liability was possible."

The *Loofbourrow* decision stated a claim becomes "compensable" to the extent that MMI has legal significance, when disability benefits are "payable." The decision was referring to the provision in § 8-42-103(1) that "a disability indemnity shall be payable as wages … subject to the following limitations: (a) If the period of disability does not last longer than three days from the day the employee leaves work as a result of the injury, no disability indemnity shall be recoverable." The decision also references the term 'payable' as used in § 8-43-103(1) and refers to injuries described in § 8-43-101(1). *Loofbourrow*, *supra*, 320 P.3d at 330. Sections 8-43-101(1) and 8-43-103(1) define injuries for which "compensation and benefits are payable" as including "injuries that result in fatality to, or permanent physical impairment of, or lost time from work … in excess of three shifts or calendar days." The term "payable" refers to the presence of conditions specified in a statute or rule that entitles a claimant to a particular benefit. Accordingly, for purposes of MMI a claim becomes payable when the injury causes more than three days loss of work, permanent impairment or death.

At the point the FAL was filed, the claimant insisted he did have a compensable claim that caused the loss of more than three days from work. Following the hearing, the ALJ agreed the claimant missed more than three workdays due to a work related injury. However, when respondents dispute that more than three days of work have been missed, either because the alleged injury was not work related, the claimant was capable of regular work or for other reasons, they may contest the claim and are not under an obligation to pay disability benefits until an ALJ adjudicates the dispute. In *Moseley v.*

U.S. Express Enterprises, Inc., W.C. No 4-530-546 (December 13, 2002), the claimant alleged the respondents violated the requirements of § 8-43-103(1) when the respondents failed to begin payment of temporary disability benefits after the claimant missed three days of work. We held benefits are not payable until an ALJ finds the prerequisite conditions for benefits set forth in § 8-43-301(1) are in fact present:

> Section 8-42-103(1), C.R.S. 2002, provides that where the industrial injury causes a disability which results in more than 3 days lost time from work, the respondents shall pay temporary disability benefits in accordance with § 8-42-105.
>
> **…**
>
> However, § 8-42-103(1) does not preclude the respondents from disputing whether the industrial injury has caused a "disability" which warrants the payment of temporary disability benefits for a particular period. Instead, the respondents may deny liability for temporary disability benefits until the claimant establishes the existence of a "disability" during a hearing before an ALJ.

Id. As a result, a claim does not become retroactively compensable. The status of the claim as one featuring payable disability payments is only effective when the ALJ's order becomes final.

Here, the ALJ did not find this claim featured payable indemnity benefits until his order was submitted on May 2, 2017. Any contrary notice of contest or inconsistent admission previously filed became ineffectual. Accordingly, the Director has adopted W.C. Rule of Procedure 5-5(C)(1). That rule provides that respondents must file a new admission consistent with any order that alters the payment of benefits. The new admission must be filed within 30 days of the date the order becomes final. In this case, the respondents have not appealed the ALJ's order awarding two days of temporary disability benefits. Because the ALJ has also found an authorized treating physician has announced the claimant is at MMI, the respondents will be required to file a new FAL (or file a General Admission and request a DIME review). W.C. Rule 5-5(E)(a) or (b). Consequently, the respondents previous FAL is moot. *Kazazian v. Vail Resorts*, W.C. No. 4-915-969-03 (April 24, 2017); *Paint Connection Plus v. Industrial Claim Appeals Office*, 240 P.3d 429 (Colo. App. 2010) (failure to properly file an FAL renders the admission void ab initio).

Similarly, the claimant's assertion of a penalty due to the employer's' failure to timely report the injury to the Division pursuant to § 8-43-101(1) does not apply. In *Urtusuastegui v. JBS USA, LLC*, W.C. No. 4-795733 (November 8, 2010) the claimant did not miss work for more than a year following the date of his injury. Because indemnity benefits were not payable for a year, we found the respondents were not required by § 8-43-101(1) to report the claim to the Division:

> We do not read § 8-43-103(1) as imposing on the employer a requirement to report all injuries to the Division, even injuries where there is no lost time, when § 8-43-101(1) specifically provides that the employer is exempt from reporting such injuries in cases where there is no lost time in excess of three shifts.
>
> **…**
>
> To the extent that the claimant argues that insurer's failure to admit or deny the claim within 20 days of when the First Report of Injury should have been filed with the Division and the First Report should have been filed immediately, we reject that argument. For the reasons noted above, it is our opinion that the requirement for filing with the Division did not occur until the claimant began to lose time from work following the surgery.

Id.

In addition, the assertion by a claimant that he has missed three days of work is subject to dispute by the respondents. Until that dispute is resolved by an ALJ, the respondents are not required to treat the claim as one requiring the payment of indemnity benefits. *See*, *Flores v. Willbros Construction*, W.C. No. 4-900-068-03 (January 13, 2014).

Accordingly, we find no compelling reason to attribute error to the decision of the ALJ and affirm the ALJ's order.

IT IS THEREFORE ORDERED that the ALJ's order issued May 2, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Examiner DeFalco-Galvan submits a Concurring opinion:

I would also affirm the ALJ's order and agree with the analysis in parts I-III of the opinion above. I disagree, however, with the reasoning in part IV and the application of *Harman-Bergstedt, Inc. v. Loofbourrow*, 320 P.3d 327 (Colo. 2014), to invalidate the February 14, 2017, final admission of liability under the facts of this case.

The claimant makes a general assertion that the respondents "should be penalized for filing the Final Admission based on an unlawful determination of MMI and no impairment rating, rendered by a mere physician's assistant." Claimant's Brief at 10. In view of the resolution of the issue of the physician's assistant in part III and the conclusion that the physician's assistant's opinion is valid, the claimant's request for penalties on this basis necessarily fails because there has been no violation of a statute, rule or order. *Allison v. Industrial Claim Appeals Office*, 916P.2d 623 (Colo. App. 1995).

The facts in *Loofbourrow* are distinguishable from the facts in the present case. Most notably, there was no final admission of liability in *Loofborrow*. Additionally, unlike *Loofbourrow*, the claimant here missed time from work before the MMI determination was made and before the final admission of liability was filed. Even assuming the rationale in *Loofbourrow* applies here, *Loofbourrow* states that a claim becomes compensable to the extent that MMI has legal significance when disability benefits are "*payable*." I do not read *Loofbourrow* to require that compensation benefits must actually be "*paid*" before there can be a valid MMI determination. There must be a mechanism for the respondents to contest payment of requested benefits, such as was done here with the final admission of liability. The benefits were arguably "payable" in the present case prior to the MMI determination, and in fact, were ultimately ordered to be paid. In my view, the fact that benefits were initially contested by the respondents

does not change the legal significance of an MMI determination to invalidate the final admission of liability.

Brandee DeFalco-Galvin

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Industrial Claim Appeals Office
633 17th Street, Suite 200
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Office of the Attorney General
State Services Section
Ralph L. Carr Colorado Judicial Center
1300 Broadway 6th Floor
Denver, CO 80203

CERTIFICATE OF MAILING

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

9/19/17 by TT .

EDWARD FLAKE, PO BOX 1619, PALMER LAKE, CO, 80133 (Claimant)
CONDIT CSAJAGHY LLC, Attn: CHRISTOPHER CONDIT, ESQ, 695 SOUTH COLORADO BLVD #270, DENVER, CO, 80246 (For Respondents)
DOWC SPECIAL FUNDS UNIT, Attn: ILIANA GALLEGOS, 633 17TH ST SUITE 400, DENVER, CO, 80202 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-034-260-01

IN THE MATTER OF THE CLAIM OF

DENNIS GIBBONS,

Claimant,

v.

FINAL ORDER

PROGRESSIVE ROOFING,

Employer,

and

ARCH INSURANCE COMPANY
c/o GALLAGHER BASSET SERVICES,
Third Party Administrator,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Felter (ALJ) dated May 25, 2017, that determined the claimant's injury was compensable and ordered the respondents liable for medical and temporary total disability (TTD) benefits. We affirm.

This matter went to hearing on whether the claimant sustained bilateral inguinal hernias during the course and in the scope of his employment, medical benefits, average weekly wage (AWW), TTD benefits, and the respondents' right to an offset for the claimant's receipt of unemployment insurance benefits.

After the hearing, the ALJ found that the claimant worked as a roofer for the respondent employer in October 2016. In "late October 2016," the claimant was working for the respondent employer and carrying some light material when he tripped over several conduit pipes on a flat roof. The claimant felt a pull in his groin area as a result. Over the ensuing days, the claimant's groin pain worsened.

On November 8, 2016, after the claimant's employment had been terminated for being a no call/no show, he returned to the employer to report his injury. In his written report, the claimant indicated that he did not previously report this injury to the employer.

He also indicated that he already had gone to a physician at Denver Health and Hospitals and was told he needed to follow up.

Medical records from Denver Health and Hospitals establish that the claimant did not seek out any medical treatment until November 10, 2016. The claimant was diagnosed with bilateral inguinal hernias.

The respondents' designated physicians, including Dr. Counts and Dr. Bloch, opined that the claimant's condition arose from work. While their opinions were dependent on the history given them by the claimant, they nevertheless opined that the mechanism of injury as described by the claimant caused the bilateral inguinal hernias.

Authorized treating physician (ATP), Dr. Weaver, eventually repaired the claimant's bilateral hernias on January 11, 2017. The claimant's ATPs have placed him on work restrictions and he is unable to work his pre-injury employment as a roofer. The ATPs have not placed the claimant at maximum medical improvement, and the claimant has not worked or earned wages since December 12, 2016.

At the request of the respondents, Dr. Lesnak performed a medical records review. He opined that the claimant's injury could not have occurred the way in which the claimant described since it did not involve a forceful Valsalva maneuver.

Prior to October 2016, the claimant had no ongoing symptoms or functional limitations in his bilateral inguinal groin area, and he had worked full duty without restrictions since his date of hire on September 22, 2016. In fact, before being hired by the respondent employer, the claimant had been examined by another potential employer in February 2016 and was found to have no symptoms and/or hernias at that time. Nevertheless, the claimant had suffered prior hernias. He injured the exact part of his body 20 years ago at age 16. However, the claimant failed to mention to the employer that he also had undergone a surgical repair of his right hernia about one year prior to reporting the injury at issue.

During the ensuing hearing, the claimant testified that he sustained his work injury on October 18, 2016. However, the employer's time cards reflected that the claimant worked on October 16, 17, 19, and 20, 2016, but not on October 18, 2016. The claimant did not have an explanation for the discrepancy in the employer time cards.

The employer's payroll records reflect that the claimant worked the week of October 15, 2016, for 38.50 hours. Yet, these same payroll records indicate that the

claimant last worked on October 15, 2016, and had voluntarily resigned for a no call/no show on that date, but was reinstated on October 20, 2016. The ALJ found that if the claimant had worked 38.50 hours the week of October 15, 2016, then he would have worked on October 20, 2016. The records further reflect that on October 20, 2016, the claimant was involuntarily terminated for being a no call/no show on October 26, 27, and 28, 2016.

The ALJ ultimately determined that the claimant sustained work-related bilateral inguinal hernias in "late October 2016." The ALJ credited the claimant's testimony regarding the mechanics of his injury. The ALJ also credited the claimant's ATPs and expressly rejected the opinion of Dr. Lesnak. Regarding the date of the claimant's work injury, the ALJ found the claimant was mistaken about the actual date of the injury. The ALJ also found that the employer payroll records were not reliable. The ALJ ordered the respondents liable for TTD and medical benefits. He also ordered that the respondents were entitled to a 100% offset for unemployment benefits that the claimant had received.

I.

On appeal, the respondents argue that substantial evidence does not support the ALJ's finding that the claimant sustained a compensable injury in "late October 2016." In support of their argument, the respondents contend that the claimant was not even working on the date he claimed to have suffered his injury, or on October 18, 2016. They also argue the ALJ abused his discretion in making this finding. Further, the respondents point to inconsistencies in the claimant's testimony, and argue the ALJ erred in crediting the claimant's testimony that he suffered a work-related injury. They argue the claimant testified regarding an incorrect date when he went to Denver General Hospital for treatment, he failed to report to the employer his surgical hernia repair one year prior to his reporting of the injury at issue, and they highlight the claimant's prior sixth degree felony for knowingly providing false information to a pawnbroker regarding the sale of items. We perceive no reversible error.

The claimant has the burden to prove that his disability was proximately caused by an injury arising out of and in the course of his employment. Section 8-41-301(1)(c), C.R.S. Whether the claimant met that burden of proof is a factual question for resolution by the ALJ, and his determination must be upheld if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). 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. *Id*.

This standard of review requires that we consider the evidence in the light most favorable to the prevailing party, and defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003). Accordingly, we are bound by the ALJ's credibility determinations unless the testimony credited by the ALJ is rebutted by such hard, certain evidence to the contrary that it would be error as a matter of law to believe that testimony. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986). Consequently, the existence of conflicting testimony or evidence that would support a contrary result does not provide a basis for setting aside the order. *See Mountain Meadows Nursing Center v. Industrial Claim Appeals Office*, 990 P.2d 1090 (Colo. App. 1999).

Here, the ALJ's finding that the claimant was injured in "late October 2016" is supported by substantial evidence, and the ALJ did not abuse his discretion in making this finding. It is true, as the respondents argue, the claimant was adamant that his injury occurred on October 18, 2016, and there is evidence indicating the claimant did not work on that date. However, it was the ALJ's sole prerogative as the fact finder to resolve the conflicts in the evidence. *See Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997)(ALJ's prerogative to evaluate evidence "extends to resolving the inconsistencies in a particular witness' testimony"); *Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31, 32-33 (Colo. App. 1990)(reviewing court is bound by resolution of conflicting evidence, regardless of the existence of evidence which may have supported a contrary result). Further, it is well settled that an ALJ may credit all, part, or none of a witness' testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968). The ALJ resolved the discrepancy in dates by finding that the claimant was simply mistaken on the date he suffered his bilateral inguinal hernias. Order at 3 ¶5. This was a reasonable inference from the evidence. *See London v. Tricon Kent,* W.C. No. 3-993-471 (April 2, 1992)(it is not required that exact date and time be identified; rather, ALJ may determine that the claimant's testimony of a specific incident attributed to a reasonably definite time is sufficient); *see also Puderbaugh v. Kabance Janitorial Service*, W.C. No. 3-895-248 (Jan. 8, 1990)(inconsistencies in the evidence concerning exact date on which injury occurred do not render claimant's testimony concerning occurrence of the injury incredible as a matter of law). The ALJ further noted that there were several anomalies in the employer's time records which confused the matter of dates surrounding the claimant's injury, and when the claimant worked. He found that the employer's payroll records were not reliable. Regardless, the ALJ also found that there was no discrepancy in the claimant's description of the mechanism of injury. He credited the claimant's testimony that he was working for the employer and was carrying some material when he tripped over conduit pipes on the roof and felt a pull

in his groin. Tr. at 15-16, 18, 23, 24-25. It was reasonable for the ALJ to infer from this evidence that the discrepancy in dates was not dipositive of whether the claimant sustained a compensable injury. Order at 3-4 ¶¶7, 9, 11, 13. Thus, while there was conflicting evidence, we conclude that it does not rise to the standard which would permit us to disturb the ALJ's credibility determinations. *See Halliburton Services v. Miller, supra*.

Moreover, the respondents argue the ALJ erred in failing to address the claimant's delay in seeking medical treatment. However, the ALJ need not make findings concerning every piece of evidence and every possible inference provided the basis of the order is apparent from the findings and conclusions which are entered, which is the case here. As such, evidence not specifically addressed is presumed to have been rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Additionally, in support of their argument that the ALJ erred in determining the claimant sustained an industrial injury in "late October 2016," not only do the respondents cite to the employer's time records, which the ALJ found not to be reliable, but they also cite to the opinions of their medical expert, Dr. Lesnak. However, the ALJ expressly found Dr. Lesnak's opinions not credible. The relative weight and credibility to be assigned competing expert medical opinions is the ALJ's province as fact finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). We may not re-weigh the evidence in an attempt to reach a result that is different from that of the ALJ. *Sullivan v. Industrial Claim Appels Office*, 796 P.2d 31, 23-33 (Colo. App. 1990). Regardless, it is clear that the ALJ recognized the inconsistencies in the claimant's testimony and he found certain testimony to be "troublesome," but he nevertheless thoroughly considered such evidence when reaching his determination. Based on the totality of the evidence, the ALJ was not convinced that the inconsistent and "troublesome" testimony outweighed the evidence which demonstrated the claimant sustained a work-related injury in late October 2016. We are not persuaded that the ALJ's credibility determinations are rebutted by such hard, certain evidence to the contrary that it would be error as a matter of law to believe such testimony. *Halliburton Services v. Miller, supra*. Consequently, we may not disturb the ALJ's order on these grounds.

To the extent the respondents argue that the ALJ erred in shifting the burden of proof to them to prove there was a non-work cause to the claimant's injury, we again are not persuaded there is any reversible error. In his Order, the ALJ expressly stated that the respondents were not required to offer another plausible cause of the claimant's bilateral

inguinal hernias. Order at 5 ¶17. Indeed, the ALJ expressly held that the claimant had the burden of proving he sustained an injury during the course and in the scope of his employment. Order at 2, 12 ¶c. Section 8-41-301(1)(c), C.R.S. As such, we may not disturb the ALJ's order on this ground.

Based on our conclusion above, we also are not persuaded the ALJ erred in awarding the claimant medical and temporary indemnity benefits. Sections 8-42-101, C.R.S., 8-42-103, 8-42-105, C.R.S.

II.

The respondents also argue that the ALJ erred in determining that the claimant's AWW is $640. In support of their argument, the respondents claim that even though the claimant was hired full-time, the evidence nevertheless establishes he never worked a 40-hour work week the entire tenure of his employment. Again, we perceive no reversible error.

Section 8-42-102(2), C.R.S. sets forth the method for calculating a claimant's average weekly wage. An ALJ has broad, statutorily granted discretion to calculate AWW "in such other manner and by such other method as will, in the opinion of the director based upon the facts presented, fairly determine such employee's [AWW]." Section 8-42-102(3), C.R.S.; *see also Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867, 869 (Colo. App. 2001)("[Section] 8-42-102(3). . . grants the ALJ discretionary authority to calculate the [AWW] in some other manner if the prescribed methods will not fairly calculate the wage in view of the particular circumstances."). The overall purpose of the statutory scheme is to calculate "a fair approximation of the claimant's wage loss and diminished earning capacity." *Campbell v. IBM Corp*., 867 P.2d 77 (Colo. App. 1993). We may not interfere with the ALJ's order unless an abuse of the ALJ's discretion in the application of the statute is shown. An abuse of discretion exists if the ALJ's order is beyond the bounds of reason, as where it is contrary to law or unsupported by the evidence. *Pizza Hut v. Industrial Claim Appeals Office*, *supra.*

Here, the respondents' argument notwithstanding, we conclude the ALJ did not abuse his discretion in determining that the claimant's AWW is $640. During the hearing, the claimant testified that he was hired to work at least 40 hours a week. He further testified that he was hired as a full-time employee at $16 an hour. Tr. at 11-12l Ex. 4 at 10. Section 8-43-301(8), C.R.S. The existence in the record of evidence that would support a contrary result is irrelevant on appeal. *Cordova v. Industrial Claim Appeals Office*, *supra*.

IT IS THEREFORE ORDERED that the ALJ's order dated May 25, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

NOTICE

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Denver, CO 80203

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LAW OFFICE OF OTOOLE & SBARBARO PC, Attn: JOHN A SBARBARO ESQ, 226 WEST TWELFTH AVENUE, DENVER, CO, 80204-3625 (For Claimant)
POLLART MILLER LLC, Attn: ERIC J POLLART ESQ, 5700 S QUEBEC STREET SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-969-386-08

IN THE MATTER OF THE CLAIM OF:

VALENTIN CASTANEDA NOYOLA,

Claimant,

v.

ORDER OF REMAND

DAVIE ROOFING, LLC, and
ECO ROOF AND SOLAR, INC.

Employers,

and

TEXAS MUTUAL INSURANCE and
PINNACOL ASSURANCE,

Insurers,
Respondents.

The claimant and respondent, Davie Roofing LLC, seek review of an order of Administrative Law Judge (ALJ) Cannici dated April 26, 2017, insofar as it dismissed respondents, Eco Roof and Solar and Pinnacol Assurance, from the claim. We set aside the ALJ's dismissal of Eco Roof and Solar and Pinnacol Assurance and remand for further proceedings.

This matter came to hearing on the issues of whether the claimant sustained a compensable injury on September 26, 2014, and whether he was entitled to medical and temporary disability benefits. The ALJ also listed the issue of whether the claimant "demonstrated by a preponderance of the evidence that Eco Roof and Solar is a statutory employer pursuant to §8-41-401(2), C.R.S." After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. Eco Roof and Solar obtained a contract for roofing work at 4400 South Fox in Englewood, Colorado. Eco Roof and Solar subcontracted the work to Davie Roofing, LLC, which is operated by Victor Lopez Zapata. Davie Roofing, LLC, hired Jose Lopez who in turn employed the claimant.

On September 26, 2014, the claimant was working on the project located at 4400 South Fox in Englewood, Colorado. As he was walking on the roof carrying shingles the roof collapsed under his left leg. The claimant's left leg plunged into a hole up to his hip

area. The claimant testified that when his left leg plunged into the hole he experienced pain in his left knee and waist. After a short break he was able to complete his work for the day. At the end of his shift the claimant reported his injury to Mr. Lopez. Mr. Lopez, however, did not have insurance. Mr. Lopez, therefore, reported the claimant's injury to Mr. Zapata of Davie Roofing, LLC. The claimant waited an additional two weeks to seek medical treatment while Mr. Zapata checked his insurance status. The claimant continued working until October 9, 2014, when he stopped working because of his injury.

The claimant eventually went to the Denver Health Medical Center Emergency Room on October 28, 2014, with complaints of neck, back, left knee, left foot and right foot pain. The claimant was diagnosed with a non-displaced comminuted fracture of the left knee patella, a thoracic strain and a foot strain. The claimant received a knee immobilizer, crutches and pain medication. The claimant continued to seek medical treatment on his own with Denver Health complaining of conditions consistent with his initial complaints. The claimant has not worked since October 9, 2014, with the exception of occasionally helping his cousin in performing landscaping duties.

Mr. Zapata, owner of Davie Roofing, testified at the hearing in this matter. Mr. Zapata explained that he began his roofing business in Texas and expanded his operations into Colorado in 2013. Mr. Zapata testified that he purchased a workers' compensation insurance policy from Texas Mutual Insurance on June 25, 2014, to cover his Texas and Colorado operations. Mr. Zapata stated that he purchased the policy under his business name, Davie Roofing, LLC, and submitted a payment of $2600.00.

Dylan Lucas, owner of Eco Roof and Solar testified that the company required all subcontractors to carry both workers' compensation insurance and liability insurance and that this is part of the agreement Eco Roof and Solar established with all subcontractors. Eco Roof and Solar is insured by Pinnacol Assurance for workers' compensation claims.

The ALJ found that before Mr. Zapata received work from Eco Roof and Solar, he contacted Texas Mutual insurance and spoke with a representative in order to confirm he was covered for workers' compensation. Mr. Zapata provided the representative of Texas Mutual Insurance with the address and FAX number of Eco Roof and Solar in Colorado. A representative of Eco Roof and Solar subsequently confirmed to Mr. Zapata that she had received notice that Davie Roofing, LLC, was insured for work injuries. Davie Roofing, LLC, then received work from Eco Roof and Solar. A Certificate of Insurance was issued by Texas Mutual Insurance through Northwest Insurance Agency of Dallas, Texas on October 28, 2014. Claimant's Exhibit 2. The Certificate of Liability Insurance certifies that a workers' compensation insurance policy was issued to Davie

Roofing, LLC, for the policy period indicated. Davie Roofing LLC, is listed as the insured and Eco Roof and Solar is listed as the certificate holder. The policy included worker's compensation insurance and employer liability limits of $1,000,000. The dates of coverage for the workers' compensation insurance policy are June 26, 2014, through June 26, 2015. The claimant's injury which occurred on September 26, 2014, is within the period listed by the Certificate of Insurance.

The ALJ found that the claimant demonstrated that he suffered a compensable injury during the course and scope of his employment on September 26, 2014, and that he is entitled to reasonable, necessary and related medical benefits and temporary total disability benefits from October 9, 2014, and continuing with credit for the time the claimant performed landscaping services for his cousin.

The ALJ also went on to find that the claimant failed to demonstrate that it is more probably true than not that Eco Roof and Solar is a statutory employer. The ALJ found that Mr. Lopez lacked workers' compensation insurance coverage but that the claimant failed to establish that Davie Roofing, LLC, as a subcontractor of Eco Roofing and Solar, lacked workers' compensation insurance. The ALJ relied on the fact that Mr. Zapata said he purchased the policy from Texas Mutual Insurance and that a Certificate of Insurance was issued to Eco Roof and Solar showing that Davie Roofing, LLC, had workers' compensation coverage from June 26, 2014, through June 26, 2015. The ALJ found that there was no evidence presented at hearing that that Texas Mutual Insurance withdrew, recanted or denied the Certificate of Insurance issued to Eco Roof and Solar on behalf of Davie Roofing, LLC. The ALJ also found that Texas Mutual Insurance received notice and opportunity to defend its position at hearing but chose not to appear for the matter. The ALJ concluded that because Davie Roofing, LLC possessed a valid Colorado Workers' Compensation insurance policy through Texas Mutual Insurance on September 26, 2014, Davie Roofing, LLC, is the claimant's statutory employer and dismissed Eco Roofing and Solar and Pinnacol Assurance from the claim.

On appeal the claimant and Davie Roofing, LLC, argue that the ALJ erred in dismissing Eco Roof and Solar and Pinnacol Assurance as the statutory employer. We agree that the ALJ appears to have misapplied the law and the findings are insufficient to permit appellate review. We, therefore, set aside the ALJ's order and remand the matter for further proceedings.

The claimant and Davie Roofing, LLC, both contend that the ALJ misapplied the burden of proof in requiring the claimant to show that Davie Roofing, LLC was uninsured. We agree.

Section 8-43-201, C.R.S. places the burden on the claimant to prove his entitlement to benefits by a preponderance of evidence and workers' compensation benefits are only payable for injuries which arise out of and in the course of employment. Section 8-41-301(1)(b), C.R.S. Consequently, the claimant bore the initial burden to prove he suffered an injury arising out of and the course of an employee/employer relationship.

An employee is a person who "performs services for pay for another." Section 8-40-202(2)(a), C.R.S. Section 8-41-401(1)(a), C.R.S., creates a statutory employment relationship where a company contracts out part or all of its work to any subcontractor. Section 8-41-401(1)(a), C.R.S., renders a general contractor liable for injuries to employees of a subcontractor if the general contractor contracted out part of its regular business operation to the subcontractor. Further, subsection 8-41-401(1)(b), C.R.S., requires the statutory employer to insure and keep insured against all liability for injuries to the employees of subcontractors but allows the statutory employer to recover the cost of such insurance from the subcontractor.

Section 8-41-401(2), C.R.S., prevents an injured employee from reaching "upstream" to impose liability on the general contractor if the subcontractor has procured insurance which covers the injury. This statutory scheme is designed to prevent employers, such a general contractors, from avoiding liability for workers' compensation injuries associated with their projects by contracting out the work to uninsured subcontractors. *Finlay v. Storage Technology Corp.*, 764 P.2d 62 (Colo. 1988). The statutory exemption created by § 8-41-402, C.R.S., is an affirmative defense to the contracting employer's liability as the statutory employer. *See Postlewait v. Industrial Claim Appeals Office*, 905 P.2d 21 (Colo. App. 1995); *cf. Valley Tree Service v. Jiminez*, 787 P.2d 658 (Colo. App 1990), *partially overruled on other grounds*, 823 P.2d 709 (Colo. 1992); *Stampados v. Colorado D & S Enterprises, Inc.*, 833 P.2d 815 (1992)(whether claimant is an independent contractor is an affirmative defense on which the employer bears the burden of proof). This is true because in the absence of proof that the subcontractor was also an insured employer, the statutory employer remains solely liable for the work-related injuries of the employees of the subcontractor. *See Buzard v. Super Walls Inc.*, 681 P.2d 520 (Colo. 1984); *City and County of Denver v. Industrial Claim Appeals Office*, 58 P.3d 1162 (Colo. App. 2002); *Trujillo v. United Medical Group and/or Mariner Health of Denver*, W.C. No. 4-537-815 (March 12, 2004).

Here, the ALJ determined, and the parties do not dispute, that the claimant sustained his burden to prove that he sustained a compensable injury. There is also record support and no dispute from any of the parties that Eco Roof and Solar contracted

out its roofing business to Davie Roofing, LLC and Davie Roofing LLC, hired Jose Lopez, who in turn hired the claimant. Therefore, the record supports the ALJ's finding the claimant sustained his burden to prove he suffered a work-related injury arising out of his statutory employment with Eco Roof and Solar. It follows that Eco Roof and Solar is solely liable for the claimant's injuries unless they can establish their immunity under § 8-41-401(2), C.R.S. by showing that there was a subcontractor with workers' compensation insurance in place to cover the claimant.

Additionally, the ALJ's reliance on the Certificate of Insurance provided to Eco Roof and Solar to establish the existence of workers' compensation insurance is misplaced. By its plain language, §8-41-401(2), C.R.S., requires that the subcontracting employer maintain insurance covering its liability for compensation. The statute provides that if a lessee, contractor, or subcontractor "is also an employer in the doing of such work and, . . . insures *and keeps insured its liability for compensation*," then the "lessee, contractor, or subcontractor, its employees, or its insurer" shall have no right of action against the putative statutory employer which is contracting out its business. (*emphasis added)*. Thus, if the subcontracting employer maintains insurance covering its "liability for compensation," the party contracting out its business is immune from claims for workers' compensation benefits by the subcontractor's employees. *See Buzard v. Super Walls, Inc., supra; Campbell v. Black Mountain Spruce, Inc.,* 677 P.2d 379 (Colo. App. 1983).

In order to obtain the immunity conferred by §8-41-401(2), C.R.S., Eco Roof and Solar were obligated to establish not only that Davie Roofing, LLC, purchased a policy of workers' compensation insurance, but that the policy covered the claimant at the time of the injury. Otherwise, Davie Roofing, LLC would not have insured its "liability for compensation" within the meaning of the statute. The existence of a Certificate of Insurance does not operate to shield a statutory employer from liability for workers' compensation benefits. *Pinnacol Assurance v. Hoff*, 2016 CO 53 (Colo. June 27, 2016). Rather, Eco Roof and Solar was required to show that there was coverage in place for the claimant and not just a Certificate of Insurance representing that coverage existed. Thus, insofar as the ALJ concluded that the *mere existence* of a workers' compensation policy covering Davie Roofing, LLC, immunized the Eco Roof and Solar respondents, he erred.

Because it is impossible to ascertain how the ALJ would have assessed the evidence had he recognized the correct law and applied the correct burden of proof, the order must be set aside and remanded for entry of a new order. Under these circumstances, the matter is remanded to the ALJ with directions to determine whether Davie Roofing, LLC had insurance in place to cover the claimant's injuries. There is

testimony in the record which if credited, establishes that the alleged policy of insurance secured by Davie Roofing, LLC, did not cover the claimant for a Colorado injury. In which case, Eco Roof and Solar would not be immune from liability pursuant to §8-41-401(2), C.R.S. The ALJ however, did not make findings on this particular issue and the findings, therefore, are insufficient to afford appellate review. Section 8-43-301(8), C.R.S. In light of this holding, we need not reach the issue of whether the ALJ had jurisdiction to hold Texas Mutual Insurance liable for the claimant's injuries.

IT IS THEREFORE ORDERED that the ALJ's order dated April 26, 2017, is set aside insofar as it dismissed Eco Roof and Solar and Pinnacol Assurance and is remanded for further proceedings.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

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

9/19/17 by TT .

LAW OFFICES OF MIGUEL MARTINEZ PC, Attn: MIGUEL MARTINEZ ESQ, 1776 VINE STREET, DENVER, CO, 80206 (For Claimant)
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PINNACOL ASSURANCE, Attn: HARVEY D FLEWELLING ESQ, 7501 EAST LOWRY BOULEVARD, DENVER, CO, 80230 (Other Party 2)
RUEGSEGGER SIMONS SMITH & STERN LLC DAVID SMITH ESQ 1401 SEVENTEENTH STREET SUITE 900 DENVER CO 80202 (Other Party)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-006-696-03

IN THE MATTER OF THE CLAIM OF:

RON OLIPHANT,

Claimant,

v.

FINAL ORDER

WARD ELECTRIC COMPANY, INC.,

Employer,

and

TRAVELERS,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Nemechek (ALJ) dated May 14, 2017, that denied and dismissed the claimant's workers' compensation claim. We affirm.

This matter went to hearing on the issues of compensability and the claimant's entitlement to temporary disability and medical benefits. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant was employed as an electrical lineman. He has a history of right shoulder issues requiring medical treatment which included a workers' compensation injury in June of 2012. The claimant continued to complain of right shoulder problems through 2015 and was never placed at maximum medical improvement (MMI) for the right shoulder.

The claimant alleged that on January 14, 2016, he sustained an injury to his right shoulder while working for the employer. On this date the claimant was picking up pieces of equipment called travelers, which weigh 60-70 pounds. The claimant was working with Mr. Grossman at the time and both he and the claimant would pick up the travelers, lift them over their heads and throw them into a basket on the back of a flatbed truck. After about an hour or two the claimant lifted a traveler over his head and said he was in pain and was unable to continue to do the job for the rest of the day. Mr. Grossman corroborated the claimant's version of events. The claimant reported the injury to the foreman.

The claimant was evaluated by Dr. Beard on February 17, 2016. Dr. Beard diagnosed a probable right rotator cuff tear and ordered an MRI. The radiologist report of the MRI noted that there was no rotator cuff tear but there was moderate supra spinatus tendinosis with bursal surface scuffing; early infraspinatus and subscapularis tendinosis moderate impingement anatomy, as described moderate arthrosis at the acromioclavicular joint. Dr. Beard reviewed the MRI and concluded that the claimant had a small, full-thickness tear in the anterior leading edge of the supraspinatus tendon without significant retraction. Dr. Beard recommended proceeding with a right shoulder arthroscopy with acromioplasty and mini open cuff repair. Dr. Beard eventually performed the right shoulder arthroscopy and right shoulder mini open rotator cuff repair. The claimant paid for the surgery and has not worked since the surgery.

The claimant underwent an IME with Dr. Klajnbart on May 12, 2016, at the respondents' request. According to Dr. Klajnbart there were no significant or acute changes in the MRI radiographic interpretations from April 28, 2014, and February 19, 2016. Dr. Klajnbart stated that the claimant may have sustained a soft tissue injury on January 14, 2016, and the pop sensation the claimant experienced would have been some previous scar tissue from his pre-existing tendinopathy and the type III curved acromion snapping over the bursal inflamed tissue from his repetitive activity. Dr. Klajnbart stated that the original origin of the right shoulder injury occurred on June 29, 2012. Dr. Klajnbart issued a supplemental report on June 27, 2016, stating that there was no evidence of an acute injury on January 14, 2016, and that there was no rotator cuff tear. Dr. Klajnbart testified at hearing consistent with his report. The ALJ found Dr. Klajnbart credible and persuasive.

Relying on the MRI findings from 2014 and 2016 and crediting Dr. Klajnbart's opinion that the claimant did not sustain an acute injury on January 14, 2016, the ALJ concluded that the claimant failed to show that the January 14, 2016, incident aggravated or accelerated the claimant's right shoulder condition. The ALJ therefore denied and dismissed the claim for compensation.

On appeal the claimant contends the ALJ erred in dismissing the claim and that the ALJ's order is not supported by substantial evidence. We are not persuaded the ALJ committed reversible error and, therefore, affirm the ALJ's order.

A claimant has the burden to prove that his injury was proximately caused by an injury arising out of and in the course of his employment. Section 8-41-301(1)(b) and (c), C.R.S. Whether the claimant has met that burden of proof is a factual question for

resolution by the ALJ, and his factual findings must be upheld if supported by substantial evidence in the record. *Dover Elevator Co. v. Industrial Claim Appeals Office*, 961 P.2d 1141 (Colo. App. 1998). 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. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

This case turned on the ALJ's evaluation of the conflicting opinions expressed by Dr. Beard and Dr. Mathwich and Dr. Klajnbart. It is the sole province of the ALJ to weigh the evidence and resolve contradictions in the evidence. *See Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968).

Here, the ALJ was more persuaded by the opinion of Dr. Klajnbart that the claimant did not sustain an acute injury on January 14, 2016, than by Dr. Beard's or Dr. Mathwich's contrary opinions. The ALJ also found persuasive the fact that the interpretation from the MRI done prior to the alleged injury was almost identical to the MRI done after the alleged injury. The claimant contends that the ALJ should have given more weight to Dr. Beard's and Dr. Mathwich's opinions. The claimant's arguments, however, go to the weight the ALJ chose to give to the conflicting opinions and do not mandate the conclusion that the claimant sustained a compensable injury on January 14, 2016.

The ALJ's order also appropriately recognized that a compensable injury may be the result of an industrial aggravation of a preexisting condition if the aggravation is the proximate cause of the disability or need for treatment. *H & H Warehouse v. Vicory*, 805 P.2d 1167, 1169 (Colo. App. 1990). The question of whether a particular disability is the result of the natural progression of a preexisting condition, or the subsequent aggravation or acceleration of that condition, is itself a question of fact. *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001). Furthermore, insofar as the ALJ found that the claimant may have experienced a "temporary aggravation" of his symptoms, the ALJ was not persuaded that this temporary aggravation was causally related to the conditions of his employment, as evidenced by Dr. Klajnbart's opinion. *See City of Brighton v. Rodriguez*, 318 P.3d 496 (Colo. 2014)(personal risks, including preexisting idiopathic illnesses or medical conditions completely unrelated to employment, generally are not compensable). The ALJ here found that the claimant's

need for medical treatment was not caused by the aggravation of a pre-existing condition. In our view Dr. Klajnbart's opinion fully supports such a determination.

This case involved starkly contrasting expert opinions. As noted above the weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. The ALJ might have accepted the opinions of Dr. Beard or Dr. Mathwich but, regardless of the ability of such evidence to support conflicting inferences, we must uphold the ALJ's determination. *See F. R. Orr Construction v. Rinta, supra*.

IT IS THEREFORE ORDERED that the ALJ's order dated May 14, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

NOTICE

- This order is **FINAL** unless you appeal it to the **COLORADO COURT OF APPEALS**. To do so, you must file a notice of appeal in that court, either by mail or in person, but it must be **RECEIVED BY** the court at the address shown below within twenty-one (21) calendar days of the mailing date of this order, as shown below.

- A complete copy of this final order, including the mailing date shown, must be attached to the notice of appeal, and you must provide a copy of both the notice of appeal and the complete final order to the Colorado Court of Appeals.

- You must also provide copies of the complete notice of appeal package to the Industrial Claim Appeals Office, the Attorney General's Office (addresses shown below), and all other parties or their representative whose addresses are shown on the Certificate of Mailing on the next page.

- In addition, the notice of appeal must include a certificate of service, which is a statement certifying when and how you provided these copies, showing the names and addresses of these parties and the date you mailed or otherwise delivered these copies to them.

- An appeal to the Colorado Court of Appeals is based on the existing record before the Administrative Law Judge and the Industrial Claim Appeals Office, and the court will not consider documents and new factual statements that were not previously presented or new arguments that were not previously raised.

- Forms are available for you to use in filing a notice of appeal and the certificate of service. You may obtain these forms from the Colorado Court of Appeals online at its website, www.colorado.gov/cdle/CTAPPFORM or in person, or from the Industrial Claim Appeals Office. **Please note address changes as listed below.**

- The court encourages use of these forms. Proper use of the forms will satisfy the procedural requirements of the Colorado Appellate Rules for appeals to the Colorado Court of Appeals. **For more information regarding an appeal, you may contact the Court of Appeals directly at 720-625-5150.**

Colorado Court of Appeals
2 East 14th Avenue
Denver, CO 80203

Industrial Claim Appeals Office
633 17th Street, Suite 200
Denver, CO 80202

Office of the Attorney General
State Services Section
Ralph L. Carr Colorado Judicial Center
1300 Broadway 6th Floor
Denver, CO 80203

CERTIFICATE OF MAILING

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

9/27/17 by TT .

BURG SIMPSON ELDREDGE HERSH & JARDINE PC, Attn: BOBBY D. GREENE ESQ, 40 INVERNESS DRIVE EAST, ENGLEWOOD, CO, 80112 (For Claimant)
POLLART MILLER LLC, Attn: ERIC J POLLART ESQ, C/O: MICHELLE L PRINCE, 5700 S QUEBEC STREET SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-955-695-02

IN THE MATTER OF THE CLAIM OF:

RUSTIE ROJAHN,

Claimant,

v.

FINAL ORDER

MONACO REHABILITATION,

Employer,

and

ACE AMERICAN INSURANCE COMPANY,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Felter (ALJ) dated March 20, 2017, that ordered the claimant's permanent impairment rating to include 9% for spinal range of motion deficits. We reverse the ALJ's order to the extent it included the 9% permanent impairment rating.

The claimant worked for the employer as a nurse. On July 14, 2014, while attempting to prevent a patient from tipping over a wheel chair, the claimant fell and fractured her left shoulder. The claimant underwent surgery to secure internal fixation of the fracture site at the neck of the humerus bone proximate to the glenohumeral joint at the shoulder. The claimant had a second surgery to resolve an adhesive capsulitis shoulder condition related to the formation of excessive scar tissue. On August 31, 2015, the claimant underwent a final surgery to remove the previously inserted hardware. The claimant's treating physician, Dr. Hattem, placed the claimant at maximum medical improvement (MMI) on February 12, 2016. Dr. Hattem calculated a permanent impairment rating of 12% of the upper extremity.

The claimant requested a Division sponsored Independent Medical Examination (DIME) review of Dr. Hattem's impairment rating. Dr. Yamamoto was selected to perform the DIME procedure. In his report of August 3, 2016, Dr. Yamamoto agreed with the date of MMI. He assigned a 16% rating of the left upper extremity.

Dr. Yamamoto also determined the rating should include a 9% whole person rating pursuant to the chapter devoted to rating impairment of the spine in the AMA Guides to the Evaluation of Permanent Impairment 3d Edition Revised (AMA Guides). The instructions in this chapter 3.3 state the physician must first obtain a diagnosis based rating through the application of Table 53. Table 53 states that it pertains to impairments due to specific disorders of the spine. After obtaining the Table 53 rating, the physician is directed to measure range of motion deficits demonstrated in any of the three areas of the spine (lumbar, thoracic and cervical) affected by the injury. The ratings from table 53 are then to be combined with the rating derived from range of motion deficits to obtain the total impairment rating.

Dr. Yamamoto derived a 9% rating from measurements of cervical range of motion deficits. He acknowledged the claimant "did not sustain a spine injury" and "there is no table 53 impairment." However, he referred to a section of the Impairment Rating Tips issued by the Division of Worker' Compensation and noted they provide an exception to the need to first obtain a diagnosis based rating before relying on range of motion deficits. The General Principles section of the Rating Tips specifies that "… in shoulder cases with accompanying neck pain, the clinician must determine whether an additional objective work related Table 53 cervical pathology qualifies for a rating ***OR*** the symptoms the patient has are those expected from the shoulder pathology and do not qualify for an additional rating." This admonition is repeated in the Spinal Rating section:

> In order to be assigned a spinal rating, the patient must have objective pathology and impairment that qualifies for a numerical impairment rating of greater than zero under Table 53. Spinal range of motion impairment must be completed and applied to the impairment rating only when a corresponding Table 53 diagnosis has been established. (References: Spine section of the *AMA Guides, 3rd Edition (rev.)*.

This statement is followed by an exception:

> • In unusual cases with established severe shoulder pathology accompanied by treatment of the cervical musculature, an isolated cervical range of motion impairment may be allowed if well-justified by the clinician. Otherwise there are no exceptions to the requirement for a corresponding Table 53 rating.

Dr. Yamamoto observed, "It is noted that she did not have documented treatment for the cervical musculature for reasons that are not clear as this is not a new finding. … In my opinion, she should not be denied the cervical range of motion impairment because the cervical musculature was not treated."

The respondents arranged for the claimant to be examined by Dr. D'Angelo. Dr. D'Angelo identified herself as a physician involved in conducting the Division's training for Level II physicians concerning the calculation of permanent impairment ratings. The doctor explained that the claimant's case did not qualify for the exception referenced by Dr. Yamamoto. She stated that the 'unusual cases' mentioned in the rating tips were pertinent to conditions of osteomyelitis (a bone infection) or avascular necrosis. Dr. D'Angelo reviewed the medical records in the claimant's case and surmised that during the course of her treatment there was an absence of complaints by the claimant of neck pain or limitations of cervical range of motion. The doctor reasoned that explained the lack of treatment of the cervical musculature. Dr. D'Angelo pointed out restrictions necessitated by adhesive capsulitis are evaluated in the AMA Guides through the measurement of deficits in shoulder range of motion. The doctor concluded that rating another body part, the cervical spine, due to adhesive capsulitis in the shoulder is not anatomically or physiologically appropriate.

The ALJ found the 12% scheduled impairment rating of the upper extremity rating calculated by Dr. Hattem to be the most appropriate. The ALJ also rejected the claimant's request to convert the extremity rating to a whole person rating. The claimant contended the location of the functional impairment was not restricted to the shoulder but extended beyond the shoulder joint to the claimant's torso. However, the ALJ found compelling Dr. Hattem's position that the injury was confined to the arm.

The ALJ determined it was not necessary to apply the Impairment Rating tips in order to justify cervical range of motion deficits as an addition to the claimant's impairment rating. The ALJ reasoned that Dr. Yamamoto had documented an impairment of the claimant's cervical musculature separate from the impairment to her shoulder. Citing the discussion in *Strauch v. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo. App. 1996), the ALJ deemed pain and discomfort referred from the fracture of the claimant's arm was sufficient to establish a site for an impairment on the torso of the body. The ALJ sequentially found that Dr. Yamamoto had adjudged a functional loss to the cervical musculature, that this was the equivalent of an impairment of the claimant' s cervical region (Finding of Fact ¶ 17), and qualified the claimant for an impairment of the cervical spine (Conclusion of Law ¶ c).

On appeal the respondents contend the addition of the 9% whole person rating for cervical range of motion deficits is contrary to the AMA Guides and the statute which requires use of the Guides to derive permanent impairment ratings, § 8-42-101(3.7), C.R.S. The respondents assert the AMA Guides require a finding of an injury to the spine before a rating may be supplemented by range of motion deficits. They argue the exception included in the impairment rating tips for unusual injuries to the shoulder does not apply in this matter due to an absence of the prerequisite conditions. Finally, the respondents point to the statutory requirement that an impairment rating may not be based on chronic pain without anatomic or physiologic correlation. Sections 8-42-101(3.7); 8-42-107(8)(c), C.R.S. The claimant argues the ALJ found the impairment rating tips exception did apply, that Dr. Yamamoto was justified in applying it, and the ALJ's decision was supported by substantial evidence.

The sections of the statute pertaining to the formulation of permanent impairment ratings are explicit that they are to be based on the AMA Guides. Section 8-42-101(3.7), C.R.S. specifies:

> … all physical impairment ratings used under articles 40 to 47 of this title shall be based on the revised third edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment" in effect as of July 1, 1991.

This same requirement is repeated in §§8-42-101(3)(a)(I), 8-42-107(8)(b.5)(II), 8-2-107(8)(c), and 8-42-107(8)(b.5)(I)(A), C.R.S.

The Division's Impairment Rating Tips are authorized by the statute. Section 8-42-101(3.5)(a)(II), C.R.S. provides:

> (II) The director shall promulgate rules establishing a system for the determination of medical treatment guidelines and utilization standards and medical impairment rating guidelines for impairment ratings as a percent of the whole person or affected body part based on the revised third edition of the "American Medical Association Guides to the Evaluation

> of Permanent Impairment", in effect as of July 1, 1991.

The principles governing the interpretation of administrative regulations are the same as those concerning statutes. *Gerrity Oil and Gas Corp. v. Magness,* 923 P.2d 261 (Colo. App. 1995), *aff'd. in part, rev'd. in part on other grounds,* 946 P.2d 913 (Colo. 1997). Thus, the overall objective is to interpret the rules in a manner, which affects the Director's intent. Because the language used is the best indicator of intent, the rules should be given their plain and ordinary meanings unless the result is absurd. Further, the rules should be read to give a consistent, harmonious and sensible effect to all their parts. *Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176 (Colo. App. 2002). We extend deference to the Division's interpretation of the AMA Guides as set forth in the Impairment Rating Tips as these Tips were written at the direction of the statute. If the applicable language is clear, we apply its plain and ordinary meaning. *Lobato v. Industrial Claim Appeals Office,* 105 P.3d 220 at 223 (Colo. 2005).

In *Serena v. SSC Pueblo Belmont,* W.C. No. 4-922-344-01 (December 1, 2015), *aff'd, Serena v. Industrial Claim Appeals Office,* (Colo. App. No. 15CA2095, November 3, 2016)(not selected for publication), we held that when an impairment rating is not specifically authorized by the terms of the AMA Guides, the rating may be justified due to an interpretation of the Guides contained in the Impairment Rating Tips. However, the plain and ordinary meaning of the language of the pertinent tip must be read to support its application. Here, the spinal rating tip referenced by the DIME physician as authority for including an impairment rating for cervical range of motion deficits specifies it may only be used where established shoulder pathology is "accompanied by treatment of the cervical musculature …". However, the DIME physician, Dr. Yamamoto, states in his report: "It is noted she did not have documented treatment for the cervical musculature …". In addition, because Dr. Yamamoto found the claimant to be at MMI, he necessarily found no treatment for the cervical musculature would be "reasonably expected to improve the condition." *See* § 8-40-201 (11.5), C.R.S. This finding precludes reliance upon the rating tip as a justification for an additional impairment rating.

The AMA Guides otherwise indicate a rating for cervical range of motion measurement is not allowed in this case. Section 3.3a, "The Spine, Principles for Calculating Impairment", provides: "Evaluation of impairment of the spine involves both diagnosis-related factors … and … factors that require physiologic measurement." AMA Guides at 78. The final step required to derive the impairment rating due to the impairment of the region of the spine instructs the evaluator to "combine the diagnosis-based impairment(s) with the impairment due to limited range of motion or ankylosis."

AMA Guides at 81. These directions indicate "both" diagnosis "and" measurements are involved and that the impairment of the spinal region must feature a combination of diagnoses and range of motion limitations. Table 53 lists the diagnosis, which are a prerequisite to a rating. These include fractures, intervertebral disc lesions, unoperated spondylolysis or spondylolisthesis and operated stenosis or segmental instability. It is not appropriate to calculate a spinal impairment relying solely on a range of motion deficit without also involving a spinal injury diagnosis. However, Dr. Yamamoto observed in his DIME report, "She did not sustain a spine injury …." Accordingly, the AMA Guides do not support a cervical spine impairment rating in this matter.

We have, in fact, on several occasions approved the determination that the AMA Guides require the finding of a diagnostic rating pursuant to Table 53 as a necessary prerequisite to assigning an impairment rating due to spinal range of motion deficits. *Silva v. Corporate Services Group Holdings, Inc*., W.C. No. 4-944-337-03 (February 23, 2016); *Wilson v. Qwest*, W.C. No. 4-486802-1 (May 23, 2012); *Villeral v. K-Mart*, W.C. No. 4-509-526 (March 13, 2003); *Lopez v. Oasis Outsourcing, Inc*., W.C. No. 4-416-822 (January 8, 2001).

Apart from the directions set forth in Chapter 3.3a of the AMA Guides, the statute requiring the use of the Guides maintains an overriding restriction. Section 8-42-101(3.7), C.R.S. sets forth that "… a physician shall not render a medical impairment rating based on chronic pain without anatomic or physiologic correlation." The ALJ made the determination the claimant deserved a cervical spine rating due to "[r]eferred pain from the primary site of the injury." This "pain and discomfort which limits a claimant's ability to use a portion of h[er] body may be considered a 'functional impairment' …" which justifies a cervical spine impairment rating. (Finding of Fact, ¶ 17). This finding however, is inconsistent with the requirement that a cervical spine rating be anatomically related to an injury to the cervical spine. The chronic pain described is correlated with the fracture of the claimant's shoulder. The statute therefore proscribes an impairment rating for the cervical spine premised on chronic pain from the shoulder. The ALJ's 9% whole person rating is contrary to the directions of the statute and may not be included in the permanent impairment rating.

The ALJ set forth an analysis to justify the cervical spine rating by pointing to the discussion in *Strauch v. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo. App. 1996). The ALJ notes the claimant sustained "functional impairment" to the cervical spine because she has difficulty turning her head due to pain in the cervical musculature. The pain was observed to prevent the clamant from driving. The ALJ reasoned, "It is not the situs of the initial injury but the situs of functional impairment that is determinative of

whole person impairment …." (Conclusions of Law, ¶ (c)). However, *Strauch* is ruling in regard to another issue distinct from that presented here. In *Strauch*, the claimant sustained a shoulder injury and was assigned an impairment rating through the AMA Guides due to an impairment of her arm. The claimant sought to have her rating compensated as a whole person rating pursuant to § 8-42-107(8), C.R.S. rather than as a scheduled rating provided by § 8-42-107(2)(a), C.R.S. In either event, the rating was derived from the impairment of the arm at the shoulder. The *Strauch* court ruled that when seeking to determine whether the schedule of injuries from § 8-42-107(2), C.R.S. applied, as opposed to the whole person rating called for in § 8-42-107(8), C.R.S., a fact finder was to look not for "the particular site of the injury or the medical reason for the loss; rather, … to the portion of the body that sustains the ultimate loss." The fact finder is directed to locate the portion of the body that sustained "a functional impairment." Earlier in his decision, the ALJ applied this standard when he ruled the rating derived from the injury to the claimant's arm and shoulder could not be considered a functional impairment of the neck. (Finding of Fact ¶ 10). However, the *Strauch* decision also advised, "This determination is distinct from, and should not be confused with, the treating physician's rating of physical impairment under the AMA Guides." *Id*. at 368**.** Accordingly, *Strauch* specifically cannot mean that locating a functional impairment would be the same as locating the part of the body for which the injury is to be rated. The ALJ is in error to do so here.

A finding that the DIME report does not comply with the directions of the AMA Guides supports a conclusion that the DIME determinations have been overcome by clear and convincing evidence. *Silva v. Corporate Services Group Holdings, Inc*., W.C. No. 4-944-337-03 February 23, 2016). Our review is limited by statute, § 8-43-301(8), C.R.S., and we are to correct, set aside, or remand an order if the award or denial of benefits is not supported by the applicable law. Section 8-43-301(8), C.R.S. *Hopper v. ReMax Properties*, W.C. No. 4-392-057 (May 26, 2015). Where the facts are undisputed, the determination of the application of the AMA Guides and interpretative material to the facts is a question of law that we review de novo. *Serena v. SSC Pueblo Belmont*, W.C. No. 4-922-344-01 (December 1, 2015), *aff'd*, *Serena v. Industrial Claim Appeals Office*, (Colo. App. No. 15CA2095, November 3, 2016)(not selected for publication), *State Dep't of Labor & Employment v. Esser*, 30 P.3d 189, 193-94 (Colo. 2001).

Accordingly, we conclude the record and the ALJ's factual findings do not support his final ruling that the claimant is entitled to a 9% whole person rating for a cervical injury. Insofar as the ALJ's order supplements the permanent impairment with a 9% whole person rating due to the loss of range of motion to the cervical spine, the decision is reversed.

IT IS THEREFORE ORDERED that the ALJ's order issued March 20, 2017, is reversed in regard to its award of permanent impairment benefits based upon 9% of the whole person.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

NOTICE

- This order is **FINAL** unless you appeal it to the **COLORADO COURT OF APPEALS**. To do so, you must file a notice of appeal in that court, either by mail or in person, but it must be **RECEIVED BY** the court at the address shown below within twenty-one (21) calendar days of the mailing date of this order, as shown below.

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Denver, CO 80202

Office of the Attorney General
State Services Section
Ralph L. Carr Colorado Judicial Center
1300 Broadway 6th Floor
Denver, CO 80203

CERTIFICATE OF MAILING

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

October 5, 2017 by KG .

THE SAWAYA LAW FIRM, Attn: SEAN KNIGHT, ESQ, 1600 OGDEN STREET, DENVER, CO, 80218 (For Claimant)
RITSEMA & LYON PC, Attn: RICHARD A BOVARNICK ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-892-836-01

IN THE MATTER OF THE CLAIM OF:

JOSEPH SIMMS,

Claimant,

v.

FINAL ORDER

SHILOH STEAKHOUSE,

Employer,

and

FARMERS/TRUCK INSURANCE EXCHANGE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Sidanycz (ALJ) dated April 12, 2017, that denied and dismissed the claimant's request for permanent total disability benefits. We affirm the ALJ's order.

A hearing was held on the issues of permanent total disability, the claimant's request for penalties, and disfigurement benefits. After hearing the ALJ made factual findings that for purposes of review can be summarized as follows. The 56 year old claimant sustained an admitted injury to his low back on July 12, 2012, when he lifted a five gallon bucket full of water and lettuce and felt tightness in his legs. The claimant was seen by physicians at La Plata Family Medicine Center where he received treatment, including surgery. The claimant was eventually placed at maximum medical improvement (MMI) on January 11, 2016 and given a 35 percent whole person rating.

The claimant's treating physician, Dr. Loftis, imposed a number of work restrictions on the claimant. Relevant to the issue here, Dr. Loftis stated that the claimant was limited to driving no more than two hours per day. Dr. Loftis also stated that the claimant was required to change position between sitting and standing every 30 minutes. The claimant underwent an independent medical examination with Dr. Schakaraschwili. According to Dr. Schakaraschwili, the claimant is capable of working in at least a sedentary position within the light duty to medium duty work categories. Dr.

Schakaraschwili agreed that the claimant should be allowed to shift positions every 30 minutes.

Vocational rehabilitation expert, Mr. Van Iderstine, provided a vocational assessment and testified at hearing for the claimant. In Mr. Van Iderstine's opinion the claimant was permanently and totally disabled. Mr. Van Iderstine considered the claimant's commutable labor market to be the Montezuma area including Dolores, Colorado, where the claimant resides, Dove Creek, and Cortez, Colorado.

Vocational rehabilitation expert, Torrey Kay Beil, testified contrary to Mr. Van Iderstine, that the claimant is employable in his commutable labor market. Ms. Beil reviewed job opportunities in Durango and Cortez, Colorado. Ms. Beil issued an addendum to her report on October 24, 2016, which specifically identified three employers with positions that Ms. Beil believed the claimant would be able to perform in Durango and Cortez. Dr. Schakaraschwili testified that the claimant would be able to work in these positions if the job duties are within the claimant's restrictions.

The ALJ credited the testimony Ms. Beil and Dr. Schakaraschwili over the contrary opinions of Mr. Van Iderstine to conclude that the claimant is able to earn wages in various types of employment in his commutable labor market, which the ALJ identified as including Cortez and Durango, Colorado. The ALJ, therefore, denied and dismissed the claimant's claim for permanent total disability benefits. The ALJ also denied the claimant's request for penalties and granted the request for disfigurement benefits which are not issues on appeal.

We note initially that the claimant attached Google printouts as Exhibits to his brief in support of petition to review. This was not presented to the ALJ below and, we therefore, do not consider it now on appeal. *Subsequent Injury Fund v. Gallegos*, 746 P.2d 71 (Colo. App. 1987) (representations in petition to review may not substitute for that which must appear of record).

On appeal the claimant contends that the ALJ's inclusion of Durango, Colorado in the claimant's commutable labor market is not supported by substantial evidence. We perceive no reversible error.

Section 8-40-201(16.5) (a), C.R.S., defines permanent total disability as the claimant's inability "to earn any wages in the same or other employment." Under the statute, the claimant has the burden of proof to establish permanent total disability. In determining whether the claimant has satisfied that burden of proof, the ALJ may

consider a number of "human factors." *Christie v. Coors Transportation Co*., 933 P.2d 1330 (Colo. 1997). These factors include the claimant's physical condition, mental ability, age, employment history, education, and the availability of work the claimant can perform. *Weld County School District RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). As argued by the claimant, the overall objective of this standard is to determine whether, in view of all these factors, employment is reasonably available to the claimant under his particular circumstances, which includes the claimant's commutable labor market. *Id.*

Because the issue of permanent total disability is generally factual, we must uphold the ALJ's findings if supported by substantial evidence in the record. § 8-43-301(8), C.R.S. Substantial evidence is that quantum of probative evidence which a rational fact finder would accept as adequate to support a conclusion without regard to the existence of conflicting evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). This standard of review requires that we consider the evidence in the light most favorable to the prevailing party, and defer to the ALJ's credibility determinations, resolution of conflicts in the evidence and plausible inferences drawn from the record. *Wilson v. Industrial Claim Appeals Office*, 91 P.3d 1117 (Colo. App. 2003).

On conflicting vocational evidence, the ALJ found the claimant failed to prove he is unable to earn wages in the same or other employment. The ALJ's order clearly articulates the basis of the order and is sufficient to permit appellate review. *See Boice v. Industrial Claim Appeals Office*, 800 P.2d 1339 (Colo. App. 1990). Crediting Ms. Beil's opinion, the ALJ found that although the claimant has work restrictions, he is capable of employment within those restrictions. The ALJ also determined that Ms. Beil testified about potential jobs in the commutable labor market that were within the claimant's work restrictions. The ALJ specifically identified the commutable labor market to include Cortez and Durango.

There was testimony from Mr. Van Iderstine about the possibility that the drive to Durango was too far for the claimant to commute for work. Dr. Loftis, however, limited the claimant to no more than two hours of driving per day. Ms. Beil testified that the drive between Dolores and Durango is approximately 40 minutes to an hour each way. Beil Depo at 69. This is within the two hour driving restriction imposed by Dr. Loftis. Depo. at 79. The claimant argues that the ALJ's finding fails to account for the medical restriction requiring the claimant to change positions every 30 minutes and did not take into consideration the claimant's testimony that his legs go numb after driving for 30 minutes. Although the evidence was subject to conflicting inferences, the ALJ found that the restrictions requiring the claimant to change positions every 30 minutes and the

claimant's subjective reports of inability to drive more than 30 minutes were not sufficient to establish that the claimant would not be able to drive to Durango. Moreover, although Dr. Loftis's January 14, 2016, report of restrictions had the option to limit the claimant's driving "[u]p to 30 min. at one time," Dr. Loftis checked the option limiting the claimant's driving to 2 "hours total in a day." Thus, it was plausible for the ALJ to conclude that the claimant could reasonably drive to Durango.

To the extent the ALJ did not make specific findings of fact concerning evidence supporting the claimant's contention that he is unable to drive to Durango, that does not establish grounds for appellate relief. The ALJ is not required to expressly cite evidence she rejected as unpersuasive. *Jefferson County Public School v. Dragoo*, 765 P.2d 636 (Colo. App. 1988). Evidence not specifically credited is implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

In any event, although the ALJ found that the claimant's commutable labor market should include Durango, the ALJ also found that there are jobs reasonably available to the claimant within the sedentary and light categories of work that are within the commutable labor market of Cortez. There appears to be no dispute that this area is within the claimant's commutable labor market as recognized by both the testimony of Ms. Beil and Mr. Van Iderstine.

The ALJ's findings reflect that he resolved the pertinent conflicts based upon his credibility determinations. *See Ralston v. Purina-Keystone v. Lowry*, 821 P.2d 910 (Colo. App. 1991)(ALJ not required to resolve all conflicts in the evidence but only pertinent conflicts). We may not reweigh the evidence on appeal. *Rockwell v. International Turnbull*, 802 P.2d 1182 (Colo. App. 1990). Neither may we substitute our judgment for that of the ALJ concerning the credibility of the expert witnesses. Therefore, we may not interfere with the ALJ's determination that Ms. Beil's testimony was more credible than the testimony of the claimant's vocational expert. The claimant's further arguments on this issue do not alter our conclusions.

It was the claimant's burden to persuade the ALJ that he is unable to earn any wages, and therefore is entitled to permanent total disability benefits. *See McKinney v. Industrial Claim Appeals Office*, 894 P.2d 42 (Colo. App. 1995). The claimant's evidence failed to persuade the ALJ, and we cannot say the evidence compels a contrary determination. The ALJ's order reflects the proper application of the law and is supported by substantial evidence and the denial of benefits was, therefore, proper.

IT IS THEREFORE ORDERED that the ALJ's order dated April 12, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

NOTICE

- This order is **FINAL** unless you appeal it to the **COLORADO COURT OF APPEALS**. To do so, you must file a notice of appeal in that court, either by mail or in person, but it must be **RECEIVED BY** the court at the address shown below within twenty-one (21) calendar days of the mailing date of this order, as shown below.

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Denver, CO 80203

CERTIFICATE OF MAILING

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10/03/17 by TT .

CRANE & TEJADA PC, Attn: BETHIAH BEALE CRANE ESQ, 575 EAST COLLEGE DRIVE, DURANGO, CO, 81301 (For Claimant)
LAW OFFICE OF ROBERT B HUNTER, Attn: JOE M ESPINOSA ESQ, 1801 BROADWAY SUITE 1300, DENVER, CO, 80202-3878 (For Respondents)
LAW OFFICE OF ROBERT B HUNTER, Attn: JOE M ESPINOSA ESQ, PO BOX 258829, OKLAHOMA CITY, OK, 73125-8829 (Other Party)
DEAN NEUWIRTH PC, Attn: DEAN NEUWIRTH ESQ, C/O: RICHILANO SHEA LLC, 1800 15TH STREET SUITE 101, DENVER, CO, 80202 (Other Party 2)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-990-597-01

IN THE MATTER OF THE CLAIM OF:

DEAN PACELLO,

Claimant,

v.

FINAL ORDER

CITY OF BOULDER FIRE DEPARTMENT,

Employer,

and

CCMSI,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Mottram (ALJ) dated June 7, 2017, that determined the claimant's Human Papillomar virus-related (HPV) oropharyngeal squamous cell carcinoma is a compensable occupational disease under the firefighter cancer presumption statute, §8-41-209, C.R.S., and ordered the respondents liable for medical benefits. We affirm.

This matter went to hearing on whether the firefighter presumption statute contained in §8-41-209, C.R.S. applies to the claimant's claim, and, if the statute applies, whether the respondents overcame the presumption by a preponderance of the medical evidence, and medical benefits.

After the hearing, the ALJ found that the claimant had been employed as a firefighter/emergency medical technician (EMT) for the respondent employer for 35 years. Prior to being hired, the claimant underwent a physical examination which did not reveal the presence of squamous cell carcinoma on his tongue. Two years after the claimant retired, a mass on the base of his tongue tested positive for HPV subtype 16/18. The ALJ found that the claimant's cancer is a cancer of the digestive system.

In the course of his employment as a firefighter, the claimant responded to motor vehicle accidents, wild land fires, house fires, gas leaks, and sprinkler activation with no fires. The claimant also was trained as an EMT. The claimant was provided with bunker

gear to protect him during firefighting activities, including bunker boots, bunker pants, a bunker coat, and a bunker hood. The employer did not clean the bunker gear but, rather, the firefighters would take the bunker gear home to clean it, or they would spray it down at the station.

The claimant was provided with a self-contained breathing apparatus for use during house fires. He would use the breathing apparatus during the suppression phase of the fires, but not during the overhaul phase when he would overturn the building to look for the cause of the fire, including tearing down ceilings, walls, and tearing up carpets. The claimant also did not use the breathing apparatus for fighting wildfires. The claimant would work 24 hour shifts and would average 56 hours over a two week timeframe. The majority of the calls involved responding to medically related EMT work that did not involve fires or smoke. The claimant retired on June 12, 2013.

Two years after the claimant retired, he became sick and was referred to Dr. Gill for evaluation. Dr. Gill identified a mass on the base of the claimant's tongue. A biopsy of the mass was positive for HPV subtype 16/18.

During the hearing, Dr. Mayer testified on behalf of the claimant. Dr. Mayer explained that the claimant's cancer is a cancer of the digestive system. Dr. Mayer further testified that HPV is a risk factor for contracting cancer. She also testified that not all patients who have HPV develop cancer. Dr. Mayer testified that the combination of the HPV virus and the claimant's exposure to known carcinogens through his work as a firefighter led to his contracting cancer.

The claimant also presented the testimony of Dr. Orent. Dr. Orent testified that oftentimes the bunker gear worn by firefighters would get soot on it, and the soot could be a carcinogen. In his opinion, the claimant was exposed to carcinogens through his job as a firefighter.

At the request of the respondents, Dr. Jacobs performed a medical records review on November 23, 2015. Dr. Jacobs opined that HPV 16/18 has a known etiologic factor that causes cancer. He explained that this takes the form of cervical cancer in women and oral/pharyngeal cancer in men and women. Dr. Jacobs stated that the transmission of the virus occurs through sexual contact. Dr. Jacobs opined that the claimant's cancer was related to the HPV virus and not his employment.

A second medical records review was performed by Dr. Bell on November 9, 2016. Dr. Bell testified that exposure to HPV does not always lead to the development of

cancer. Dr. Bell opined that the claimant's occupation as a firefighter did not have anything to do with the development of his cancer. Rather, he testified that the claimant's cancer was caused by a virus that was sexually transmitted. Dr. Bell explained that the DNA of the HPV virus will integrate itself with the human body, and while the process takes decades, it will cause cancer. Dr. Bell further testified that there is no data to establish that firefighting is related to HPV developed cancer.

The ALJ found that the claimant established he is a firefighter who has completed five or more years of employment as a firefighter and has cancer of the digestive system as contemplated by §8-41-209, C.R.S. He also found that prior to being hired by the respondent employer, the claimant underwent a physical examination that did not reveal the presence of squamous cell carcinoma on the claimant's tongue. The ALJ therefore determined that the presumption contained in §8-41-209, C.R.S. applied to the claimant's claim. The ALJ credited the testimony and opinions of Dr. Mayer over those of Dr. Jacob and Dr. Bell. Citing to *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990), the ALJ expressly credited Dr. Mayer's opinion that it was "the combination of HPV and claimant's exposure to known carcinogens that cause[d] the claimant to contract cancer." After weighing the respondents' risk factor evidence and considering the totality of the evidence, the ALJ also found that the respondents "failed to establish by (sic) preponderance of the evidence that claimant's cancer was not caused by his exposure to carcinogens while employed as a firefighter." He ordered the respondents liable for reasonable and necessary medical benefits related to the claimant's cancer including the cost of the treatment provided by Dr. Orent.

I.

On appeal, the respondents argue that the ALJ misconstrued and misapplied the firefighter presumption statute contained in §8-41-209, C.R.S. They reason that this occurred when the ALJ credited Dr. Mayer's opinion that the "combination" of the claimant's HPV infection and his exposure to firefighting carcinogens caused the claimant to contract cancer. The respondents argue that this conclusion by the ALJ rendered the statutory presumption irrebuttable contrary to the Colorado Supreme Court's announcements in *City of Littleton v. Industrial Claim Appeals Office*, 370 P.3d 157 (Colo. 2016) and *Industrial Claim Appeals Office v. Town of Castle Rock*, 370 P.3d 151 (Colo. 2016). According to the respondents, by crediting a "combination" or "multifactorial" causal opinion, this precludes the possibility of an employer ever overcoming the firefighter presumption with substantial evidence that a non-occupational factor is the greatest or highest risk factor in causing a firefighter's particular cancer. The respondents contend that just because one risk factor, or the claimant's exposure to firefighting carcinogens, suggests a cancer may arise from an occupational source, a risk

factor that is shown to be the actual cause of the cancer, or the HPV virus, shows by more than a preponderance of the evidence the cancer arose from a non-occupational source. We perceive no error.

The firefighter presumption statute contained in §8-41-209, C.R.S. provides as follows:

> (1) Death, disability, or impairment of health of a firefighter of any political subdivision who has completed five or more years of employment as a firefighter, caused by cancer of the brain, skin, digestive system, hematological system, or genitourinary system and resulting from his or her employment as a firefighter, shall be considered an occupational disease.
>
> (2) Any condition or impairment of health described in subsection (1) of this section:
>
> (a) Shall be presumed to result from a firefighter's employment if, at the time of becoming a firefighter or thereafter, the firefighter underwent a physical examination that failed to reveal substantial evidence of such condition or impairment of health that preexisted his or her employment as a firefighter; and
>
> (b) Shall not be deemed to result from the firefighter's employment if the firefighter's employer or insurer shows by a preponderance of the medical evidence that such condition or impairment did not occur on the job.

Section 8-41-209, C.R.S. recently has been the subject of considerable litigation. In *City of Littleton*, the Colorado Supreme Court held that §8-41-209(2), C.R.S. does not establish a conclusive or irrebuttable presumption. Rather, §8-41-209(2), C.R.S. merely shifts the burden of persuasion to the employer to show, by a preponderance of the medical evidence, that the firefighter's condition or health impairment caused by a listed cancer "did not occur on the job." The Court explained that an employer can meet its burden by establishing the absence of either general or specific causation. This is done by showing, by a preponderance of the medical evidence, either: (1) that a firefighter's known or typical occupational exposures are not capable of causing the type of cancer at issue; or (2) that the firefighter's employment did not cause the firefighter's particular cancer where, for example, the claimant firefighter was not exposed to the substance or substances that are known to cause the firefighter's condition or impairment, or where the medical evidence renders it more probable that the cause of the claimant's condition or

impairment was not job-related. The Court added that in meeting its burden, §8-41-209(2), C.R.S. does not require the employer to prove that the cancer was not, or could not have been, caused by anything the firefighter encountered on the job. Additionally, in *Town of Castle Rock*, the Court held that an employer need only establish, by a preponderance of the medical evidence, that the firefighter's employment did not cause the firefighter's cancer because the firefighter's particular risk factors rendered it more probable that the firefighter's cancer arose from a source outside the workplace.

Here, we conclude the ALJ did not misapply §8-41-209, C.R.S., or contradict the Court's holdings in *City of Littleton* and *Town of Castle Rock* when crediting Dr. Mayer's opinion that the "combination" of HPV and the claimant's work exposure to known carcinogens caused his cancer. Nothing in the plain language of §8-41-209, C.R.S. or in the Court's holdings of *City of Littleton* and *Town of Castle Rock* preclude an ALJ from finding a compensable occupational disease when crediting an expert witness who gives a "multifactorial" causal opinion. Similarly, nothing in the statute or these cases require the claimant's cancer to be caused solely by his firefighting duties to be considered a compensable occupational disease under the plain language of §8-41-209, C.R.S., as the respondents appear to argue. Rather, what *City of Littleton*, *Town of Castle Rock*, and the plain language of §8-41-209, C.R.S. require is that the employer show that the risk factors render it more probable than not that the cancer arose from a source outside of work. The ALJ's holding here is consistent with this applicable law. The ALJ merely found that while the claimant was exposed to a non-occupational risk factor, or the HPV virus, this risk factor did not outweigh the occupational factors in causing the claimant's cancer to develop. While the respondents argue that the ALJ's determination in this regard essentially required them to disprove causation from every conceivable occupational substance, we do not agree. Rather, as explained by the *City of Littleton* Court, if a firefighter's exposure to an occupational substance is speculative, remote, or illogical, then it is not typical of the occupation. The ALJ here applied this risk factor weighing analysis and essentially found, however, that while the claimant's HPV virus preexisted his developing squamous cell carcinoma, it nevertheless was the claimant's exposure to the workplace carcinogens that combined with the HPV virus to cause his cancer to develop.

The ALJ's determination in this regard is not inconsistent with well settled workers' compensation law. Namely, in *Seifried v. Industrial Com'n*, 736 P.2d 1262 (Colo. App. 1986), the Colorado Court of Appeals held that the claimant is not required to prove the conditions of the employment were the sole cause of his or her occupational

disease.[1] Rather, it is sufficient if the claimant proves the hazards of employment were a significant causative factor in causing the disability for which compensation is sought. *See also Anderson v. Brinkhoff*, 859 P.2d 819, 824-825 (Colo. 1993). Clearly, the ALJ here found that the hazards of the claimant's employment were a significant causative factor for the development of his squamous cell carcinoma. Thus, we have no basis to disturb the ALJ's order on this ground. Section 8-43-301(8), C.R.S.

II.

The respondents further argue that they showed the claimant's cancer did not occur on the job. The respondents contend they demonstrated it was "more probable" that the claimant's cancer was caused by something other than his exposures as a firefighter, namely his sexually transmitted HPV. They explain that the claimant was not exposed to HPV on the job, and HPV was the primary cause of his cancer. Thus, the respondents contend they overcame the firefighter presumption contained in §8-41-409, C.R.S. by establishing the absence of both general and specific causation. Again, we are not persuaded by the respondents' argument.

Causation is an issue of fact for determination by the ALJ. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337, 1339 (Colo. App. 1997). We are bound by the ALJ's findings if they are supported by substantial evidence in the record. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999). Substantial evidence is that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). Accordingly, the issue on review is not whether the record contains some evidence, which if credited, might support the result sought by the claimant, but whether the ALJ's factual determinations are supported by substantial evidence and plausible inferences drawn from the record. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

Further, under the substantial evidence test we are precluded from substituting our judgment for that of the ALJ concerning the sufficiency and probative weight of the

[1] The Colorado Court of Appeals previously has applied the holding in *Seifried* to an occupational disease case. *Subsequent Injury Fund v. Industrial Claim Appeals Office*, 131 P.3d 1224 (Colo. App. 2006). Also, in *National Health Labs. v. Industrial Claim Appeals Office*, 844 P.2d 1259, 1260 (Colo. App. 1992), the Court essentially determined that the holdings in *Vicory* and *Seifried* are not inconsistent since under either analysis an injury is compensable as long as it is direct and consequential.

evidence, as well as the resolution of conflicts in the evidence. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). Nor may we interfere with the ALJ's credibility determinations unless the credited testimony is rebutted by such hard, certain evidence that, as a matter of law, the ALJ erred in believing the testimony. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986). Accordingly, the scope of our review is exceedingly narrow. *Metro Moving & Storage Co. v. Gussert, supra.*

As explained above, the ALJ credited Dr. Mayer's testimony that it was "the combination of HPV and the carcinogens to which [the claimant] was exposed, specifically the polycyclic aromatic hydrocarbons and, more specifically, benzo(a)pyrene that significantly elevated his risk of developing the cancer." Tr. at 102. She further testified that only a very small percentage of individuals infected with the HPV 16 virus contract squamous cell carcinoma. Tr. at 111. Further, in her report, Dr. Mayer opined in pertinent part as follows:

> [I]n my medical opinion, HPV infection should not be considered an alternate risk factor but rather as an additional risk factor that increased his risk synergistically with his fire-fighting exposures.
>
> * * *
>
> In my opinion, there can be no preponderance of the medical evidence that his particular risk factors render it more probable that his tongue cancer arouse (sic) from a source outside of the workplace when the existing literature indicates a multiplicative effect between HPV and carcinogens in oropharyngeal cancer development. This medical opinion is consistent with the opinions of Drs. Chimonas and Orent, the designated treating providers for the City of Boulder, who opined there should be no question in regard to causality in this case, i.e. work-related. Ex. 20 at 9-10.

Additionally, the ALJ also implicitly credited Dr. Orent's opinions. When testifying that the claimant's job as a firefighter is one in which there are known and typical occupational exposures capable of causing cancer, Dr. Orent referred to Dr. Mayer's causal opinion and the study she relied on to form such opinion. Tr. at 137. Dr. Orent testified that the claimant's cancer is related to his occupation as a firefighter. He explained that cancer is a multifactorial disease, and the claimant's 35-year exposure to carcinogens in his job was the trigger that caused the HPV virus to become malignant:

> A Indeed, I believe strongly that [the claimant's] cancer is related to his occupation as a firefighter.
>
> Q Can you tell us why?
>
> A Yes. Cancer -- we seem to be focusing on one single, quote, cause of cancer. Cancer is a multifactorial disease. It starts with the process whereby that something changes in the DNA of the cell. And when that happens, most of the time our bodies have a surveillance process where our immune systems go around, and we pick up malignancies, and we destroy them.
>
> The – the malignancy that [the claimant] developed is a result of not just the exposure to carcinogens or the presence of HPV. It is a product of the fact that the necessary soil for cancer is the HPV and the carcinogen. Something has to make that seed grow. The HPV is sitting there doing nothing until the carcinogen comes along and suppresses the immune system to the point where the malignancy develops.
>
> And that's how I put this together. We know that there are multiple causes of immunosuppression in firefighters. For example, shift work is a very important one. In addition, one of the things we know about carcinogen exposure is it is dose-related. So if we're talking more probable than not about dose – this man is a 35-year firefighter.
>
> He has been exposed to uncounted amounts of toxins in the course and scope of his job. That compared to chewing tobacco for a year or two is simply - - the preponderance of evidence, in my view, is overwhelming that his exposures to carcinogens in the course and scope of his work are far more important than any other factor in activating that HPV that was there. Tr. at 136-137; see also Ex. 4 at 51-53.

Thus, since substantial evidence supports the ALJ's determination that the respondents did not demonstrate by a preponderance of the medical evidence that it was "more probable" the claimant's cancer was caused by something other than his carcinogenic exposures as a firefighter, we have no basis to disturb the ALJ's order on this ground. Section 8-43-301(8), C.R.S.

The respondents further contend that the Court's construction of the firefighter statute in *City of Littleton* and *Town of Castle Rock* precluded the ALJ from applying the holding in *Vicory*. They reason that the claimant's HPV cancer was not a pre-existing condition, and in fact, for the statutory firefighter presumption to apply, a listed cancer cannot be a pre-existing condition and, therefore, *Vicory* is inapplicable. Again, we perceive no error.

In *Vicory*, the claimant was at work when a door suddenly and unexpectedly opened which startled him and caused him to hastily move his arm. The claimant presented evidence that an undetected cancerous growth had undermined the strength of the humerus bone and that, as a result, his rapid arm movement in response to the door opening caused the bone to fracture. The ALJ awarded the claimant benefits, finding that the claimant's fractured humerus resulted from "a combination of abnormal motion in response to a startling stimulus, and the pre-existing weakness in the bone resulting from the cancer condition." The Panel and the Colorado Court of Appeals affirmed. The Court held that it was the sudden opening of the door, rather than any pre-existing condition, that was the initiating and precipitating cause of the claimant's injury. The Court explained that "the existing disease of an employee does not disqualify a claim if the employment aggravates, accelerates, or combines with the disease or infirmity to produce the disability for which workers' compensation is sought." *Id*. at 1169. The Court further ordered the respondents liable for medical, temporary disability, and disfigurement benefits since substantial evidence demonstrated that the work-place fracture significantly increased the rate of the cancer's spread and that prior to the incident the tumor was slow-growing and had not disabled the claimant, but within four months of the incident, the tumor had grown rapidly and resulted in a partial amputation of the arm.

Initially, we conclude that the Court's holdings in *City of Littleton* and *Town of Castle Rock* did not prevent the ALJ from applying the holding in *Vicory* to support his causal determination. The holdings in *City of Littleton* and *Town of Castle Rock* merely require the ALJ to weigh the particular risk factors, and determine whether the respondents have shown that the firefighter's particular risk factors rendered it more probable that his or her cancer arose from a source outside the workplace. The holding in *Vicory* is not inconsistent. The holding in *Vicory* also requires that the hazards of employment combine with the pre-existing condition to cause a need for medical treatment. Moreover, it is true, as the respondents argue, that for the statutory presumption in §8-41-209, C.R.S. to apply, the firefighter must have undergone a physical examination that "failed to reveal substantial evidence" of such cancer pre-existing his or her employment as a firefighter. However, there is no dispute that prior to

being hired, the claimant underwent a physical examination which did not reveal the presence of squamous cell carcinoma on his tongue. Instead, it was the claimant's HPV virus, and not the cancer, that the ALJ found was his pre-existing medical condition. The holding in *Vicory* clearly applies in light of Dr. Mayer's and Dr. Orent's testimony that it was the combination of the claimant's HPV virus and his 35-year exposure to firefighting carcinogens that caused the development of the squamous cell carcinoma on his tongue. Again, as explained by Dr. Orent, the HPV was dormant until the claimant's exposure to carcinogens from his job suppressed his immune system and allowed the malignancy to develop. Thus, similar to *Vicory*, it was the claimant's exposure to the work place carcinogens rather than his HPV virus that was the precipitating cause of his oropharyngeal squamous cell carcinoma. Thus, we perceive no error in the ALJ's analysis and we therefore have no basis to disturb the ALJ's order on this ground. Section 8-43-301(8), C.R.S.

Moreover, in support of their argument that the ALJ erred in finding the claimant's cancer compensable, the respondents rely heavily on the testimony and opinions from Dr. Bell. The ALJ, however, expressly credited the opinions of Dr. Mayer over those of Dr. Bell. We have no authority to substitute our judgment for that of the ALJ concerning the credibility of witnesses and we may not reweigh the evidence on appeal. *Delta Drywall v. Industrial Claim Appeals Office, supra*. The respondents also cite to testimony from Dr. Mayer that they argue does not support the ALJ's causal determination. However, testimony which is merely inconsistent or conflicting is not necessarily incredible as a matter of law. *See People v. Ramirez*, 30 P.3d 807 (Colo. App. 2001). Further, it is well settled that 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). Additionally, as noted above, we may not substitute our judgment for that of the ALJ unless the testimony the ALJ found persuasive is rebutted by such hard, certain evidence that it would be error as a matter of law to credit the testimony. *Halliburton Services v. Miller, supra*. That is not the case here. Accordingly, we may not disturb the ALJ's order on these grounds. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated June 7, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

NOTICE

- This order is **FINAL** unless you appeal it to the **COLORADO COURT OF APPEALS**. To do so, you must file a notice of appeal in that court, either by mail or in person, but it must be **RECEIVED BY** the court at the address shown below within twenty-one (21) calendar days of the mailing date of this order, as shown below.

- A complete copy of this final order, including the mailing date shown, must be attached to the notice of appeal, and you must provide a copy of both the notice of appeal and the complete final order to the Colorado Court of Appeals.

- You must also provide copies of the complete notice of appeal package to the Industrial Claim Appeals Office, the Attorney General's Office (addresses shown below), and all other parties or their representative whose addresses are shown on the Certificate of Mailing on the next page.

- In addition, the notice of appeal must include a certificate of service, which is a statement certifying when and how you provided these copies, showing the names and addresses of these parties and the date you mailed or otherwise delivered these copies to them.

- An appeal to the Colorado Court of Appeals is based on the existing record before the Administrative Law Judge and the Industrial Claim Appeals Office, and the court will not consider documents and new factual statements that were not previously presented or new arguments that were not previously raised.

- Forms are available for you to use in filing a notice of appeal and the certificate of service. You may obtain these forms from the Colorado Court of Appeals online at its website, www.colorado.gov/cdle/CTAPPFORM or in person, or from the Industrial Claim Appeals Office. **Please note address changes as listed below.**

- The court encourages use of these forms. Proper use of the forms will satisfy the procedural requirements of the Colorado Appellate Rules for appeals to the Colorado Court of Appeals. **For more information regarding an appeal, you may contact the Court of Appeals directly at 720-625-5150.**

Colorado Court of Appeals
2 East 14th Avenue
Denver, CO 80203

Industrial Claim Appeals Office
633 17th Street, Suite 200
Denver, CO 80202

Office of the Attorney General
State Services Section
Ralph L. Carr Colorado Judicial Center
1300 Broadway 6th Floor
Denver, CO 80203

CERTIFICATE OF MAILING

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

10/10/17 by TT

LAW OFFICE OF OTOOLE AND SBARBARO PC, Attn: NEIL D OTOOLE, 226 WEST 12TH AVE, DENVER, CO, 80204-3625 (For Claimant)
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