COLORADO
Department of
Labor and Employment

Division of Workers' Compensation
633 17th Street, Suite 400
Denver, CO 80202-3660
303-318-8700

September Case Law Update

Presented by Judge Elsa Tenreiro and Judge Craig Eley

This update covers ICAO and COA decisions issued from August 4, 2018 to September 7, 2018

Colorado Supreme Court Decision

Industrial Claims Appeals Office Decisions

Nevada Supreme Court Decision

Subscribe to the Case Law Update mailing list.

The Case Law Update is offered as an educational and informational program. The discussions and commentary should not considered a policy statement by the Division of Workers' Compensation or an indication of how the presenters would rule on any future pending cases.

COLORADO COURT OF APPEALS

DATE FILED: August 16, 2018
CASE NUMBER: 2017CA1505

Court of Appeals No. 17CA1505
Industrial Claim Appeals Office of the State of Colorado
WC No. 5-002-866

Mirzeta Becirovic,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, Interstate Management Company, LLC, d/b/a Residence Inn Colorado Springs Residence Inn, and Zurich American Insurance Company,

Respondents.

ORDER AFFIRMED

Division VI
Opinion by JUDGE TERRY
Navarro and Freyre, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced August 16, 2018

Frederick W. Newall, Colorado Springs, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

The Kitch Law Firm, P.C., Marsha A. Kitch, Evergreen, Colorado, for Respondents Interstate Management Company, LLC and Zurich American Insurance Company

¶ 1 In this workers' compensation action, claimants, Mevludin, Lejla, and Arnes Becirovic, surviving spouse and children of decedent petitioner-appellant, Mirzeta Becirovic, seek review of a final order of the Industrial Claim Appeals Office (Panel), affirming the dismissal of their claim for death benefits as time barred. We affirm.

I. Background and Procedural History

¶ 2 Mirzeta Becirovic sustained a work-related injury to her back in August 2011, for which she sought workers' compensation benefits. She passed away on November 19, 2013, of a pulmonary embolism. At the time of her death, her workers' compensation claim was still pending and a hearing had not yet been held.

¶ 3 Nearly a year and a half after Mirzeta Becirovic's death, on March 23, 2015, Dr. Timothy Hall sent a letter to claimants' attorney opining that Ms. Becirovic's back injury may have contributed to her death. Specifically, Dr. Hall wrote that her

> inactivity/relative immobility related directly to her compensable injury contributed substantially to her eventual pulmonary embolism, likely via deep vein thrombosis. . . . This inactivity/immobility, particularly in this setting of obesity, is a major contributor to the development of deep

> vein thrombosis and subsequent emboli. It is clear in the record that there was a dramatic reduction in her walking and standing activities subsequent to the work-related injury and ongoing pain.

¶ 4 Just over three months later, on July 2, 2015, claimants' counsel faxed an entry of appearance, dependent's notice of claim, children's birth certificates, marriage license, and Ms. Becirovic's death certificate to the Colorado Springs Office of Administrative Courts (OAC). Several months later, on November 5, 2015, petitioners' counsel faxed the same documents to the OAC in Denver. Finally, on December 9, 2015, claimants' counsel faxed the documents to the Division of Workers' Compensation (Division) in Denver. The parties agree that the correct place to file a claim for death benefits is with the Division in Denver.

¶ 5 On January 7, 2016, the Division notified Ms. Becirovic's employer, Residence Inn, and its insurer, Zurich American Insurance (collectively employer), of claimants' notice of claim. Employer filed a notice of contest on March 3, 2016, contending that the applicable statute of limitations, section 8-43-103(2), C.R.S. 2017, barred the claim because it had been filed with the Division more than two years after Ms. Becirovic's death.

¶ 6 The administrative law judge (ALJ) who heard the case agreed and dismissed the claim. The ALJ rejected claimants' contentions that the statute of limitations should not have commenced running until Dr. Hall expressed his opinion that Ms. Becirovic's death was work-related. Instead, the ALJ found that claimants had ample time to learn of, or at least inquire into, the relatedness of Ms. Becirovic's death, and that all the medical information necessary to determine whether her work-related injury caused her death was available when she died. The ALJ also rejected claimants' alternative argument that they showed good cause for filing their claim with the Division more than two years after Ms. Becirovic's death. The ALJ was not persuaded that claimants' mistaken filing with the OAC was reasonable, and questioned claimants' failure to check the status of their claim after sending it to the OAC.

¶ 7 On review, the Panel affirmed, holding that substantial evidence supported the ALJ's factual findings.

II. Statutory Filing Deadlines

¶ 8 In order to be timely filed under the Act, a claim for workers' compensation must be filed within two years of the alleged injury. The Act provides:

> The right to compensation and benefits provided by said articles shall be barred unless, within two years after the injury or after death resulting therefrom, a notice claiming compensation is filed with the division. This limitation shall not apply . . . if it is established to the satisfaction of the director within three years after the injury or death that a reasonable excuse exists for the failure to file such notice claiming compensation. . . .

§ 8-43-103(2). "[T]he limitation period commences when the claimant, as a reasonable person, should recognize the nature, seriousness, and probable compensable character of the injury." *City of Durango v. Dunagan*, 939 P.2d 496, 498 (Colo. App. 1997).

III. Constitutional Claims

¶ 9 Claimants first raise two constitutional arguments, asserting that (1) their rights to due process were violated by the failure of the Division to date stamp documents as soon as they were received; and (2) their rights to equal protection were violated because the ALJ failed to equally apply the statutory presumption that a death that occurred more than two years after the date of an injury is unrelated. We disagree that they suffered any constitutional violation.

¶ 10 At the outset, we address employer's contention that these arguments were not preserved below and therefore are not properly before us. This is incorrect. The fact that these constitutional challenges were not raised below does not preclude claimants from asserting them here. *See Montezuma Well Serv., Inc. v. Indus. Claim Appeals Office*, 928 P.2d 796, 798 (Colo. App. 1996). In general, "because neither an ALJ nor the Panel is authorized to address constitutional challenges to the Act, such challenges can be raised for the first time on appeal." *United Airlines v. Indus. Claim Appeals Office*, 2013 COA 48, ¶ 27. Consequently, "[t]his court has initial jurisdiction to address constitutional challenges to the Workers' Compensation Act (Act)." *Zerba v. Dillon Cos.*, 2012 COA 78, ¶ 8. We therefore turn to the merits of claimants' constitutional arguments.

A. No Due Process Violation

¶ 11 "The fundamental requisites of due process are notice and the opportunity to be heard." *Franz v. Indus. Claim Appeals Office*, 250 P.3d 755, 758 (Colo. App. 2010) (quoting *Hendricks v. Indus. Claim Appeals Office*, 809 P.2d 1076, 1077 (Colo. App. 1990)). Although it is true that workers' compensation benefits are a constitutionally

protected property interest, those property rights are protected by the due process guarantees of notice and an opportunity to be heard. *See Whiteside v. Smith*, 67 P.3d 1240, 1247 (Colo. 2003). Because it is a flexible standard, no specific procedure is required "as long as the basic opportunity for a hearing and judicial review is present." *Ortega v. Indus. Claim Appeals Office*, 207 P.3d 895, 899 (Colo. App. 2009); *see also Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1195 (Colo. App. 2002); *Wecker v. TBL Excavating, Inc.*, 908 P.2d 1186, 1188 (Colo. App. 1995).

¶ 12 Claimants contend that the entry of appearance form they incorrectly filed with the OAC in Denver was forwarded to the Division and bears a date stamp of November 5, 2015. They claim that this offers proof that the entire packet was forwarded to the Division before the deadline. But, this evidence neither establishes this connection nor supports a contention that claimants' due process rights were violated.

¶ 13 First, we note that the only document that bears that date stamp in question is the entry of appearance form, not the notice of claim. The ALJ did not find, and we cannot assume, that a date stamp on one document evidences filing of all the documents.

Moreover, the date stamp in the record to which claimants point us actually states that the document was received in the "Office of Administrative Courts." As we read the document, though, it bears no markings from the Division. Although the document is also date stamped January 6, 2016, we have no way of knowing when or if OAC forwarded the documents to the Division. Indeed, the ALJ expressly rejected claimant's assertion that the OAC forwarded the documents to the Division, finding there was "no evidence" to support this assertion. We are bound by this factual finding where, as here, it is supported by substantial evidence in the record. *See Paint Connection Plus v. Indus. Claim Appeals Office*, 240 P.3d 429, 431 (Colo. App. 2010) ("When an ALJ's findings of fact are supported by substantial evidence, we are bound by them.").

¶ 14 Second, and perhaps more importantly, claimants' contentions were fully heard before the ALJ. Their exhibits were introduced into evidence and they were given the opportunity to call and question witnesses. This is all due process requires. *Franz*, 250 P.3d at 758. Even if we were to assume that the date stamp was incorrect or late — and we make no such finding — the hearing gave claimants the opportunity to establish that they timely filed their claim. They

failed to do so even after a full hearing. The fact that the ALJ remained unconvinced is not a deprivation of due process but rather a rejection of claimants' contentions.

B. No Equal Protection Violation

¶ 15 Claimants next contend that their rights to equal protection were violated because the "ALJ held that [employer was] entitled to the presumption [created by section 8-41-207, C.R.S. 2017], but not [claimants.]" Section 8-41-207 provides that "[i]n case death occurs more than two years after the date of receiving any injury, such death shall be prima facie presumed not to be due to such injury . . . ." Claimants posit that "[t]here is nothing in the statute that suggests that the presumption is to be applied only for the employer's benefit." As we understand claimants' argument, they contend that the ALJ improperly relied upon the presumption to assume Ms. Becirovic's death was not compensable, in violation of their equal protection rights. We perceive no basis for setting aside the Panel's order on this ground.

> The threshold question in an equal protection challenge is whether the legislation results in dissimilar treatment of similarly situated individuals. To violate equal protection provisions, the classification must arbitrarily

> single out a group of persons for disparate treatment from other persons who are similarly situated.

Peregoy v. Indus. Claim Appeals Office, 87 P.3d 261, 265 (Colo. App. 2004). Claimants here have not cogently articulated how they were treated differently than another group. They appear to claim that they were entitled to the statutory presumption that a death is unrelated to a work injury if the death occurs more than two years after the injury. Yet, claimants fail to explain how this presumption should have been applied to their benefit. We therefore cannot say that the ALJ applied the statutory presumption unequally. *Id.*

¶ 16 And, even if we assume that the ALJ incorrectly applied the presumption here, the ALJ's inclusion of it in his order had no bearing on the final ruling. The claim was dismissed not because the ALJ presumed Ms. Becirovic's death was unrelated to her work injury, but rather because claimants' claim for dependent benefits was untimely. The presumption did not affect the statute of limitations' application. Consequently, we find no equal protection violation here.

IV. Substantial Evidence Supports Finding that Statute of Limitations Accrued with Ms. Becirovic's Death

¶ 17 Claimants next contend that the statute of limitations should not have commenced running until Dr. Hall's March 2015 report linking Ms. Becirovic's November 2013 death to her August 2011 work-related injury. Claimants argue that until Dr. Hall issued his report, they could not have reasonably known that Ms. Becirovic's pulmonary embolism was likely linked to her back injury. *See Dunagan*, 939 P.2d at 498. At the very least, they contend, Ms. Becirovic's daughter, Lejla, should not have been held to the statute of limitations because she did not turn eighteen until July 2015. We are not persuaded by these arguments.

¶ 18 In workers' compensation cases, "the time begins to run for filing 'a notice claiming compensation' when the claimant, as a reasonable man, should recognize the nature, seriousness and probable compensable character of his injury." *City of Boulder v. Payne*, 162 Colo. 345, 351-52, 426 P.2d 194, 197 (1967). In general, when a statute of limitations accrues — i.e. when a claimant should reasonably have known of a compensable injury — is a question of fact for determination by the ALJ. *See Jackson v.*

Am. Family Mut. Ins. Co., 258 P.3d 328, 332 (Colo. App. 2011) ("Ordinarily, when a claim accrues and, consequently, whether a claim is barred by the statute of limitations are questions of fact for a jury to resolve."); *Morris v. Geer*, 720 P.2d 994, 997 (Colo. App. 1986) ("The time when a plaintiff discovered, or through the use of reasonable diligence should have discovered, the negligent conduct is normally a question of fact which must be resolved by the trier of fact.").

¶ 19 Despite claimants' protestations that they could not have known Ms. Becirovic's death was work-related until they received Dr. Hall's report, the ALJ found, with record support, that the report was addressed to claimants' counsel — indicating that claimants requested the report — and that all the medical records Dr. Hall reviewed were available when Ms. Becirovic died. Claimants offered no explanation to the ALJ — nor to this court — why they did not seek medical advice about the cause of Ms. Becirovic's pulmonary embolism until more than a year after her death. As the ALJ found, no additional information became available which may have prompted them to seek advice; they possessed the same knowledge when they eventually sought Dr.

Hall's advice as was available to them when Ms. Becirovic passed away. The ALJ therefore found that the statute of limitations accrued in November 2013, when Ms. Becirovic passed away.

¶ 20 These findings are amply supported by the record, and we therefore are bound by them and may not set them aside. *See* § 8-43-308, C.R.S. 2017; *Paint Connection Plus*, 240 P.3d at 431.

¶ 21 Claimants nevertheless point to several cases in which the statute of limitation's accrual was delayed until a claimant or plaintiff reasonably should have known of his or her injury, arguing that they likewise should not be barred because they could not have known sooner that Ms. Becirovic's death was related to her work injury. *See Payne*, 162 Colo. at 351-52, 426 P.2d at 197; *Dunagan*, 939 P.2d at 498; *Intermountain Rubber Indus., Inc. v. Valdez*, 688 P.2d 1133, 1137 (Colo. App. 1984); *City & Cty. of Denver v. Moore*, 31 Colo. App. 310, 315, 504 P.2d 367, 370 (1972).

¶ 22 But, in each of the cases claimants cite, the reviewing court simply upheld the fact-finder's determination that the injury could not reasonably have been discovered until a later time, which delayed accrual of the statute of limitations. *See Payne*, 162 Colo. at 351-52, 426 P.2d at 197 (upholding award of compensation for

claim filed six years post-injury); *Dunagan*, 939 P.2d at 498 (affirming ALJ's award of medical benefits and rejecting employer's contention that, as a matter of law, claimant should have recognized seriousness of injury earlier); *Intermountain Rubber Indus.*, 688 P.2d at 1137 ("[T]he evidence supports the hearing officer's determination that claimant did not know the nature, seriousness, or compensable character of his injury until he was diagnosed in 1980 as suffering from a herniated disc."); *Moore*, 31 Colo. App. at 315, 504 P.2d at 370 (rejecting employer's contention that statute of limitations had run and upholding commission's findings as "adequate" to support award of benefits). We likewise must uphold the ALJ's factual finding that the statute of limitations accrued in November 2013, when Ms. Becirovic passed away, because the finding is supported by substantial evidence in the record. *See* § 8-43-308; *Paint Connection Plus*, 240 P.3d at 431; *see also Payne*, 162 Colo. at 351–52, 426 P.2d at 197; *Dunagan*, 939 P.2d at 498; *Intermountain Rubber Indus., Inc.*, 688 P.2d at 1137; *Moore*, 31 Colo. App. at 315, 504 P.2d at 370.

¶ 23 With respect to claimants' assertion that the statute of limitations should have been tolled because Lejla Becirovic was a

minor at the time of her mother's death, we note that claimants did not raise this argument before the ALJ. The failure to raise an issue before the ALJ renders an issue unpreserved. *See Dunagan*, 939 P.2d at 500 ("Petitioners did not raise this specific argument before the ALJ and it was only raised before the Panel in petitioners' reply brief, which was stricken from the record by the ALJ." The argument therefore was not addressed on appeal.). Consequently, we decline to address this contention further.

V. Substantial Evidence Supports Finding that There Were No Reasonable Excuses for Late Filing of Claim

¶ 24 Alternatively, claimants contend that they presented reasonable excuses for their failure to file their claim timely. They point to "the negligence [of] the staff's faxing the claim to the fax number located on the Entry of Appearance form," and, citing *Martin v. Indus. Comm'n*, 43 Colo. App. 521, 524, 608 P.2d 366, 369 (1979), assert that they made a "timely attempt to file a notice of claim." They contend the ALJ should have weighed these factors in their favor. We disagree.

¶ 25 Whether a claimant has established a reasonable excuse for failing to file a claim in a timely fashion is a question of fact within

the ALJ's wide discretion, and will therefore only be set aside if a claimant establishes fraud or abuse of discretion. *See Indus. Comm'n v. Canfield*, 172 Colo. 18, 21, 469 P.2d 737, 739 (1970) ("Since the commission is the agency specifically entrusted with the discretionary power to determine the reasonableness of the excuse and the prejudice resulting from the delay, it is given broad discretion in determining those questions and the decision of the commission will only be set aside upon a showing of fraud or abuse of discretion.").

¶ 26 The ALJ found that claimants failed to explain why they waited so many months after Ms. Becirovic's death to obtain Dr. Hall's report, and that, regardless, because the report was not a prerequisite to filing their claim, they could have filed their claim without it. It is undisputed that claimants did not forward their claim to the Division until December 2015, having previously mistakenly faxed their claim to two Offices of Administrative Courts. The ALJ found that "there is no evidence that anyone *misdirected* [c]laimants in any fashion. There is no evidence of *fraud or mistake of fact*." And, the ALJ found that, although several months elapsed

with no word on their claim from the OAC or the Division, claimants made no effort "to check the status of the claim."

¶ 27 The ALJ also observed that "filing . . . a document with the incorrect Office of Administrative Courts location does not result in timely filing." Another division of this court has indeed articulated this rule: "The timely filing requirement extends to and requires that a petition be filed with the proper administrative or judicial forum." *Buschmann v. Gallegos Masonry, Inc.*, 805 P.2d 1193, 1194 (Colo. App. 1991). Thus, "if a failure properly to mail or deliver a petition for review of an ALJ's order in a workers' compensation proceeding results in an untimely filing at the office indicated in the ALJ's order, then the petition is jurisdictionally defective and review on the merits is barred." *Id.* at 1195.

¶ 28 Accordingly, we perceive no abuse of discretion in the ALJ's determination that claimants failed to articulate a reasonable excuse for filing their claim late. *Canfield*, 172 Colo. at 21, 469 P.2d at 739. We therefore reject this contention, as well.

VI. Conclusion

¶ 29 The order is affirmed.

JUDGE NAVARRO and JUDGE FREYRE concur.

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-935-523-04

IN THE MATTER OF THE CLAIM OF:

MICHAEL POTTER,

Claimant,

v.

FINAL ORDER

GROUNDS SERVICE COMPANY INC,

Employer,

and

TRUCK INSURANCE EXCHANGE,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Lamphere (ALJ) dated February 28, 2018, that affirmed the decision of the Division sponsored Independent Medical Examination (DIME) physician that the claimant was not at maximum medical improvement (MMI) and ordered the respondents liable for the costs of an EMG electrical nerve exam and a surgical consult. We affirm the ALJ's order concerning the finding there is an absence of MMI and the allocation for the cost of the EMG. We set aside the order insofar as it authorizes a surgical consult.

The claimant worked for the respondent employer as a truck driver and equipment operator in its landscaping business. The claimant sustained an injury at work on September 10, 2013. When the claimant stepped from his riding lawnmower, he slipped on some wet grass, fell and hit a steel beam with his low back. The claimant treated with Dr. Anderson, the authorized treating physician. An MRI of the lumbar spine was obtained. The December 14, 2013 MRI showed severe right side stenosis at L4-5, a severe bilateral stenosis at L5-S1 and a bulging disc at L3-4 with a small central disc protrusion. The claimant received physical therapy. By March 2014, the claimant reported to Dr. Anderson his previous pain from sciatica had largely resolved and his range of motion had improved. Dr. Anderson placed the claimant at MMI on March 7, 2014, with no permanent impairment and no work restrictions.

The claimant requested a DIME review of the MMI and impairment determination. A DIME exam was conducted by Dr. Henke on July 9, 2014. Dr. Henke obtained a history indicating that after the claimant was placed at MMI on March 7, he suffered a reoccurrence of low back pain radiating into his right leg. The claimant had twice been to the emergency room since April 2014. Dr. Henke concluded the claimant was not at MMI and recommended a bilateral lower extremity EMG (electromyogram) examination and a neurosurgical consultation. At the respondents' request, the claimant was evaluated by Dr. Shih. The doctor did not believe the claimant's back condition had been caused by the September 10, 2013, fall at work. The respondents elected to challenge the finding regarding MMI at hearing. Following a December 3, 2014, hearing, ALJ Margot Jones affirmed the DIME determination that the claimant was not at MMI.

The respondents referred the claimant for an independent examination by Dr. Walker in September 2015. Dr. Walker noted inconsistencies in the history provided by the claimant and in his activities depicted in a surveillance video. She concluded the claimant had indeed achieved MMI on March 7, 2014. The claimant requested a follow up DIME evaluation by Dr. Henke. In a December 11, 2015, report Dr. Henke disagreed with Dr. Walker. Dr. Henke again concluded the claimant was not at MMI and required an EMG exam and a neurosurgical consultation. The respondents then filed a General Admission of Liability and referred the claimant for additional treatment with Dr. Miller. Dr. Miller recommended physical therapy, aquatic therapy, epidural injections, and adjusted the claimant's pain medication. After three visits, on June 23, 2016, Dr. Miller wrote the claimant was not interested in injections and wished to be placed at MMI. The doctor did not refer the claimant for an EMG or surgical consultation.

Dr. Henke saw the claimant for a third DIME review. On October 20, 2016, Dr. Henke wrote the claimant had increased symptoms of right leg radiculopathy and back pain. He noted this was consistent with MRI images. Dr. Henke again found the claimant was not at MMI. He recommended a bilateral lower extremity EMG and a neurosurgical consultation. The respondents submitted an application for a hearing to challenge this determination that MMI had not yet been attained and to contest the reasonableness and necessity for the recommended EMG and surgical consult.

A hearing was held on May 23, 2017. The claimant testified at the hearing. Dr. Henke and Dr. Walker testified through depositions. The ALJ found the testimony of Dr. Henke persuasive. The contrary opinions of Dr. Walker, Dr. Shih and Dr. Anderson were described as falling short of the clear and convincing evidence necessary to set aside Dr. Henke's observation concerning MMI. The ALJ upheld the recommendations of Dr.

Henke for additional EMG diagnostic testing and a surgical evaluation as justified. He found compelling the contention they would assist in determining whether the claimant's leg pain was due to a spinal disc compression and whether spinal surgery presented a reasonable prospect for curing and relieving the claimant of the effects of his September 2013 work injury. The ALJ concluded the claimant had not reached MMI. The ALJ also ordered the respondents to pay for all expenses associated with the completion of an EMG and a neurosurgical consultation.

On appeal, the respondents contend the DIME decision of Dr. Henke was issued without regard for the Director's Impairment Rating Tips and the AMA Guides to Permanent Impairment. The respondents assert the DIME report relied on medical records that had not been exchanged with the respondents in contravention of the Director's rules for DIME exams. The respondents argue the ALJ incorrectly applied the law of the case by adopting the determinations of ALJ Jones despite subsequent significant changes in the development of the claim. Lastly the respondents maintain the ALJ lacked authority to require the respondents to pay for medical treatment not recommended by any authorized physician.

I.

The respondents point out the Director's Impairment Rating Tips direct a DIME physician to provide a provisional impairment rating despite the absence of MMI. Such a provisional rating is noted to be helpful to the parties in settlement negotiations. The respondents also set forth that the AMA Guides require a DIME physician dealing with a spine injury to complete three sets of range of motion measurements and to attach the rating sheets recording the measurements to the final DIME report. Dr. Henke did not complete these tasks. The ALJ ruled these technical deviations did not affect the credibility of the decision concerning MMI. We find the ALJ's conclusion correct. The determination of MMI is controlled by the definition in § 8-40-201(11.5). The notation that a claimant has reached MMI signifies the claimant's medical condition has become stable and "no further treatment is reasonably expected to improve the condition." The achievement of MMI is a prerequisite to the determination of permanent impairment. Should it be resolved the claimant is not a MMI, any consideration of permanent impairment is premature. The statute directs the role of the AMA Guides to be germane solely to the calculation of the degree of permanent impairment. Section 8-42-101(3.7) specifies the AMA Guides to the Evaluation of Permanent Impairment, third edition revised, is a standard only for "physical impairment ratings." *Talboys v. Greenhouse Restaurant*, W.C. No. 4-597-998 (September 25, 2013). Accordingly, the specifications of the AMA Guides, concerned as they are exclusively with the permanent impairment

rating, play no role in considerations of MMI. *Mandel v. Sears*, W.C. No. 4-575-413 (January 24, 2005); *Lopez v. The Evangelical Lutheran Society*, W.C. No. 4-972-365-01 (April 6, 2016). The Impairment Rating Tips that are interpretations of the AMA Guides similarly have no application to the appreciation of MMI. The absence of a provisional permanent impairment rating, or range of motion deficits described in Chapter 3.3 of the AMA Guides, present no implications for a determination of MMI. The standard advocated by the respondents to suggest error in the DIME report's MMI conclusion is not applicable.

The respondents argue the ALJ was mistaken in adopting ALJ Jones's prior order as the law of the case. The respondents point out changes in the claimant's condition occurring subsequent to the date of his first DIME examination make application of ALJ Jones's review of that DIME exam inapposite to the subsequent review by ALJ Lamphere. It appears the respondents have misread ALJ Lamphere's position about the order of ALJ Jones. ALJ Lamphere nowhere says he adopts ALJ Jones's determinations as binding on his findings. He stated: "… the undersigned concludes, as did ALJ Jones that Respondents have failed to produce clear and convincing evidence to establish that Dr. Henke's determination regarding MMI is highly probably incorrect." Conclusions of Law ¶ (G). This finding signifies only that the decisions of both ALJs reached the same final conclusions pertinent to MMI. It does not reflect a decision by ALJ Lamphere to apply the determination of ALJ Jones as the law of the case.

The respondents maintain that three other physicians, and the statements of the claimant himself, placed the claimant at MMI. Hence the ALJ was in error to rule the DIME finding of no MMI was not overcome. This contention notwithstanding, the ALJ found compelling the testimony of the claimant that he never advised his treating physicians he was at MMI. Once the issue of MMI has been reviewed by a DIME physician, an ALJ may consider the strength of an MMI determination provided by a treating doctor. *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513, 516 (Colo. App. 2002). However, the number of authorized physicians stating MMI has been achieved is not significant. Each of those opinions may be overcome by simply a preponderance of the evidence. In contrast, the MMI decision of the single DIME doctor must be overcome by clear and convincing evidence. It is not a situation where the evidentiary weight of each authorized doctor is multiplied by the number of additional authorized physicians recruited to join in the same MMI determination. The ALJ found the applicable DIME decision was not overcome by clear and convincing evidence. This finding is supported by substantial evidence in the record. It is immaterial if one, or several, authorized physicians, in conjunction with an IME and the claimant himself, arrives at a contrary MMI conclusion. Absent legal error, once the DIME determination

has been upheld for lack of clear and convincing evidence, any other opinion regarding MMI is no longer of consequence.

The respondents contend Dr. Henke relied in his DIME evaluation on medical records supplied by the claimant that were not exchanged with the respondents. Workers' Compensation Rule of Procedure (WCRP) 11-3(K) requires supplemental records provided the DIME physician be copied and delivered to all other parties at least seven days prior to the DIME appointment. In his second DIME report of December 11, 2015, Dr. Henke wrote that the claimant had been treating with his personal physician. Dr. Henke described how the claimant brought with him MRI images taken on September 28, 2015. That MRI had been arranged by the personal physician. Dr. Henke described in his deposition that he viewed the MRI and then returned it to the claimant. The doctor did record in his October 20, 2016, DIME report that the MRI revealed severe L4-5 and L5-S1 foraminal stenosis bilaterally, and a L3-4 central disc protrusion. The respondents state this MRI was never provided to them and its use by the DIME physician rendered the DIME review illegitimate. The respondents complain they were denied adequate notice of this significant evidence and were rendered incapable of providing an adequate response. However, the respondents did not dispute the December 11, 2015, DIME report. Instead, they filed a corresponding General Admission of Liability. The respondents also did not raise the issue with the ALJ at the May 23, 2017, hearing when they disputed the October 2016 DIME findings. WCRP 11-10 requires that disputes over the DIME process should be taken before an ALJ. In addition, the DIME physician did review the MRI completed on December 14, 2013, in the first DIME report of July 18, 2014. That MRI was read to show severe L5-S1 left and mild right foraminal stenosis, L4-5 severe right foraminal stenosis and moderate left foraminal stenosis as well as posterior and central disc bulging and protrusion at L3-4. Therefore, the findings of the December 2013 MRI were functionally equivalent to those of the September 2015 MRI. In order to obtain a new DIME review, a party must demonstrate a prejudicial effect caused by any alleged abridgement of a rule. *Youngs v. White Moving & Storage*, W.C. No. 4-648-693 (October 3, 2018). The equivalency of the MRIs renders the lack of exchange inconsequential and non-prejudicial.

II.

The respondents complain the ALJ was without authority to order them to pay for an EMG test and a neurosurgical consult. They assert no authorized physician has requested either of those procedures. The respondents rely on the decisions in *Torres v. City and County of Denver*, W.C. No. 4-917-329-03 (May 15, 2018) and *Short v. Property Management of Telluride*, W.C. No. 3-100-726 (May 4, 1995). Those opinions

hold the ALJ may not order an authorized treating physician to provide a particular form of treatment that has been prescribed only by a physician unauthorized to treat. In *Torres*, the ALJ ordered the respondents liable for a discectomy and fusion surgery recommended solely by a DIME physician. Due to the absence of a similar suggestion for such surgery by an authorized doctor, we set aside the ALJ's order as beyond the ALJ's authority. The present matter also features an order by the ALJ for medical procedures advocated by the DIME physician but not prescribed by an authorized doctor.

We conclude that the order pertinent to the neurosurgical consult is controlled by the analysis in *Torres* and is set aside. However, the order directing payment for an EMG exam is significantly distinct from the surgical consult and the surgery ordered in *Torres.* Consequently, we find the ALJ has the authority to require the respondents to bear the costs of the EMG.

The Rules concerning the conduct of DIME reviews were amended in 2001 to provide a mechanism for securing the results of medical tests felt necessary by the examiner to complete the DIME review. The Rule, now denominated as WCRP 11-4(A), was supplemented with a second paragraph:

> It is expected that a test essential under the AMA Guides, 3rd Edition (revised) or the Level II accreditation curriculum for an impairment rating to be rendered will have been performed prior to the IME. Routine tests necessary for a complete IME should be performed as part of the IME with no additional cost. If an essential test is non-routine or requires special facilities or equipment, and such test was not previously performed, or was previously performed but the findings are not usable at the time of the IME, the physician performing the IME shall notify the Division, who will notify the parties. Unless extraordinary circumstances exist that result in an ALJ issuing a ruling to the contrary, the physician performing the IME will either perform the essential test or refer out the essential test for completion, and the insurer shall be responsible for paying for the essential test.

An EMG, or electromyography, involves the application of small needles, electrodes, through the skin into the muscles. When the patient contracts the muscles, the resulting electrical signal from the responsible nerve is transmitted by the electrode to an oscilloscope. The signal received is then read to determine the degree, or absence, of nerve impulses. Dr. Henke testified the EMG could verify whether the claimant suffered from a nerve impingement and a radiculopathy that may cause his symptoms. The EMG would also identify the level in the spine causing any impingement. Dr. Henke indicated in his DIME reports he did not feel the claimant was at MMI. However, he explicitly stated in his deposition his analysis was not necessarily that the claimant was not at MMI but, rather, that without the EMG he could not determine that "no further treatment is reasonably expected to improve the condition."

> Well, the definition of MMI still should be followed, which is that the patient's condition, first, is stable, and that there's knowledge of knowing why the person had whatever symptoms they had from that reported accident. And because of lack of having additional diagnostics, an EMG being certainly one of them, that kind of evidence, … you cannot make a statement of MMI because you don't have the basis for determining that. So it's an open question. (Henke Depo. at 24.)

As a result, the record reveals the EMG is considered by the DIME physician to be a test "necessary for a complete IME." The EMG test has not been performed previously and it requires special equipment. The EMG qualifies as an 'essential test' referenced by WCRP 11-4(A). The Division and the parties have been notified of the need for the EMG test through the three DIME reports authored by Dr. Henke. In turn, the respondents sought a hearing concerning the reasonableness and necessity for this test. Tr. at 4, and the claimant requested the ALJ order the respondent insurer to pay for the procedure.

In *Beede v. Allen Mitchek Feed & Grain*, W.C. No. 4-317-785 (April 20, 2000), we held that diagnostic testing costs requested by a DIME examiner pursuant to WCRP 11-4(A), secondary to performing a DIME, do not constitute medical 'benefits'. They are more accurately characterized as serving an evidentiary purpose. Medical testing suggested by a DIME physician concerning MMI and permanent impairment, is not sought for the purposes of 'diagnosis and treatment' of the work related injury. "Rather, such tests are incidental to the DIME physician's evidentiary function in determining the issues of MMI and permanent medical impairment." *Id*. If the test involves procedures

which will "assist the IME physician in making the necessary factual and evidentiary determinations underlying the findings of MMI and medical impairment", the test is not to be seen as a medical cost but as a cost adjunct to the DIME process. An MRI deemed necessary by the DIME doctor in *Brickell v. Overhead Door Co*., W.C. No. 4-586287 (February 4, 2005), was authorized pursuant to WCRP 11-4(A) when it was found "to assist the DIME physician in performing his evidentiary role." Testing including blood tests, methacoline tests, a spirometry, allergy testing and a CAT scan were held in *Omer v. Lonestar Steakhouse*, W.C. No. 4-293-337 (February 15, 2001), to be controlled by WCRP 11-4(A) as tests described in the Rule that will "assist the DIME physician in making the necessary factual and evidentiary determinations underlying the findings." The EMG test requested by Dr. Henke in this matter similarly qualifies as a diagnostic test designated by WCRP 11-4(A) as an 'essential test'. The cost of that test therefore, is not a medical benefit, but is a cost of the DIME process. The determination in *Torres* that an ALJ lacks authority to order certain medical benefits would not apply to a medical cost described by WCRP 11-4(A), seeing as how that cost does not stem from a medical benefit.[1]

However, the order concerning the cost of a neurosurgical consult could not fairly be described as an 'essential test' subject to WCRP 11-4(A). Such a consultation is a request to secure an opinion from another physician. It does not involve special equipment and is not a test at all. Further, WCRP 11-2(F) directs a DIME doctor to "Not refer any IME claimant to another physician for treatment or testing unless an essential test is required pursuant to section 11-4(A) of this rule." Such a consultation constitutes a medical benefit. Pursuant to *Torres*, absent a prior recommendation for the consultation by an authorized physician, the ALJ is without authority to order the respondents liable for the neurosurgical consultation.[2]

---

[1] WCRP 11-4(A) existed previously as Rule XIV(L)(4)(a). The version of the Rule referenced by both the *Bede* and the *Omer* decisions consisted entirely of the text now appearing in the first paragraph of current Rule 11-4(A). That first paragraph discusses the situation where the DIME reviewer is facing a voluminous amount of medical records. Pursuant to the Rule, the DIME may request additional fees in that case. The Rule also contained one sentence pertinent to necessary diagnostic tests: "The same processes as listed above shall apply with regard to any clinical or diagnostic testing requested by physicians performing IMEs." The current version in Rule 11-4(A), circa 2001, retains this sentence in its first paragraph but added a second paragraph devoted exclusively to 'essential tests'. The "same processes" refers to similarities in the two paragraphs that require the DIME physician to request the additional fees from the Division, which is to then request approval from the parties. However, in the current version, as before, the 'requesting party' is liable for auxiliary fees related to unusually extensive record reviews, whereas the insurer is now responsible to pay for essential tests.

[2] Section 8-43-301(2) indicates we may only review final orders. A final order as defined in that section requires that a party be ordered to pay a penalty or benefits or deny the claimant a benefit or penalty. In *Beede*, *supra*, the decision noted that because the tests requested by the DIME physician to complete the review, i.e. an exercise stress test and an echocardiogram, were not medical benefits, but instead, were expenses incident to a DIME procedure,

Rule 11-4(A) specifies an essential test required by a DIME physician is to be requested by that physician by notifying the Division and the Division is then to inform the parties. WCRP Rule 11-2(I) requires either agreement by the parties or approval by an ALJ. The ALJ is to deny the request only upon a finding of 'extraordinary circumstances'. Following approval, the insurer "shall be responsible for paying for the essential test". Neither party suggested any extraordinary circumstances present to preclude the EMG test. No negative side effects have been demonstrated nor has there been sufficient evidence presented that an EMG fails to measure any phenomena identified by Dr. Henke as relevant to the MMI determination. Accordingly, the ALJ appropriately ordered the respondent insurer liable for the costs of the EMG test pursuant to WCRP 11-4(A). As per the instruction in Rule 11-4(A), the DIME physician may either perform the test or refer out the essential test for completion.

III.

Both parties argue on appeal that issues concerning liability for the recommendations of the DIME doctor were not raised by the other party before the ALJ. To the contrary, the respondents' application for hearing designates medical benefits as an issue for hearing. The Case Information Sheet submitted by the claimant agrees medical benefits are an issue. At the outset of the May 23, 2017, hearing the ALJ inquired as to the issues at bar and asks specifically about "a request for, or a suggestion that additional medical benefits, or medical treatment be obtained here?" In response, respondents' counsel states: "That is correct. There have been a couple of recommendations by the DIME physician, which would be respondents' position are not reasonable and necessary. They've never – the requests were made by the DIME physician, but we've never received a request from an authorized treating physician on

---

any order concerning those costs would be interlocutory, and not final. Accordingly, § 8-43-301(2) prohibited our issuance of a decision in the matter. We have often ruled that issues surrounding the DIME process will prevent our review for this reason. *See Fisher v. University of Colorado Health*, W.C. No. 5-041-216-01 (June 12, 2018). However, the interlocutory issue may become reviewable when it is associated with an ALJ's order that does order or deny a benefit such that the order may be characterized as final. "Where an order neither awards nor denies benefits, it is merely interlocutory and is 'not ripe for appellate review.' … However, "an interlocutory order becomes reviewable when appealed incident to or in conjunction with an otherwise final order." *BCW Enters., Ltd. v. Indus. Claim Appeals Office*, 964 P.2d 533, 537 (Colo. App. 1997)." *Youngs v. Industrial Claim Appeals Office*, 316 P.3d 50, 55 (Colo. App. 2013). In this matter, unlike in *Beede*, the ALJ authorized a neurosurgical consult for the claimant. We have determined such a surgical consult is not an expense incident to a DIME review. Instead, we have deemed it a medical benefit. Therefore, pursuant to *BCW Enterprises* and *Youngs* the costs for the EMG tests, that we have construed as DIME expenses, may be reviewed in conjunction with the final order of the ALJ awarding the surgical consult medical benefit.

the matter, and that's why we're here." Tr. at 4. The need for the medical recommendations noted by Dr. Henke was raised in the testimony of both Dr. Walker, Walker Depo. at 10, and Dr. Henke, Henke depo. at 12-13, 21, 24, 34, 36, 42. Litigation of the issue may serve as the waiver of an objection. *Robbolino v. Fischer-White Contractors*, 738 P.2d 70 (Colo. App. 1987). At the conclusion of the evidence, the claimant included in his proposed findings to the ALJ findings of fact regarding the medical suggestions, ¶ 18, 19, 20 and a request that the ALJ order the respondents to pay for the EMG and the surgical consultation, ¶ 63. The issues were clearly raised before the ALJ, it was appropriate that he ruled on them, and the pertinent arguments raised by both parties in their appeal briefs regarding a request to allocate the cost of the procedures and the application of WCRP Rule 11 underscore that the issues were properly raised below. *Heckler v. Wern Air, Inc*. W.C. No. 4-877-223-04 (December 16, 2014).

IT IS THEREFORE ORDERED that the ALJ's order issued February 28, 2018, is affirmed insofar as it upholds the DIME physician's finding the claimant has not yet reached MMI and requires the respondent insurer to assume the cost of the DIME's recommended EMG test. As to ordering the respondents responsible for the costs of a neurological consult, we set aside that portion of the order.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

John A. Steninger

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-044-870-01

IN THE MATTER OF THE CLAIM OF

CYRUS RAJABI,

Claimant,

v.

FINAL ORDER

ARVADA FIRE PROTECTION DISTRICT,

Employer,

and

COLORADO SPECIAL DISTRICTS PROPERTY AND LIABILITY POOL c/o TRISTAR RISK MANAGEMENT,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Margot Jones (ALJ) dated February 22, 2018, that denied and dismissed his request for in home services and yard services. We affirm.

The claimant has been a volunteer firefighter for the respondent employer since 2011, but his primary occupation is as an attorney. On April 23, 2017, the claimant was participating in training for the respondent employer when he sustained an admitted injury to his right hand, primarily to the third and fourth digits. The claimant treated with Dr. VanderHorst who restricted him to light desk work and maximal grip and pinch of one pound with the right hand.

Dr. VanderHorst eventually referred the claimant to Dr. Davis. The industrial injury ultimately required surgery on the claimant's right ring finger, PIP joint, and ligaments throughout the right hand. This surgery was performed by Dr. Davis on April 26, 2017.

By June 2017, the claimant had developed complications related to his industrial injury. He developed right upper extremity pain, trophic changes, which included increased hair growth, swelling, mottling changes of the skin, and discoloration to the

claimant's right upper extremity. Dr. Davis suspected the claimant had developed complex regional pain syndrome (CRPS).

Multiple physicians eventually diagnosed the claimant with CRPS. In particular, Dr. VanderHorst assessed the claimant with a diagnosis of CRPS, Type 2 of the right upper extremity, weight loss of more than 10 pounds in 90 days, avulsion fracture of the proximal phalanx of finger, dislocation of the right ring finger, and anxiety disorder due to his general medical condition.

The claimant ultimately received extensive medical treatment, including stellate ganglion blocks, peripheral nerve blocks, interregional bier blocks, cervical sympathetic blocks, occupational and physical therapy, and daily medications. Further, after the claimant's surgery, Dr. Davis performed four to five cortisone injections in the joints of the claimant's right hand for pain and range of motion limitations. When these injections did not help, Dr. Davis referred the claimant to Dr. Ogin for pain management.

In June and July 2017, Dr. Davis wrote the claimant prescriptions for "home assistance" and "in home assistance." In a prescription dated June 5, 2017, Dr. Davis recommended that the claimant receive home assistance three days per week, for a four-week time period. Dr. Davis then wrote another prescription dated July 19, 2017, for in-home assistance for five hours per day, four days per week, for the next six to eight weeks, as needed.

On August 17, 2017, Dr. Davis wrote a letter to the respondent's counsel, advising that the claimant required "assistance with general home services and activities, including yard services. . . ." Dr. Davis explained that the claimant required this assistance to receive relief from his symptoms. He further explained that the performance of the tasks for which he sought assistance could cause re-injury to the right hand. Dr. Davis stated that the claimant needed in-home assistance five hours per day for five days per week for an additional six to eight weeks, as needed.

The claimant reported to his doctors that he experienced constant pain with paresthesia into the fingers and intermittent sharp shooting pains at 8-9/10. He explained that he is in excruciating pain all the time. His pain is burning, aching, and a dull sensation, with the pain at night being worse. The claimant also explained that the CRPS had created mirror pain in the left upper extremity and while not as bad, some pain in the bottom of the claimant's feet and hypersensitivity in his shoulders.

At the request of the respondents, the claimant underwent an independent medical examination (IME) with Dr. Olsen. Dr. Olsen opined that the claimant was able to bathe, dress, and perform his activities of daily living, and did not require any assistance with them. Dr. Olsen further explained that the claimant was not having any difficulties attending his medical appointments.

As pertinent here, at the commencement of the hearing on December 12, 2017, the respondents submitted Exhibits A through D. The claimant objected to admission of only Exhibit A, which was the IME report of Dr. Olsen. The claimant argued that the report was not timely provided to him until November 29, 2017, and was not received until December 4, 2017, in violation of the 20-day deadline set forth in WCRP 9-1 (Rule). In response, the respondents stated as follows:

> Your Honor, he's absolutely right. But Dr. Olsen is here to testify; he's an endorsed witness. So what we will do is simply admit – or submit the – his report in the context of his testimony. Tr. at 5-6.

The ALJ then ruled that Exhibit A would not be admitted at that time.

Subsequently, the respondents called Dr. Olsen to testify. The claimant objected to Dr. Olsen's testimony. The claimant stated that he was provided with interrogatory responses saying that Dr. Olsen would testify consistent with the contents of his report. However, the claimant again argued the report was not timely provided to him, and while there were passing references in the report to home assistance, the report nevertheless provided no opinions from Dr. Olsen pertaining to Dr. Davis' prescription for home and yard services. The claimant then read to the ALJ the respondents' interrogatory response:

> Dr. Olsen will testify as to his determination of what medical treatment, comma, including the provision of essential services, comma, is reasonable and necessary in this case.
>
> * * *
>
> Dr. Olsen will testify consistent with the contents of his report.

In response, the respondents stated that Dr. Olsen would be providing opinions about the claimant's entitlement to essential services, that they gave "the general sense of that," and that they would be asking questions that had "more to do with information exchanged during the evaluation as opposed to an actual opinion." The ALJ stated that since she had not yet read the report, she would allow Dr. Olsen to testify and then rule on the objections at some point later when she had had the opportunity to review his

report and compare whether the failure to update interrogatory responses with Dr. Olsen's opinions on the subject are an issue that could cause his testimony to be stricken. Tr. at 28-29.

During later questioning of Dr. Olsen, the respondents moved for admission of Dr. Olsen's IME report. The claimant again objected, and the respondents argued that Dr. Olsen had laid a foundation for his report following his IME. The ALJ summarily admitted Exhibit A into evidence. Tr. at 30-32.

The ALJ subsequently entered her order determining that the claimant failed to establish his need for home services and yard assistance was medical in nature. Relying on the Colorado Court of Appeals' holding in *Bellone v. Industrial Claim Appeals Office*, 940 P.2d 1116 (Colo. App. 1997), the ALJ reasoned that these services would not cure and relieve the symptoms and effects of the claimant's industrial injury. She further reasoned that these services were not incidental to medical treatment because they were not part of a home healthcare program designed to treat the claimant's symptoms. In determining that the claimant's request for in home services and yard services was not a reasonably necessary medical benefit, the ALJ also credited the opinions of Dr. Olsen. In her order, the ALJ did not specifically address the claimant's objections to Dr. Olsen's opinions based on Rule 9-1. She denied and dismissed the claimant's request for in home services and yard services.

I.

On appeal, the claimant argues that the ALJ erred in relying on a prior order of the Panel in *Schwartz v. Dillon Companies*, W.C. No. 3-989-875-09 (June 5, 2017) to deny and dismiss his request for home and yard services. The claimant reasons that in *Schwartz*, the Panel erred in ignoring the controlling authority of the Court in *Bellone* and applied the wrong legal standard in addressing requests for housekeeping services. We perceive no reversible error.

Section 8-42-101(1)(a), C.R.S. provides for medical treatment necessary to cure and relieve the effects of the injury. Medical treatment involves not only improvement of the claimant's condition, but relief from symptoms including pain. *See Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999). Thus, home healthcare services, including housekeeping services, may be considered medical in nature if they relieve the symptoms and effects of the injury and are directly associated with claimant's physical needs or are incidental to medical treatment because the services were provided as part of an overall home health care program designed to treat the claimant's condition. *Bellone v. Industrial Claim Appeals Office, supra*.

The determination of whether treatment or services provided under §8-42-101, C.R.S. are reasonable and necessary is one of fact for resolution by the ALJ. *See Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999). We must uphold the ALJ's factual determinations if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. Substantial evidence is that quantum of probative evidence, which a rational fact finder would accept as adequate to support a conclusion without regard to the existence of conflicting evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995).

As pertinent here, in *Bellone and Country Squire Kennels v. Tarshis*, 899 P.2d 362 (Colo. App. 1995), different divisions of the Colorado Court of Appeals set forth differing standards relevant to home health care services. *See Valentine v. Mountain States Mut. Cas. Co*., 252 P.3d 1182, 1195 (Colo. App. 2011)(one division of the court of appeals is not bound by the decision of another division). In *Bellone*, a physician had prescribed assisted child-care to allow the claimant to attend medical appointments and to rest during the day. The respondents stipulated that they would pay any reasonable and necessary child-care expenses incurred to allow the claimant to attend authorized medical appointments but refused to pay such expenses for the purpose of allowing the claimant to rest or engage in other non-medical appointment activities. The ALJ found that the prescribed child care services were medically necessary to cure and relieve the claimant from the effects of her work-related injury and further found that she was entitled to reimbursement for child care of up to 20 hours per week. The Panel reversed. However, the Court reinstated the ALJ's order, holding that the child care services were medical in nature because they relieved the symptoms and effects of the injury and were directly associated with the claimant's physical needs. Further, the *Bellone* Court held that the child care services were incidental to medical treatment because the services were provided as part of an overall home healthcare program designed to treat the claimant's condition. Since there was supporting medical testimony demonstrating that the child-care services were to relieve the claimant of the effects of her industrial injury, the *Bellone* Court determined that child-care services were compensable to the extent necessary to allow claimant to attend medical appointments and to allow her time to rest.

Conversely, in *Tarshis*, another division of the Court of Appeals held that a claimant who has suffered an admitted work-related injury may not receive compensation for medically prescribed housecleaning services if those services are not incidental to the expense of providing reasonably necessary medical, nursing, or attendant care treatment services. The *Tarshis* Court summarized the existing case law as determining that for expenses incurred for housekeeping services to be compensable, such services must

enable the claimant to obtain medical care or treatment or, alternatively, must be relatively minor in comparison to the medical care and treatment.

Here, to the extent the claimant argues that the ALJ erred in relying on *Schwartz* to deny and dismiss his request for home and yard services, we do not agree. While it is true that the respondents cited to *Schwartz* in their position statement, the ALJ nevertheless did not cite to or rely on *Schwartz* in her order. Rather, in her order, the ALJ cited to the Court's opinion in *Bellone* and determined the claimant failed to satisfy the standard set forth in that opinion when denying and dismissing his request for home and yard services. It is apparent from the ALJ's order that she was not persuaded by either the claimant's testimony or by the opinions of Dr. Davis that the home and yard services would cure and relieve the claimant from the effects of his work injury or that they were incidental to medical treatment. She expressly found that the claimant "aggressively acquired workers' compensation benefits" and that "Dr. Davis's evolving prescription for in home services and yard services leaves question about the credibility and persuasiveness of Dr. Davis's opinion." Order at 8 ¶10. The ALJ also credited the opinion of Dr. Olsen that the claimant was able to perform the activities of daily living. Order at 8 ¶10. The ALJ's ruling essentially was based on her credibility determinations. We may not set aside the ALJ's credibility determination unless the testimony of a particular witness, although direct and unequivocal, is "so overwhelmingly rebutted by hard, certain evidence directly contrary" that a fact finder would err as a matter of law in believing the witness. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986). Consequently, the ALJ's credibility determinations are binding except in extreme circumstances. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2001). Since we perceive no extreme circumstances here, we may not disturb the ALJ's order on this ground.

We further conclude that the ALJ's order is consistent with the liberal standard set forth in *Bellone*. We do not read the ALJ's order, as suggested by the claimant, as limiting an award of attendant care only if a claimant is unable to perform activities of daily living. Rather, not only did the ALJ find that the claimant could perform his ADLs without assistance, but she also found, based on her credibility determinations, that the requested house and yard services were not reasonable and necessary to cure and relieve the claimant from the effects of his compensable injury. Tr. at 34-35. *Arenas v. Industrial Claim Appeals Office, supra*. Thus, even under the less restrictive standard articulated in *Bellone*, the ALJ's order is supported by substantial evidence and consistent with the legal standard announced there. Section 8-43-301(8), C.R.S. Additionally, to the extent the ALJ erred in finding that Dr. Olsen opined "the claimant's request for in home and yard services was not a reasonably necessary medical benefit," we conclude

such error was harmless. While Dr. Olsen did not state this in his report or offer this particular testimony during the hearing, he nevertheless testified and opined in his report that the claimant did not need assistance performing his ADLs. As explained above, the ALJ relied, in part, upon this finding in making her determination. Tr. at 35; Ex. A at 3. Section 8-43-310, C.R.S. (harmless error to be disregarded); CRE 103(a); *Mountain Meadows v. Industrial Claim Appeals Office*, 990 P.2d 1090 (Colo. App. 1999). We therefore will not disturb the ALJ's order on these grounds.

II.

Next, the claimant contends that the ALJ erred in allowing the respondents to introduce Dr. Olsen's testimony and report into evidence. The claimant argues that Dr. Olsen's testimony and report should have been precluded for lack of disclosure. As detailed above, the claimant reasons that in discovery responses, he was informed Dr. Olsen would testify consistent with his report, but his report was not produced within the 20-day deadline enunciated in Rule 9-1, and it also set forth no opinion regarding Dr. Davis' prescription for attendant services. We perceive no reversible error.

Rule 9-1 applies to discovery in workers' compensation procedures and provides in pertinent part as follows:

> (E) Discovery, other than depositions, shall be completed no later than 20 days prior to the hearing date, except for expedited hearings.
> (F) If any party fails to comply with the provisions of this rule and any action governed by it, an administrative law judge may impose sanctions upon such party pursuant to statute and rule. However, attorney fees may be imposed only for violation of a discovery order.
> (G) Once an order to compel has been issued and properly served upon the parties, failure to comply with the order to compel shall be presumed willful.

Section 8-43-207(1)(e), C.R.S. permits an ALJ to impose the sanctions provided in the rules of civil procedure for the "willful failure to comply with permitted discovery. " In order for a discovery violation to be considered "willful" the ALJ must determine that the conduct was deliberate or exhibited "either a flagrant disregard of discovery obligations or constitutes a substantial deviation from reasonable care in complying with discovery obligations." *Reed v. Industrial Claim Appeals Office*, 13 P.3d 810, 813 (Colo. App. 2000).

The ALJ has wide discretion in determining whether a discovery violation has occurred and, if so, the appropriate sanction to be imposed. See §8-43-207(1)(e) and (p), C.R.S.; C.R.C.P. 37; *Sheid v. Hewlett Packard*, 826 P.2d 396 (Colo. App. 1991). Because the ALJ's determinations in this respect are discretionary, however, we may only disturb the ALJ's order if it exceeds the bounds of reason, such as where it is wholly unsupported by the evidence or is contrary to applicable law. *See Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993).

Here, the record demonstrates that the respondents admittedly violated Rule 9-1. While Dr. Olsen was disclosed as a witness in the respondents' response to the claimant's application for hearing, the respondents failed to provide the claimant with Dr. Olsen's report or opinions no later than 20 days prior to the hearing date. However, the record also does not demonstrate that the claimant filed a motion to compel or moved to compel Dr. Olsen's report and opinions prior to the hearing. *See O'Reilly v. Physicians Mutual Insurance Co*., 992 P.2d 644 (Colo. App. 1999)(absence of a prior order compelling discovery precluded C.R.C.P. 37(b) sanctions for any alleged violation); *McCormick v. Exempla Healthcare*, W.C. No. 4-594-683 (March 25, 2013)(ALJ erred in drawing adverse inference as a discovery sanction when no order compelling discovery previously had been entered), *aff'd Exempla Healthcare v. Industrial Claim Appeals Office*, 14CA0761 (Dec. 4, 2014). Since the Court previously has held that the absence of a prior order compelling discovery precludes C.R.C.P. 37(b) sanctions, we are unable to disturb the ALJ's order on the basis she failed to impose sanctions for the untimely disclosure. Section 8-43-207(1)(e), C.R.S.

Additionally, we are unable to conclude the ALJ erred in allowing Dr. Olsen to testify regarding the claimant's ability to perform ADLs. Witness preclusion is one sanction that may be imposed for a party's failure to disclose expert testimony without substantial justification, unless the failure to disclose is harmless. *See* C.R.C.P. 37; *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988)(Colorado rules of civil procedure apply insofar as they are not inconsistent with the procedural or statutory provisions of the Act). In evaluating whether a failure to disclose is harmless, the question is whether the failure to disclose the evidence in a timely fashion will prejudice the opposing party by denying that party an adequate opportunity to defend against the evidence. *See Todd v. Bear Valley Village Apartments*, 980 P.2d 973 (Colo. 1999). Failure to disclose expert testimony is harmless if the opposing party had the opportunity for cross examination on the objected topic. *See Antolovich v. Brown Group Retail, Inc.*, 183 P.3d 582 (Colo. App. 2007).

Here, during the hearing, the claimant conducted cross-examination of Dr. Olsen regarding his opinions on ADLs. The claimant also asked Dr. Olsen whether his report contained opinions addressing home services, and Dr. Olsen responded in the negative. Further, the claimant confronted Dr. Olsen, in part, with the following evidence: numerous other doctors diagnosed the claimant with CRPS due to complications from his industrial injury; the claimant has increased pain with continued use of his right upper extremity; light touch of the claimant's hand, wrist, or right upper extremity is an aggravating factor; Dr. Olsen generally agreed if one has CRPS then use of the arm can cause a flare-up; and Dr. Davis' opinion is that the claimant suffers from CRPS and needs home and yard services. Tr. at 36-43. Moreover, the claimant did not request a continuance or the opportunity to take a post-hearing deposition to submit additional evidence to address Dr. Olsen's opinions on ADLs. *See Ortega v. Industrial Claim Appeals Office*, 207 P.3d 895 (Colo. App. 2009); *see also City of Boulder v. Dinsmore*, 902 P.2d 925, 927 (Colo. App. 1995)(in evaluating claim of denial of due process, reviewing court may balance several factors, including "substitute procedural safeguards"). Thus, based on this record, we are unable to conclude that the claimant's due process rights were violated. Consequently, we have no basis to disturb the ALJ's order on this ground.

IT IS THEREFORE ORDERED that the ALJ's order dated February 22, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Kris Sanko

John A. Steninger

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-020-939-01

IN THE MATTER OF THE CLAIM OF:

SHANE GIBSON,

Claimant,

v.

ORDER

ATLANTIC RELOCATION SYSTEMS,

Employer,

and

LIBERTY MUTUAL,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Mottram (ALJ) dated March 12, 2018, that denied their request to strike the Division-sponsored independent medical examination (DIME) and that awarded the claimant permanent partial disability (PPD) benefits based on the DIME physician's opinion. We affirm the ALJ's denial of the respondents' request to strike the DIME. However, we set aside the ALJ's award of PPD benefits and remand the matter to the ALJ to make new findings and enter a new order on the respondents' contention that they overcame the DIME opinion on permanent impairment by clear and convincing evidence.

This matter went to hearing on the respondents' request to strike the DIME based on the holding in *Harman-Bergstedt v. Loofbourrow*, 320 P.3d 327 (Colo. 2014), and whether the claimant was entitled to an award of PPD based on the 19% whole person impairment rating provided by the DIME physician, Dr. Machanic.

The ALJ found that the claimant sustained an admitted industrial injury on November 22, 2014. The claimant was taking carpet rolls off of a pyramid of carpets when he fell off the carpets to the ground. The claimant struck his head, lost consciousness, and suffered pain in his lower back.

The claimant was referred to Concentra Medical Center and Dr. Burris for treatment. The claimant was provided with work restrictions that included "no work"

when he was evaluated on November 24 and 26, 2014. The claimant remained off work until he was released to modified duty as of December 2, 2014. The claimant was limited to a four hour work shift. On December 5, 2014, the physical restrictions again limited the claimant to a four hour work shift, but his work shift was increased to six hours on December 16, 2014, with a 10 pound lifting restriction. These restrictions were kept in place through May 14, 2015, when the claimant's lifting restriction was increased to 20 pounds and he was allowed to work an eight hour shift.

While on restrictions, the claimant mostly performed desk work. The claimant did not lose any wages after his injury since he was a salaried employee and the respondent employer continued to pay his full wages.

Prior to the claimant's work injury, he had received medical treatment for his lumbar spine dating back to at least 2006. This treatment included a spinal cord stimulator implant in 2010, replacement of the stimulator in 2012, and reprogramming of the stimulator at a subsequent date.

After suffering his industrial injury, the claimant was referred for physical therapy before being referred to Dr. Ghiselli for a surgical consultation. Dr. Ghiselli noted that the claimant had segment degeneration at T12-L1 and L1-L2. Dr. Ghiselli ultimately did not recommend surgery at the time of his evaluation and instead recommended the claimant continue with physical therapy.

On April 8, 2016, after the claimant had undergone physical therapy, injections, and blocks, Dr. Burris placed the claimant at maximum medical improvement (MMI). Dr. Burris noted that the claimant continued to have back pain one-and-a-half years after his work injury, but diagnostic testing had failed to reveal any new issues. Dr. Burris opined that the claimant's current back complaints were related to his pre-existing issues. He opined the claimant had no permanent impairment as a result of the work injury.

The claimant ultimately filed a worker's claim for compensation on July 5, 2016. The respondents filed a Final Admission of Liability (FAL) admitting for $26,035.49 in medical expenses, but no temporary or permanent disability. The claimant filed a timely objection to the FAL and requested a DIME.

The claimant underwent a DIME with Dr. Machanic on August 9, 2017. Dr. Machanic opined that the claimant was at MMI as of April 8, 2016. Dr. Machanic provided the claimant with a 19% whole person impairment rating after apportionment.

He based this impairment rating off of the claimant's medical treatment, including two rhizotomies.[1]

The respondents obtained an independent medical examination with Dr. Lesnak. Dr. Lesnak opined that there was no medical evidence to support Dr. Machanic's opinion that the claimant would qualify for a 19% whole person impairment rating.

The ALJ ultimately rejected the respondents' argument that the holding in *Loofbourrow* barred the claimant from pursuing a DIME. He found that while the claimant did not suffer a wage loss, he did suffer a disability. The ALJ explained that even though the employer continued paying the claimant's full salary, the claimant nevertheless was taken off of work completely by the authorized treating physician for over a week following the initial injury and then was precluded from working his regular eight hour shift for another five months. The ALJ further reasoned that the respondents filed a FAL which triggered the claimant's time period for applying for a DIME to address the issues of MMI and permanent impairment. The ALJ ordered the respondents liable for PPD benefits based on Dr. Machanic's 19% whole person impairment rating. The ALJ, however, did not address the respondents' contention that they overcame the DIME physician's opinion on permanent impairment by clear and convincing evidence.

I.

On appeal, the respondents argue that the ALJ erred in awarding the claimant PPD benefits based on Dr. Machanic's opinion. They contend that the DIME should have been stricken as a matter of law based on the holding in *Loofbourrow*. The respondents explain that the concept of MMI does not apply in this action since the claimant did not miss more than three days of work or suffer a loss of earnings and, therefore, the right to apply for a DIME was not triggered under §8-42-107(8)(c), C.R.S. in the first place. We disagree.

In *Loofbourrow*, the claimant worked as a manager of a fast food restaurant. The claimant sustained a lower back injury while lifting and cooking chicken at the restaurant. The claimant reported the industrial injury, and her employer referred her for medical treatment. While the claimant had some work restrictions, her employer was able to accommodate those restrictions without wage loss and therefore did not report the injury to the division of workers' compensation or admit or deny liability. After receiving medical treatment, the authorized treating physician (ATP) placed the claimant at MMI.

[1] Relying on the holding in *Loofbourrow*, the respondents filed a motion to strike the claimant's DIME. Prehearing ALJ Goldstein denied the respondents' motion.

Several months later, the claimant experienced back pain and sought treatment from her private physician. Her physician recommended work restrictions, but the employer was unable to accommodate them, so the claimant sought temporary total disability (TTD) and other workers' compensation benefits.

The ALJ found the claimant's injury to be compensable and awarded TTD benefits. The ALJ concluded that she suffered a worsening of her low back condition as a natural progression of the initial injury and ordered temporary benefits. The employer appealed, and a Panel of the Industrial Claim Appeals Office affirmed in part but reversed that portion of the ALJ's order awarding TTD benefits. The Panel concluded that since the claimant reached MMI, TTD benefits could not be awarded in the absence of a DIME. The Panel also noted that the claimant's case did not involve reopening, the case was not found to be compensable until the entry of the ALJ's order, no admission of liability had ever been filed, and the ALJ failed to address reopening in his statement of issues.

On appeal, the Colorado Court of Appeals set aside the Panel's order and remanded the case with directions to reinstate the ALJ's award of TTD benefits. The Court held that where the claimant was alleging a worsening condition as distinguished from contesting the finding of MMI, where she had not been given a chance to request a DIME, and where substantial evidence supported the ALJ's determination that she had proven a worsening of her original condition, the statute requiring temporary benefits to cease upon reaching MMI was inapplicable. Instead, the Court held that the statutory scheme did not preclude the assertion of a post-MMI worsening of condition in an open claim.

The Colorado Supreme Court granted certiorari. The Court affirmed but based on different reasoning. Importantly, in its opinion, the Court noted that the sole issue before it was whether the claimant could be entitled to an award of temporary disability benefits without having challenged, by means of a DIME, the initial treating physician's assessment that she had reached MMI. The Court stated in pertinent part as follows:

> 'Maximum medical improvement,' as a statutory term of art, therefore has no applicability or significance for injuries insufficiently serious to entail disability indemnity compensation in the first place. See § 8-42-107(8)(b)(I). While the concept is defined in terms of the ineffectiveness of further medical treatment and may therefore be useful in assessing the extent to which an employer is obligated to continue furnishing medical services to an injured employee, as a statutory term of art with

> consequences for contesting a final admission of liability, reopening a closed claim, or, as in this case, filing a new claim for an injury that has become compensable for the first time, it can logically have applicability only for injuries for which disability indemnity is payable. Whether or not an employer continues to furnish medical treatment for a worker whose injury can be accommodated without the loss of work time in excess of three days--and whether or not the division finds it useful for billing and recording purposes to 'close' cases based on a determination that no further treatment is likely to improve the employee's condition, without regard to whether the injury was ever compensable. . . the statutory consequences of a finding of 'maximum medical improvement' can apply only to injuries as to which disability indemnity is payable.

Id. at 331.

Here, we reject the respondents' contention that under the holding in *Loofbourrow*, no DIME could occur in this case since the claimant did not miss more than three days of work or suffer a loss of earnings and, therefore, the right to apply for a DIME was not triggered under §8-42-107(8)(c), C.R.S. Not only is *Loofbourrow* distinguishable, but we also conclude the respondents' interpretation of the *Loofbourrow* holding is incorrect.

We agree with the ALJ that the claimant suffered a "disability" as contemplated by the temporary indemnity statutes, §§8-42-103, 8-42-105, and 8-42-106, C.R.S., despite the employer's decision to pay the claimant his full wage. *See Montoya v. Industrial Claim Appeals Office*, 2018 COA 19 (Feb. 8, 2018)(although the concept of disability incorporates both "medical incapacity" and "loss of wage earnings," a claimant need not prove both components to establish entitlement to disability benefits under the Act). The claimant's "disability" is demonstrated by his physical restrictions, which impaired his ability effectively to perform the duties of his regular job. As detailed above, the claimant was taken off work completely by the ATP for over one week following his industrial injury, and he then was placed on restrictions for another five months. Ex. N. *See Ortiz v. Charles J. Murphy & Co*., 964 P.2d 595 (Colo. App. 1998)("disability" may be evidenced by showing complete inability to work, or by physical restrictions, which impair claimant's ability effectively to perform duties of regular job). The claimant's "disability" under the temporary indemnity statutes thereby required the ATP to make a determination on MMI and impairment. Sections 8-40-201(11.5), 8-42-103, 8-42-105, and 8-42-106., C.R.S.

It is well settled that if a party wishes to challenge the ATP's MMI determination, the impairment rating, or both, the party must request a DIME in accordance with the procedures established in §8-42-107.2, C.R.S. Section 8-42-107(8)(b)(II), C.R.S.; §8-42-107(8)(c), C.R.S.; *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186, 190 (Colo. App. 2002). If we were to hold that the employer's payment of the claimant's full salary prevented a finding of "disability," then this would allow employers to defeat the DIME process merely by having wage continuation plans. *See Whiteside v. Smith*, 67 P.3d 1240, 1246 (Colo. 2003)(right to a DIME is a statutory right, denial of which violates Fourteenth Amendment of United States Constitution). Consequently, we conclude that *Loofbourrow* is distinguishable.

Additionally, our understanding of *Loofbourrow* is that it does not operate to preclude a DIME under any circumstances. *Loofbourrow* addressed the sole issue of whether the claimant could be entitled to an award of TTD benefits without having challenged, by means of a DIME, the initial treating physician's assessment that she had reached MMI when she had suffered no wage loss and had not originally filed a claim. Thus, the issue in that case was whether the claimant's claim for TTD was barred by not having first proceeded through the DIME process. The Court held that the claim was not barred for lack of the DIME process. The *Loofbourrow* Court did not state that claimants are barred from pursuing the DIME process altogether when they have not suffered more than three days of work or wage loss.

We recognize that the *Loofbourrow* Court used quite broad language in its opinion when it stated that "the statutory consequences of a finding of 'maximum medical improvement' can apply only to injuries as to which disability indemnity is payable" and that "'[m]aximum medical improvement,' as a statutory term of art, therefore has no applicability or significance for injuries insufficiently serious to entail disability indemnity compensation in the first place." *Id.* at 331. However, by taking this language out of context and reading it so broadly as to prevent a DIME here, then this would leave injured workers who have not suffered wage loss or lost time and are placed at MMI with a zero percent impairment rating without any remedy for challenging MMI or the zero percent impairment rating. This certainly was not the intent of the General Assembly when it enacted the DIME process, *see* §8-42-107(8)(c), C.R.S. ("[i]f either party disputes the authorized treating physician's finding of medical impairment, *including a finding that there is no permanent medical impairment,* the parties may select an independent medical examiner in accordance with section 8-42-107.2.")(emphasis added), nor could it have been the intent of the *Loofbourrow* Court. Such an approach would render §8-42-107(8)(c), C.R.S. ineffective, and lead to an unjust and unreasonable result. *See* §2-4-201, C.R.S. (entire statute is intended to be effective; just and reasonable

result is intended); *see Whiteside v. Smith*, *supra*. It is well settled that a "statutory scheme must be read as a whole 'to give a consistent, harmonious, and sensible effect to all its parts.'" *Franz v. Industrial Claim Appeals Office*, 250 P.3d 1284, 1287 (Colo. App. 2010)(quoting *Dillard v. Industrial Claim Appeals Office*, 121 P.3d 301, 303, *aff'd*, 134 P.3d 407 (Colo. 2006)). Thus, reading the Workers' Compensation Act as a whole, as we are required to do, we conclude that a claimant who has not suffered wage loss or lost time and is placed at MMI with a zero percent impairment rating, is entitled to request a DIME to challenge MMI and the rating. *See* §8-42-107(8)(c), C.R.S.

Additionally, as stated by the ALJ, nothing in §§8-42-107(8)(c) or 8-42-107(8)(b)(II), C.R.S. provides that the DIME process is limited to only those cases where temporary disability benefits have been paid, or those cases where the claimant has lost more than three working days due to their industrial injury. *See* §8-42-105, C.R.S. To hold otherwise would be reading non-existent provisions into the Act, which we are precluded from doing. *See Kraus v. Artcraft Sign Co*., 710 P.2d 480 (Colo. 1985)(court should not read non-existent provisions into the Act). Further, as explained above, the respondents here filed a FAL consistent with the ATP's zero percent impairment rating. Pursuant to §8-42-107.2, C.R.S., therefore, the claimant's right to request a DIME was triggered.

We recognize that the Panel has issued divergent orders on applying *Loofbourrow*. *See Kazazian v. Vail Resorts*, W.C. No. 4-915-969-03 (April 24, 2017); *Trujillo v. Elwood Staffing*, W.C. No. 4-957-118-02 (June 22, 2017); *compare Ramirez-Chavez v. In-Out Oil Field Services*, 5-019-466-01 (April 12, 2018)(footnote 3). However, as explained above, we do not view the *Loofbourrow* decision as precluding a claimant from seeking a DIME review in a case with no wage loss or no lost time. To the extent prior orders of the Panel conflict with this interpretation of *Loofbourrow*, we choose not to follow them. Also, while it was procedurally incorrect to state in footnote 3 in *Ramirez-Chavez* that the language in *Kazazian* is modified to interpret "the statute to allow the claimant to request a DIME," we nevertheless agree with this particular reasoning in *Ramirez-Chavez* that the holding in *Loofbourrow* does not preclude a claimant from seeking a DIME review in a case with no wage loss or no lost time. Accordingly, we affirm the ALJ's order to the extent it denied the respondents' request to strike the DIME.

II.

Next, the respondents argue that the ALJ erred in failing to address their alternative argument that they overcame the DIME physician's opinion on permanent impairment by clear and convincing evidence. We agree.

Section 8-42-107(8)(c), C.R.S., provides that the DIME physician's finding of medical impairment is binding unless overcome by clear and convincing evidence. "Clear and convincing" evidence has been defined as evidence which demonstrates that it is "highly probable" the DIME physician's rating is incorrect. *Qual-Med, Inc., v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). The question of whether the claimant has overcome the DIME opinion on permanent impairment by clear and convincing evidence is one of fact for the ALJ's determination. *Metro Moving & Storage Co. v. Gussert, supra*.

Further, pursuant to §8-43-301(8), C.R.S., we have authority to set aside an ALJ's order only where the findings of fact are not sufficient to permit appellate review, conflicts in the evidence are not resolved, the findings of fact are not supported by the evidence, the findings of fact do not support the order, or the award or denial of benefits is not supported by applicable law.

Here, we conclude the ALJ's order does not contain findings of fact sufficient to permit appellate review on the issue of whether the respondents overcame the DIME opinion on permanent impairment by clear and convincing evidence. In his order, the ALJ did not address the respondents' contention in this regard. We may not make findings initially. Accordingly, it is necessary to remand the matter for the ALJ to enter new findings and a new order on this issue.

IT IS THEREFORE ORDERED that the ALJ's order dated March 12, 2018, is affirmed to the extent it denied the respondents' request to strike the DIME;

IT IS FURTHER ORDERED that the ALJ's order awarding the claimant PPD benefits is set aside and the matter is remanded for new findings and a new order on the respondents' contention that the DIME physician's opinion on permanent impairment was overcome by clear and convincing evidence.

INDUSTRIAL CLAIM APPEALS PANEL

Kris Sanko

John A. Steninger

IN THE SUPREME COURT OF THE STATE OF NEVADA

IN THE MATTER OF DISCIPLINE OF JAMES W. PENGILLY, ESQ., BAR NO. 6085.

No. 74316

FILED

SEP 07 2018

ELIZABETH A. BROWN
CLERK OF SUPREME COURT
BY
CHIEF DEPUTY CLERK

ORDER OF SUSPENSION

This is an automatic review, pursuant to SCR 105(3)(b), of a Southern Nevada Disciplinary Board hearing panel's findings of fact, conclusions of law, and recommendation for discipline of attorney James W. Pengilly. After a hearing, the panel found that Pengilly violated RPC 8.4(d) (misconduct) based on his conduct during a deposition wherein he was representing himself as the defendant in a defamation lawsuit. Ultimately, the panel recommended a six-month-and-one-day suspension, fees in the amount of $2,500, and the costs associated with the disciplinary proceedings.

The misconduct involves Pengilly's behavior during a noticed plaintiff's deposition at his office. When questioning the deponent, Pengilly used vulgarities, called the deponent derogatory names, aggressively interrupted the deponent and opposing counsel, answered questions for the deponent, and repeatedly made inappropriate statements on the record. Pengilly went on to ask the deponent if he was "ready for it" while positioning his hand near his hip. The deponent briefly left the room, but when he returned Pengilly displayed a firearm he had holstered on his hip to the deponent and opposing counsel. As a result, the deposition was

terminated and the underlying defamation litigation was put on hold pursuant to an order by the discovery commissioner. The discovery commissioner also sanctioned Pengilly for his conduct.

The State Bar has the burden of showing by clear and convincing evidence that Pengilly committed the violation charged. SCR 105(2)(f); *In re Discipline of Drakulich*, 111 Nev. 1556, 1566, 908 P.2d 709, 715 (1995). We employ a deferential standard of review with respect to the hearing panel's findings of fact, SCR 105(3)(b), and will not set them aside unless they are clearly erroneous or not supported by substantial evidence. *See generally Sowers v. Forest Hills Subdivision*, 129 Nev. 99, 105, 294 P.3d 427, 432 (2013); *Ogawa v. Ogawa*, 125 Nev. 660, 668, 221 P.3d 699, 704 (2009).

Having reviewed the record on appeal, we conclude that there is substantial evidence to support the panel's findings that Pengilly violated RPC 8.4(d) (prohibiting an attorney from engaging in conduct that is prejudicial to the administration of justice). Indeed, the deposition transcript, coupled with the testimony at the formal hearing, demonstrates that Pengilly displayed appalling behavior toward the deponent. Additionally, the record is clear, and Pengilly admits, that he displayed a firearm. Accordingly, we agree with the hearing panel that Pengilly committed the violation set forth above.[1]

The panel recommends a six-month-and-one-day suspension. Pengilly asserts that a suspension is not appropriate and argues for a lesser

[1]Although the panel made findings of fact regarding other incidents between Pengilly and the deponent, the misconduct violation was based solely on Pengilly's actions at the deposition. As such, we need not address those findings or Pengilly's related arguments.

discipline. While the hearing panel's recommendation is persuasive, we are not bound by it and we review the proposed form of discipline de novo. SCR 105(3)(b); *In re Discipline of Schaefer*, 117 Nev. 496, 515, 25 P.3d 191, 204 (2001). In determining the appropriate discipline, we weigh four factors: "the duty violated, the lawyer's mental state, the potential or actual injury caused by the lawyer's misconduct, and the existence of aggravating or mitigating factors." *In re Discipline of Lerner*, 124 Nev. 1232, 1246, 197 P.3d 1067, 1077 (2008).

Pengilly violated his duty to the legal system by engaging in conduct that was prejudicial to the administration of justice. Pengilly argues that his conduct should be viewed under a negligence standard, but we agree with the panel that he acted knowingly as he was consciously aware of his conduct and knew his behavior was inappropriate. His conduct caused actual injury to the proceeding as the deposition concluded early and the discovery commissioner had to issue a protective order, causing the case to be delayed. Both the deponent and his attorney testified they were afraid Pengilly was going to shoot them, and their fears were documented: they immediately called the police, filed police reports the next day, filed for a TPO, and filed bar grievances. Further, there was the potential for serious injury to every one present—the deponent, his attorney, the court reporter, Pengilly's office staff, and even Pengilly himself—because a deadly weapon was involved. Considering the foregoing, the baseline sanction is suspension. *See* Standards for Imposing Lawyer Sanctions, *Compendium of Professional Responsibility Rules and Standards*, Standard 6.22 (Am. Bar Ass'n 2017) ("Suspension is generally appropriate when a lawyer knows that he or she is . . . caus[ing] interference or potential interference with a legal proceeding.").

Pengilly argues that the panel did not give sufficient weight or consideration to mitigating circumstances pursuant to SCR 102.5, the applicable ABA standards, and the Nevada State Bar Disciplinary Rules of Procedure (DRP), as the panel did not address any mitigating circumstances in its written recommendation. The governing rule, however, merely provides that the panel *may* consider aggravating and mitigating circumstances, it does not require it to do so. *See* SCR 102.5 ("Aggravating and mitigating circumstances may be considered in deciding what sanction to impose . . . ."). And, furthermore, although the panel did not make explicit findings regarding mitigating circumstances, Pengilly did present evidence and argument regarding relevant mitigating circumstances to the panel and the panel's recommendation expressly states that its decision is "based upon the pleadings on file, the testimony given, and the evidence admitted during the hearing." We therefore conclude that the failure to explicitly address mitigating circumstances in its final decision does not diminish the persuasive value of the panel's recommendation.

Based in part on the panel's alleged failure to consider mitigating circumstances, Pengilly argues that suspension is too harsh. Having considered all the factors, Pengilly's arguments regarding relevant mitigating circumstances, and the evidence supporting those arguments, we conclude that the panel's recommended suspension is appropriate as it is sufficient to serve the purpose of attorney discipline—to protect the public, the courts, and the legal profession. *See State Bar of Nev. v. Claiborne*, 104 Nev. 115, 213, 756 P.2d 464, 527-28 (1988). We also agree with the panel's recommendation to impose the required administrative costs and the costs of the disciplinary proceeding under SCR 120.

Accordingly, we hereby suspend attorney James W. Pengilly from the practice of law in Nevada for six months and one day, commencing from the date of this order. Pengilly is further ordered to pay administrative costs in the amount of $2,500 plus the costs associated with the disciplinary proceedings within 30 days from the date of this order. The parties shall comply with SCR 115 and SCR 121.1.[2]

It is so ORDERED.

Douglas, C.J.
Douglas

Cherry, J.
Cherry

Gibbons, J.
Gibbons

Pickering, J.
Pickering

Hardesty, J.
Hardesty

Stiglich, J.
Stiglich

cc: Chair, Southern Nevada Disciplinary Panel
Lewis Roca Rothgerber Christie LLP/Las Vegas
Lipson Neilson Cole Seltzer & Garin, P.C.
Bar Counsel, State Bar of Nevada
Kimberly K. Farmer, Executive Director, State Bar of Nevada
Perry Thompson, Admissions Office, U.S. Supreme Court

---

[2]In addition to the notices and disclosures required by SCR 121.1, the State Bar shall send a copy of this order to any other state bar wherein Pengilly is licensed to practice law.

The Honorable Ron Parraguirre, Justice, voluntarily recused himself from participation in the decision of this matter.